STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G102	A. BUILDING ____ B. WING ____	R 08/09/2011

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CLEARBROOK CENTER	3201 WEST CAMPBELL STREET ROLLING MEADOWS, IL 60008

(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 FOLLOW UP TO ANNUAL CERTIFICATION SURVEY OF 9/21/10 COMPLAINT INVESTIGATION Complaint # 1191895/IL53415-No deficiencies	{W 000}		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility's governing body failed to provide oversight and management for 3 of 10 clients in the sample (R3, R8, and R6) and 25 additional clients (R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R17, R29 and R30) when the facility failed to ensure: 1. Appropriate safeguards are in place for 3 of 10 clients in the sample (R3,R8, and R6), and 1 additional client (R12) to prevent neglect. 2. Individual rights are maintained for 3 of 10 clients in the sample (R2, R3 and R6) and 25 additional clients (R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R17, R29 and R30). 3. Allegations of abuse and neglect are thoroughly investigated and reported to the	W 102		

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.

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W 102	Continued From page 1 Administrator or other officials in accordance with State Law. 4. Specific programming is conducted as identified in the IPP (Individual Program Plan), is approved by the specially constituted committee, with consent of the client or guardian, promote growth and independence of the client, and include systemic interventions to manage inappropriate behaviors. 5. Clients placed in restraint is checked at least every 30 minutes, released from the restraint as quickly as possible and a record kept of the checks and restraint usage. 6. Health care needs include training in health and hygiene methods, medications are administered as physician orders and records of medications completed. 7. Nursing services meets the needs of clients with skin care needs and incontinence. These failures impacted 3 of 10 clients in the sample (R3, R8, and R6) and 25 additional clients (R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R17, R29 and R30). Refer to deficiencies cited under: W104 - The governing body must exercise general policy, budget, and operation direction over the facility W122 - Condition of Participation: Client Protections	W 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 102	Continued From page 2 W125 - Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. W153 - The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures W154 - The facility must have evidence that all alleged violations are thoroughly investigated W249 - As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan W262 - The facility's specially constituted committee must review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights W263 - Insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or	W 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 102	Continued From page 3 legal guardian W268 - Promote the growth, development and independence of the client W289 - The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan W301 - A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints W302 - Released from the restraint as quickly as possible W303 - A record of these checks and usage must be kept W331 - The facility must provide clients with nursing services in accordance with their needs W340 - Training clients and staff as needed in appropriate health and hygiene methods W365 - An individual medication administration record must be maintained for each client W368 - The system must assure that all drugs are administered in compliance with the physician's orders.	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		

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W 104	Continued From page 4	W 104		

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility's governing body failed to provide oversight and management for 3 of 10 clients in the sample (R3, R8, and R6) and 25 additional clients (R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R17, R29 and R30) when the facility failed to ensure:

1. Appropriate safeguards are in place for 3 of 10 clients in the sample (R3,R8, and R6), and 1 additional client (R12) to prevent neglect.

2. Individual rights are maintained for 3 of 10 clients in the sample (R2, R3 and R6) and 25 additional clients (R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R17, R29 and R30).

3. Allegations of abuse and neglect are thoroughly investigated and reported to the Administrator or other officials in accordance with State Law.

4. Specific programming is conducted as identified in the IPP (Individual Program Plan), is approved by the specially constituted committee, with consent of the client or guardian, promote growth and independence of the client, and include systemic interventions to manage inappropriate behaviors.

5. Clients placed in restraint is checked at least every 30 minutes, released from the restraint as quickly as possible and a record kept of the

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W 104	Continued From page 5 checks and restraint usage. 6. Health care needs include training in health and hygiene methods, medications are administered as physician orders and records of medications completed. 7. Nursing services meets the needs of clients with skin care needs and incontinence. These failures impacted 4 of 10 clients in the sample (R3, R8, and R6) and 25 additional clients (R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R17, R29 and R30). Refer to deficiencies cited under: W104 - The governing body must exercise general policy, budget, and operation direction over the facility W122 - Condition of Participation: Client Protections W125 - Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. W153 - The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other	W 104		

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W 104	Continued From page 6 officials in accordance with State law through established procedures W154 - The facility must have evidence that all alleged violations are thoroughly investigated W249 - As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan W262 - The facility's specially constituted committee must review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights W263 - Insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian W268 - Promote the growth, development and independence of the client W289 - The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan W301 - A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints	W 104		

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W 104	Continued From page 7 W302 - Released from the restraint as quickly as possible W303 - A record of these checks and usage must be kept W331 - The facility must provide clients with nursing services in accordance with their needs.	W 104		
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: 1) Based on interview and record review, the facility failed to implement their policy to prevent neglect for 1 of 1 client (R6) who was hospitalized and a foreign body was surgically removed from his bowel, when the facility failed to ensure: 1. Client with known behavior of PICA has sufficient safeguards and supervision to prevent injuries. 2. Client has a specific behavioral objective in place related to behaviors of PICA. 3. Client with PICA behavior is served food items which are identified as targeted items for this behavior. R6 was hospitalized on 6/18/11 with a Small Bowel Obstruction, requiring surgery, where a bezoar - determined to be plastic wrap - was removed. This resulted in an Immediate Jeopardy. Findings include:	W 122		

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W 122	Continued From page 8 On 6/24/11 at 1:30pm an Immediate Jeopardy was identified to have begun on 6/18/11 at 3pm when the facility failed to ensure R6 was provided with appropriate supervision and safeguards. The facility failed to ensure R6 is not served food items with protective wrap as identified as a targeted item or ensure a specific behavioral objective to meet R6's needs. This resulted in an Immediate Jeopardy. E1 (Administrator) was notified of the Immediate Jeopardy on 6/24/11 at 1:30pm. E1 was notified that the Immediate Jeopardy was removed on 6/28/11 at 9:45am. 2) Based on interview and record review, the facility failed to implement their policy to prevent neglect for 2 of 10 clients in the sample (R3 and R8) and 1 client outside the sample (R12) who have had multiple documented falls/probable falls with injuries. The facility failed to provide sufficient safeguards to protect clients from falls / probable falls, with a known falls history. Refer to deficiencies cited under: W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client W227 - The Individual Program Plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.	W 122		
W 125	483.420(a)(3) PROTECTION OF CLIENTS	W 125		

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W 125	Continued From page 9 RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 2 of 2 clients observed outside the sample (R18 and R19) had freedom of movement after staff locked their wheelchair brakes; and 15 of 15 clients (R1, R32, R33, R34, R2, R35, R3, R36, R37, R38, R39, R40, R41, R42 and R43) residing in Plum Hall had access to their kitchen; and 14 of 14 clients (R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R6, R17, R29 and R30) residing in Teal Hall had access to their refrigerator. Findings include: 1) R18, per review of Inspection of Care information sheet dated 6/30/11, is a 27 year old female diagnosed with Profound Mental Retardation. R19, per review of Inspection of Care information sheet dated 6/30/11, is a 52 year old male diagnosed with Profound Mental Retardation. R18 and R19 were observed on 6/21/11 at 4:43pm in the living room area in Peach Hall. At	W 125		

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W 125	Continued From page 10	W 125		

4:43pm E12 was observed to lock R18 and R19's wheelchair brakes.
Surveyor asked E12 why she locked R18 and R19's wheelchair brakes. Regarding R18, E12 stated, "That is what I usually do." Regarding R19, E12 stated, "This one will go to the bathroom and turn the water on."

R18 and R19's clinical records were reviewed and there is no documentation that staff are to lock R18 and R19's wheelchair brakes to prevent them from having freedom of movement.

2) Review of Inspection of Care information sheet dated 6/30/11, noted the following diagnoses:
R1 - Profound Mental Retardation
R32 - Profound Mental Retardation
R33 - Moderate Mental Retardation
R34 - Profound Mental Retardation
R2 - Profound Mental Retardation
R35 - Profound Mental Retardation
R3 - Profound Mental Retardation
R36 - Profound Mental Retardation
R37 - Severe Mental Retardation
R38 - Profound Mental Retardation
R39 - Profound Mental Retardation
R40 - Moderate Mental Retardation
R41 - Profound Mental Retardation
R42 - Moderate Mental Retardation
R43 - Profound Mental Retardation

On 6/21/11 at 4:35pm surveyor attempted to enter the Plum Hall dining room / kitchen. At this time the door was locked. E13 (direct care) was observed in Plum Hall and was asked why the door to the Plum Hall dining room / kitchen was locked. E13 stated, "I usually lock the doors

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W 125	Continued From page 11 behind me, they are usually locked until dinner time." As observed on 6/21/11 at 4:35pm 15 of 15 clients residing in Plum Hall did not have access to their dining room / kitchen. 3) Review of Inspection of Care information sheet, dated 6/30/11, noted the following diagnoses: R21 - Profound Mental Retardation R22 - Profound Mental Retardation R23 - Severe Mental Retardation R24 - Severe Mental Retardation R25 - Profound Mental Retardation R26 - Profound Mental Retardation R27 - Moderate Mental Retardation R28 - Profound Mental Retardation R31 - Profound Mental Retardation R15 - Severe Mental Retardation R6 - Profound Mental Retardation R17 - Profound Mental Retardation R29 - Profound Mental Retardation R30 - Severe Mental Retardation On 6/28/11 at 10:45am surveyors entered the Teal dining room / kitchen and observed a padlock on the refrigerator. E1 (Administrator) was interviewed on 6/28/11 at 10:52am. E1 stated that yesterday (6/27/11) he asked maintenance to put a lock on the refrigerator. E1 explained that they needed a place to put food that does not disappear. As observed on 6/28/11 at 10:45am 14 of 14 clients residing in Teal Hall did not have access to their refrigerator.	W 125		

{W 149} 483.420(d)(1) STAFF TREATMENT OF CLIENTS {W 149}

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:
REPEAT

1. Based on interview and record review, the facility failed to implement their policy to prevent neglect for 1 of 1 client (R6) who was hospitalized and a foreign body was surgically removed from his bowel, when the facility failed to ensure sufficient safeguards and supervision to prevent injuries are in place.

2. Based on interview and record review, the facility failed to implement their policy to ensure 1 of 1 clients outside the sample (R16) who requires a shower chair during personal care is provided the correct adaptive equipment.

3. Based on interview and record review, the facility failed to implement their policy to prevent neglect including thoroughly investigating and initiating safeguards including a system to monitor for trends and patterns for 2 of 10 clients in the sample (R3 and R8) and 1 client outside the sample (R12). R3, R8 and R12 have had multiple documented falls with injuries.

Findings include:

On 6/24/11 at 1:30pm an Immediate Jeopardy was identified to have begun on 6/18/11 at 3pm when the facility failed to ensure R6 was provided

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{W 149}	Continued From page 13	{W 149}		

with appropriate supervision and safeguards. The facility failed to implement their policy to prevent neglect. This resulted in an Immediate Jeopardy.
E1 (Administrator) was notified of the Immediate Jeopardy on 6/24/11 at 1:30pm.

1) R6, per review of his 6/9/11 to 7/8/11 POS (Physician's Order Sheet), is a 30 year old male whose diagnoses include Profound Mental Retardation, Autism and Bowel Retention Syndrome.
R6's 1/6/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies that R6 is ambulatory and essentially non-verbal.

On 6/21/11 at approximately 10am E1 (Administrator) was interviewed regarding the current census at the facility. E1 stated that 1 client was hospitalized. E1 identified that client as R6. E1 stated the reason for R6's hospitalization was a possible bowel obstruction.

R6's nursing progress notes were reviewed. On 6/18/11 at 8pm, nursing staff documented that R6 was sent to the Emergency Department due to change in mental status and dehydration. Nursing staff also documented that a nurse at the hospital stated the hospital is awaiting test results to rule out a bowel obstruction.

On 6/24/11 at 10am, E1 told surveyor that there was information to share regarding R6. E1 stated that R6 had surgery on 6/23/11 at approximately 4pm. E1 stated that when R6 was opened up, plastic was found in his colon. E1 stated that R6 must have ingested something. E1 stated that R6 has a history of PICA behavior. E1 stated that R6

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{W 149}	Continued From page 14 might eat the plastic off of a sandwich if it was given to him wrapped in plastic. The facility's policy, titled "Client Treatment Policy", dated 2/05 was reviewed. The policy includes the following: "Under no circumstances shall any abuse or neglect of a client be tolerated. All staff shall receive training regarding the rights of clients and concerning proper staff behavior when dealing with different aspects of client care. Training is included in the initial orientation and Developmental Disabilities Aide course and is also an annual training requirement for staff. Training includes such topics as neglect, respect, dignity of the client during personal care and privacy. ..." R6's nursing progress notes were reviewed. The following was documented by nursing staff: - "6/17/11 5:20p Resident was not behaving as usual (post) fun fest today. He acted very sedate. Checked to make sure he could swallow which he did. B/P (blood pressure) 101/84, P(pulse) 94, T (temp) 97.2, R (respiration)16, BS (bowel sounds) + 4. Abdomen rounded and firm. ... (on call physician notified)..." - "6/18/11 0735 Resident had a good night. Sleep was monitored throughout the night. Vital signs remain stable, still acting unusual very quiet, refused to eat dinner..." - "6/18/11 2000 Continued to monitor client VS (vital signs) 135/70, P80, R18, T97.9, BS normoactive to hypoactive. Abdomen rounded and very firm. Skin is pale, dry and cool. Eyes appear sunken in. Very lethargic, not eating. Refused breakfast, lunch, and afternoon snack, which is very uncharacteristic behavior for this	{W 149}		

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{W 149}	Continued From page 15 client. Gave the client 240ml of water, 120ml of Resource 2.0, and 500ml juice (Hab aide gave at dinner). Client had 2 wet diapers and 2 loose BM's since this morning. Paged MD on call with results. Per (physician) (telephone order): Send client to (local) hospital ED (Emergency Department) for change in mental status and dehydration. Client taken to ED via (facility) van accompanied by (facility) employee. Per (nurse) at hospital, client stable receiving IV fluids, awaiting results of CT scan of abdomen to R/O (rule out) bowel obstruction (@1730). Client admitted to hospital; spoke to nurse (at hospital) at 2020. ..." - "6/21/11 1005 Spoke with (nurse) at (local hospital). States 'R' (resident) has confirmed Dx. (diagnosis) of SBO (small bowel obstruction). ... (Nurse) also states that 'R' has unconfirmed diagnosis of pneumonia. ..." On 6/24/11 E1 provided surveyor a copy of R6's surgical report. The surgical report includes the following: On 6/23/11 an Exploratory Laparotomy with bowel resection was performed on R6. R6 was diagnosed with a Small Bowel Obstruction. A foreign body, also known as a "bezoar", was identified and removed from R6's small bowel. The foreign body is described as: "The specimen is labeled "small bowel bezoar." Received in bile stained formalin are multiple fragments of black - tan to red, plastic, membranous folded material aggregating 6.9 X 4.9 X 2.9 cm (centimeter) in aggregate. No tissue is grossly identified. Gross description only." R6's 1/6/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies the following:	{W 149}		

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{W 149}	Continued From page 16 - "(R6) needs to work on food foraging, the pace at which he consumes his food, and refraining from placing inedible objects in his mouth." - "The removal of his comforter is due to history of chewing (through) his bed mattress." R6's behavior program, implemented on 2/1/11, was reviewed. R6's behavior program notes the following: "Due to past incidents of Pica and eating his comforter and top sheet, (R6's) comforter and top sheet will be removed during non-sleep hours." E7 (QMRP) was interviewed on 6/29/11 at 10:35am. E7 confirmed that she was made aware that R6 was hospitalized on 6/18/11 and diagnosed with a small bowel obstruction. E7 stated she was also aware that R6 had surgery and a foreign object was found and removed. E7 verified that R6 currently has a behavior program that was implemented on 2/1/11. E7 stated R6's targeted maladaptive behaviors are; anxiety, agitation and insomnia. E7 was asked if R6 has an objective to address his PICA behavior - ingesting inedible items. E7 stated that R6 does not have an objective for PICA or ingestion of inedible items. E7 was asked if she was aware of R6's PICA behavior. E7 stated she was aware and that is why R6's comforter and top sheet are removed from his bed after he gets out of bed in the morning. E7 stated that in the past year R6 grabbed a sandwich that was wrapped in plastic. E7 stated she does not remember the specific details, or when the incident occurred. E7 stated the sandwich was wrapped in plastic, but she does not think that R6 ingested the plastic.	{W 149}		

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{W 149}	Continued From page 17 E7 was asked to identify R6's level of supervision. E7 stated that R6's level of supervision was a 15 minute roll call. E7 stated that staff are to check on R6 every 15 minutes. E7 stated that R6's level of supervision is every 15 minutes due to his behavior of wandering and insomnia. E7 stated that R6 does not receive any specific monitoring due to his PICA behavior. E21 (Dietary Food Service Manager) was interviewed on 6/28/11 at 10:33am. E21 was asked to describe R6's current dietary orders. E21 stated that R6 receives a mechanical soft diet with double portion of the entree and double portion of cereal at breakfast. E21 was asked if R6 receives sandwiches. E21 explained that R6 does receive sandwiches with soft meats (e.g. tuna salad ...). E21 stated that R6 does receive sandwiches that are served in a plastic bag. E21 was asked if R6 receives any food items that are packaged in other types of plastic wrap. E21 showed surveyor graham crackers and other small cookies / crackers that come pre-packaged in red and / or colored plastic material. The facility completed an investigation, dated 6/30/11, of R6's ingestion of a foreign body. The facility identifies that the majority of R6's food is wrapped in clear plastic. However, a few of the snack items are packaged in red plastic. The facility determined: "Based on this information it can be potentially concluded that (R6) consumed a snack item without removing the plastic." The facility failed to provide adequate supervision for a client (R6) with a known special need (PICA - ingesting inedible objects). The facility failed to provide adequate safeguards to ensure R6's	{W 149}		

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{W 149}	Continued From page 18 safety. The facility's failure to provide R6 with necessary supervision and safeguards resulted in R6 being hospitalized on 6/18/11. E7 (QMRP) verified, on 6/29/11 at 10:35am, that R6's supervision level was not reviewed and / or revised due to R6's PICA behavior. R6 was diagnosed with a small bowel obstruction. On 6/23/11 R6 had surgery and a foreign body was noted and removed from his small bowel. This resulted in an Immediate Jeopardy. E1 was notified that the Immediate Jeopardy was removed on 6/28/11 at 9:45am when the surveyor confirmed through interview and review of the facility plan that the facility took the following actions to remove the Immediate Jeopardy: 1. R6 will be a 1:1 aide during all waking hours. The 1:1 aide is to ensure that R6 does not have access to inedible objects that he might ingest. Staff will be inserviced regarding the importance of keeping such objects out of R6's environment. 2. All clients who demonstrate PICA behavior will have a behavior program addressing the issues and an IDT (Inter Disciplinary Team) meeting will be held to ensure appropriate strategies are in place. 3. R6's bedroom was searched for any items that could be swallowed. All items are to be removed by staff. 4. Staff will check R6's bedroom on a daily basis for any items that might be a hazard to R6. 5. The IDT will convene to discuss environmental changes, R6's medical condition, changes to R6's behavior program and R6's level of supervision. 6. Plastic bags will no longer be used to pack R6's lunch. 7. All staff at R6's residence and day program	{W 149}		

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{W 149}	Continued From page 19	{W 149}		

will be inserviced on all changes to R6's behavior program.

While the Immediate Jeopardy was removed on 6/28/11, the facility remains out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan.

2) R16, per review of Inspection of Care information sheet, dated 6/30/11, is a 51 year old male diagnosed with Profound Mental Retardation.

The facility's Incident Reports were reviewed. On 1/20/11 at 6:25pm the following incident of neglect was noted :
"(R16) was in the shower chair. After I showered him I pulled him out the shower in the shower chair and then I turned to turn off the water and by the time I turned around (R16) fell on the floor. The shower chair didn't have a belt. I thought because the shower chair was in the bathroom I though it was the one he uses. After (R16) fell, I left him on the floor to go get the staff and the nurse."

E1 (Administrator) and E4 (RSD - Residential Services Director) were interviewed on 6/23/11 at 10:40am. E1 verified that R16 fell after he was showered on 1/20/11. E1 was asked if staff were using the correct shower chair when R16 was showered. E1 stated, "Sounds like the wrong shower chair - he should have belt on at all times." E1 was asked if R16 sustained any injuries. E1 stated that R16 bumped his head and was on neuro checks for 24 hours.

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3) On 6/23/11 at 3:20pm the facility failed to provide sufficient safeguards to protect clients (R8, R12, R3) from further falls with a known history of falls.

3a) R8, per review of Physician Order Sheet dated 6/1/10-6/30/10, is a 44 year old male whose diagnoses include Mentally Retarded, Seizure Disorder, Intention Tremors, Aggressive Impulse Control Disorder, and Mood Disorder.

The Event Report involving R8 dated and timed 10/4/10 at 7:45am was reviewed. Under description it reads, "Client was noted to be bleeding from a 3 inch laceration located above his left ear. Upon examining the client, he was noted to have blood underneath his fingernails. Client was transported to ER for sutures." Under comment, it reads, "R8 has dermatitis on his scalp and a history of scratching his head, causing bleeding. The nursing notes dated 10/4/10 regarding R8 were reviewed. It reads, but is not limited to, "...Res has 3 inch laceration to upper lt(left) ear. Profusely bleeding. Res very uncooperative...to ER for eval...Rec'd(received) 2 staples behind Lt ear to scalp laceration...Staples intact, clean and dry."

The Interim Staffing/IDT (Interdisciplinary Team)/CST Meeting involving R8 dated 10/15/10 was reviewed. Under reason for staffing, it reads, "Recent incidents, use of wheelchair." Under Medical, it reads, "Recent incident where he was found with blood behind ear, needed staples. Not sure if it was a fall or he scratched himself. Pretty sure he gouged the wound." Under Physical/Occupational/Speech Therapies, it reads, "Recent order to use wheelchair, parents

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{W 149}	Continued From page 21 aren't complying fully. Reiterate importance of wheelchair use for staff @(at) commons." Under recommendations by IDT, it reads, "In-service staff regarding if R8 can not be 1:1 assisted when walking, he should be in wheelchair long distances; @ commons should be in wheelchair, unless 1:1 provided when walking." The Event Report involving R8 dated and timed 10/23/10 at 9:30am was reviewed. Under description, it reads, "Client was noted to have bleeding to back of his head from a 3 cm (centimeter) laceration. Client was transported to ER and returned with 3 sutures." The Investigation Report involving R8 dated 10/28/10 was reviewed. Under Conclusion/Summary, it reads, "Based on information above(investigation report), it is unknown at this time how R8 sustained the laceration to the back of his head. He was not noted to have any falls or strike his head against any objects." Under action to be taken, it reads, "The nursing department and staff will continue to monitor R8 for self-injurious behavior. If R8 continues to engage in self-injurious behavior, an IDT will be held with the behavior department." The Event Report involving R8, dated and timed 11/1/10 at 8:15am was reviewed. Under description, it reads, "Client noted to be sitting on the floor of kitchen." The Investigation Report involving R8, dated 11/8/10 was reviewed. Under Conclusion/Summary, it reads, "Based on the information above, it is likely that R8 attempted to stand up from the chair he was sitting in, and lost his balance, causing him to sit on the floor." The Interim Staffing/IDT Meeting/CST Meeting involving R8, dated 11/12/10 was reviewed.	{W 149}		

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{W 149}	Continued From page 22 Under Reason for Interim Staffing, it reads, "New additions/changes to Behavior program." Under Physical/Occupational/Speech Therapies, it reads, "Will initiate Bed Alarm for recent falls and non-compliance with staying in bed." The nursing notes involving R8, dated and timed 2/26/11 at 7:35am was reviewed. It reads, "Res was found lying on the floor by the nurses station in front of the refrigerator. On assessment, no injuries were noted at the moment. Upper and lower extremities ROM(range of motion) WNL(within normal limits)." No incident report was available from the facility for this incident. The Interim Staffing/IDT Meeting/CST Meeting involving R8 dated 2/28/11 was reviewed. Under reason for Interim staffing, it reads, "R8's new behavior plan, removal of door alarm." Under Recommendations by IDT, it reads, "Bed alarm is more to prevent falls and door alarm is to alert others that R8 is out of his room, due to a history of ISB(Injurious Self Behavior). The Activity Assessment, dated 2/3/11, was reviewed. Under Precautions / Restrictions for Out of House Activities, it reads, "He (R8) may wander from group. Needs someone to walk with him at all times. His balance is not very good. Need to watch him around small children." The nursing notes involving R8 dated and timed 3/25/11 at 8:00am were reviewed. It reads, but is not limited to, "..trying to walk resident back to his room. Resident walking too fast. He then accidently fell on his left side of the body. Resident didn't hit his head....No injuries noted at the time of assessment." No incident was presented to this surveyor by the facility for this	{W 149}		

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{W 149}	Continued From page 23 witnessed fall. The nursing notes involving R8 dated and timed 4/9/11 at 8:40pm was reviewed. It reads, "Left message for mother to inform her that R8 became angry and threw his glasses. R8 stood up, and fell on his buttocks. No injury noted." The Event Report involving R8 dated and timed 8:15pm was reviewed. Under what did the client do, under comment, it reads, "Client threw glasses across room, and fell after picking them up." The Event Report involving R8 dated and timed 5/5/11 at 8:18am, was reviewed. Under description, it reads, "Client dropped to the ground, and struck head, causing bleeding. Client was transported to ER for evaluation and returned with sutures." No IDT was conducted after this last fall. During an interview with E4 (Residential Services Director) on 6/23/11 at 10:00am, E4 was asked about the incident on 10/4/10 involving R8. E4 stated that R8 received 2 staples for a 3 inch laceration above his left ear. E4 stated that the injury was self inflicted, because R8 has a dermatitis issue, and chronically scratches his head vigorously. This surveyor asked if R8 could have just been touching the wound after a fall, because it hurt, and that is how he obtained the blood under his finger nails. E4 stated that was possible. E4 stated that they as a facility should have been doing more for his scalp issues, since it does not seem to be improving, although R8 is followed by a dermatologist, and uses creams topically to his scalp.	{W 149}		

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{W 149}	Continued From page 24 The interview continued with E4 on 6/23/11 at this same time. E4 stated that R8 does have a bed alarm, but no alarm on his wheelchair. E4 verified that if R8 were to get up on his own, while in his bedroom, they could not prevent him from falling, since he is not a 1 to 1, and is only on 15 minute checks. E4 stated that there was a recent order for a wheelchair, because R8 has had an ongoing pattern of falling, but the parents were reluctant to place R8 in the wheelchair. E4 stated that with his fall on 2/26/11, R8 was found lying on the floor by the nurses station. E4 stated that she was out on leave at this time, but that there was no IDT meeting held after this fall. E4 stated that on 3/25/11, staff was trying to walk with the resident, but R8 was walking too fast, and accidently fell on the left side of his body. E4 stated that there was no incident completed, because it was witnessed. E4 also confirmed that no investigation was completed after this fall, and therefore, she could not be sure how staff was holding R8 when he fell. E4 stated that for the 5/5/11 incident, R8 fell in the hallway; R8 pulled away from the staff assisting him, and flopped to the ground. E4 stated that staff was holding him with one hand under his arm pit, and the other hand on R8's forearm. E4 stated that staff does not use a gait belt for ambulation. E4 stated that since this fall was more behavioral in nature, that they did not conduct an IDT meeting after this fall. During an interview with E3 (Assistant Director of Nursing) on 6/23/11 at 12:15pm, E3 confirmed that R8's physician did write an order to use a wheelchair for safety back on 5/21/10. E3 stated that R8's family did not want R8 to be in a wheelchair all the time. E3 stated that they held	{W 149}		

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{W 149}	Continued From page 25 an IDT meeting, and after discussion, contacted the physician, and he changed the order on 5/24/10 to ambulation with staff, and wheelchair for long distances. This interview continued at the same time and date with E4. E4 stated that they have only started tracking falls 3-4 months ago. E4 confirmed that R8 has a history of falls, preceding 10/4/10. E4 stated that R8 fell back on 5/12/10, and fell at his home in his living room on 8/7/10. E4 stated that there was another fall on 9/16/10 when he was walking with a hab aid, and their legs became tangled up with each other, and R8 was guided to the floor by the hab aid. This surveyor asked if there has been any update by Physical Therapy, with all of R8's falls. E4 stated that she is not sure if an addendum has been done by therapy, but that she would ask R8's Qualified Mental Retardation Professional, E6. During an interview with E6 on 6/23/11 at 1:00pm, E6 was asked if a Physical Therapy addendum or new assessment had been completed since R8's pattern of increasing falls. E6 stated that the physical therapist never completed the addendum. E6 stated that the referral for a new physical therapy assessment was obtained 5/26/10, and that she put the referral in on 6/11/10, and again on 10/8/10. E6 stated that it was her responsibility to continue to follow through, and ensure that a new physical therapy evaluation was actually completed. The document entitled In-Service, dated 5/24/10 regarding R8-Assistance with walking, reads, but is not limited to, "Due to R8's recent falls and continuing unsteady gait, we would like to remind staff that R8 should not be walking without	{W 149}		

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{W 149}	Continued From page 26 physical assistance from staff. Staff should be walking R8 at ALL times. If R8 is sleepy or sleeping, staff should try to avoid leaving R8 unattended for long periods of time." A second In-Service dated 12/16/10, untitled was reviewed. It reads, but is not limited to, "Due to R8's recent falls, we are putting a bed alarm in place. The alarm is a flat panel placed under R8's bed sheets....If at any time during the night, R8 get's up from his bed, the alarm will sound, and the pager will start making noise to notify staff. At this time staff should go to R8's room to check on him, and assist him in any way." R8's Individual Support Plan dated 2/3/11 was reviewed. Under level of supervision it reads, "R8 requires 15-minute role call checks while at the facility." Under Special provisions needed for Safety and Security, it reads, "R8 should be escorted when walking up and down stairs and should not be left alone when walking or in the bathroom." Under PT(Physical Therapy), it reads, but is not limited to, "R8 was re-evaluated on 6/23/09. At this time, R8 will be d/cd from PT services due to inconsistency with the application of AFO's." No further PT assessment was documented in R8's medical chart, since his increase in pattern of falls. The facility neglected to ensure R8's safety was secured with his increased pattern of probably falls since October of 2010 to the current date, resulting in 3 different injuries requiring a trip to the Emergency Room, requiring either sutures or staples. R8 had a total of 10 falls / probable falls / unknown injuries from May of 2010 through May of 2011. A bed alarm has been added, but no Physical therapy evaluation has been completed	{W 149}		

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{W 149}	Continued From page 27 since the increase in falls. Without the guidance of Physical therapy, no recommendations were recommended regarding the use of possibly a gait belt, walker, or any other assistive device. R8 is on 15 minute checks during the day, and 30 minute checks at night time. R8 is not under constant supervision during the other times of the day, allowing for the potential for R8 to ambulate unassisted, and possibly lose his balance and fall. The facility failed to provide sufficient safeguards to protect clients from falls, for clients with a known history of falling. 3b) R12, per review of Physician Order Sheet dated 7/9/11-8/7/11, is a 71 year old male whose diagnoses include Mental Retardation, Contracture of Right Hip, Degenerative Right Hip Joint, and Osteoporosis. Per review of Event Report involving R12 dated and timed 12/8/10 at 7:28pm, under description, it reads, "R12 was noted to be on the floor of his room with blood on his fingers. Upon nursing assessment, R12 was found to have a laceration to his right frontal lobe. R12 was transported to ER and returned with staples to the injured area." Per review of Investigation Report dated 12/15/10, regarding R12, under Conclusion/Summary, it reads, "Based on the information above, it is likely that R12 was attempting to access his closet, and fell out of his wheelchair, causing the laceration to his head. R12 was noted to be on the ground next to his closet with the doors open, and the seatbelt to his wheelchair unbuckled." Under Actions to be taken, it reads, "A seatbelt alarm will be	{W 149}		

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{W 149}	Continued From page 28 requested for R12's chair so that staff are notified if R12 attempts to unfasten his seatbelt, and move from his wheelchair without assistance." The Post Fall Assessment involving R12, dated 12/8/10 was reviewed. Under suggested response plan, it reads, "Client will receive a chair alarm for his wheelchair. Monitored by staff with toileting and showering. Assist with ADL's(Activities of Daily Living). The Notice of Rights Restriction dated 12/14/10 involving R12 was reviewed. It reads, but is not limited to, "To have R12 have a seat belt alarm on his wheelchair as a safety precaution. R12 has a tendency to release his seatbelt which has led to him having a fall where he struck his head, causing him to need sutures." The Injury Report involving R12 dated and timed 2/5/11 at 4:15pm was reviewed. Under description, it reads, "Client was observed lying on his back on the floor next to his bed, between his w/c and bed. Head to toe body check completed, no injury was noted." The Investigation Report involving R12 dated 2/12/11 was reviewed. Under Conclusion/Summary, it reads, but is not limited to,"...It can be potentially concluded that R12 fell while attempting to get in or out of bed. Facility nurses assessed R12 for injury and no injury was noted." Under Actions to be taken, it reads, "R12 will have an IDT meeting." The Post Fall Assessment dated 2/5/11 involving R12 was reviewed. Under Suggested Response Plan, it reads, "Continued monitoring by staff, assistance with all ADL's (Activities of Daily Living), and use of chair alarm." The Interim Staffing/IDT Meeting/CST Meeting involving R12 dated 2/9/11 was reviewed. Under	{W 149}		

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{W 149}	Continued From page 29 Recommendations by IDT, it reads but is not limited to, "...continue to have wheelchair alarm. Staff will monitor R12 as informed per roll call. Staff will be informed how to use wheelchair alarm. Nurse will be informed of any falls. R12 will have matting placed in room by bed for safety." The Event Report involving R12 dated and timed 3/11/11 at 9:30pm was reviewed. Under Description, it reads, "As staff was checking on clients, staff observed the client lying on the floor next to his bed. Staff informed the nurse who performed a body check to see if the client had any injuries. The client did not have any injuries." Under Final Disposition, it reads, "R12 has had increasing difficulties transferring from his wheelchair to bed, and bed to wheelchair independently as he has gotten older and less mobile due to arthritis. An IDT was held to put in place a seat belt alarm to alert staff if R12 is attempting to transfer from his wheelchair without staff assistance. R12 currently has a low bed and to prevent injuries from attempting to transfer out of his bed without assistance, a padded mat will be placed next to his bed at night." The Interim Staffing/IDT Meeting/CST Meeting dated 3/22/11 involving R12 was reviewed. Under reason for staffing, it reads, but is not limited to, "to discuss concerns about if lift should be used during transfers." Under recommendations by IDT, it reads, but is not limited to, "R12 may use the lift if tolerated. R12 must be secured safely in the lift, and could be assisted by two staff if needed." The attendance sheet for this staffing notes the signatures of E7 and E19 (Behavioral Specialist), but no Physical Therapist is noted on the	{W 149}		

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{W 149}	Continued From page 30 attendance sheet for their guidance or input.	{W 149}		

Continued From page 30
attendance sheet for their guidance or input.

The Nursing notes involving R12 dated and timed 4/14/11 at 7:30pm was reviewed. It reads, but is not limited to, "Resident was found on the floor. On assessment, an abrasion was noted to left side of the forehead. Res is alert and responsive...Will continue to monitor." No incident report was presented by facility for this fall occurrence.

The Event Report involving R12 dated and timed 4/24/11 at 5:15pm was reviewed. Under Description, it reads, "Client's belt alarm was heard. Staff entered the room, and noted there to be blood on the floor, and R12 lying on the floor next to his wheelchair. Nursing assessment noted a laceration to the frontal region."

During an interview with E4 (Residential Services Director) on 6/29/11 at 12:25pm, E4 stated that R12 received 5 sutures to the head for his 3 cm (centimeter) laceration to his right frontal area on 12/8/10. E4 confirmed that R12 fell a total of 5 times from December of 2010 through April of 2011.
E7 (Qualified Mental Retardation Professional) joined the interview at 12:50pm. E7 was asked what type of safety precautions were put into place since his pattern of falling increased in December of 2010. E7 stated that she was told to get an alarm for R12's wheelchair. E7 stated that she ordered the alarm on December 8th, but it took until the 14th before they received the alarm in the mail. E7 confirmed that from the 8th through the 14th, no other precautions were put into place to prevent R12 from falling. E7 stated that she knows they held an IDT meeting after

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R12 fell in February. E7 stated she knows they placed a mat on the floor next to R12's bed. E7 was asked if Physical Therapy re-evaluated R12 to see if he was a candidate for therapy, or possible recommendations for a gait belt, walker, etc. E7 stated that she did not think Physical Therapy re-evaluated R12 for possible safety measures.

R12's Physical Therapy Evaluation was reviewed. The last evaluation date is noted as 4/23/07. R12's Individual Service Plan dated 11/16/10 was reviewed. R12's level of supervision is noted as constant supervision with personal care.

The facility neglected to implement the appropriate safeguards to prevent R12 from falling, when R12 began an increased pattern of falls, starting in December of 2010 through April of 2011.

3c) R3, per review of Physician Order Sheet dated 7/10/11-8/7/11, is a 71 year old male whose diagnoses include Mild Mental Retardation, Congenital Deformity of Right hand, and Chronic Bronchitis.

While reviewing the nursing notes for R3, it was documented that R3 fell nine times since January of 2011 on the following dates: 1/25/11, 1/28/11, 3/5/11, 4/16/11, 4/30/11, 5/13/11, 5/20/11, 5/27/11, and 6/29/11.
On 1/25/11 at 1600, nursing notes state, "went into room and found him (R3) seated on the floor in the bathroom. No apparent injuries."
1/28/11 at 4:30pm-"Resident noted on his knees, hands over his w/c(wheelchair) on the floor. Nurse addressed pt.(patient). No injuries."

{W 149} Continued From page 32 {W 149}

3/5/11 at 1:20am.-"Resident fell out of his w/c sat. on his buttocks in the hallway. Witnessed by staff. Assessment done, no injuries."
4/16/11 at 1:45pm- "Client in w/c during a fire drill outside-slipped forward onto knees going over a crack in the sidewalk. Small abrasion on R (right) knee."
4/30/11 at 12:45am-"Found on floor in room by staff-client stated that he fell after going to bathroom. No injuries noted."
5/13/11 at 3:30pm-"While in bathroom-pt found on floor shouting, "I fell." Pt stated he hit his head on the door, and pointed to the left side of his head. Only injury noted at this time is small abrasion to L(left) elbow- 1 cm in length."
5/20/11 at 8:00am-"Resident was noted with 13 cm long and 3 cm wide abrasion on r side lower back. Pt said it was due to a fall."
5/27/11 at 10:00pm-"Pt found on floor in bedroom by closet, on knees. Stated he fell...Right hand noted to have <(less than) 0.2 cm abrasion c(with) small amt of bleeding."
6/29/11 at 2:45pm-"Pt brought down from day program for reported fall while waiting to use the bathroom. Body check done. No injuries at this time. Per staff, may have tripped over another wheelchair's foot rest. Staff said that fall was unwitnessed, and pt quickly got himself back into his w/c."

R3's Individual Support Plan dated 7/29/10 was reviewed. Under Level of supervision, it reads, "R3 is currently on a 30 minute roll call check. R3 can ambulate independently."
Under Special provisions needed for safety and security, it reads, "R3 needs intermittent supervision when toileting and showering. Additionally, due to frequency of falls, R3 needs

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to be reminded of safety precautions."
Under Physical Therapy consultation completed on 7/13/10, it reads, but is not limited to, "Recommendations include: ensure proper shoe fitness, avoid oversized pants, provide close supervision whenever ambulating due to impulsiveness, monitor O2 saturation, allow use of wheelchair for periods of the day following falls."
Under areas that I need to work on, it reads, "Ways of coping with his anxiety, compulsions, and safety when ambulating."

During an interview with E4 (Residential Services Director) on 6/30/11 at 11:00am, E4 stated that of the above incidents of falls involving R3, only 3/5/11, 4/16/11, 4/30/11, and 5/20/11 have incident reports. E4 stated that she could not find incident reports on the other five incidents of falls.

During an interview with E14 (Qualified Mental Retardation Professional) on 6/30/11 at 11:30am, E14 was asked what safeguards were put into place to prevent R3 from sustaining future falls. E14 stated that she just started in November of 2010. E14 stated that she was out on leave for the month of June, 2011. E14 confirmed that R3 does have a wheelchair seat belt, and is capable of unfastening it by himself. E14 stated that he does not have an alarm for his wheelchair. E14 stated that right now he is totally in the wheelchair, for all mobility needs, but can get up by himself if he has staff assistance. E14 confirmed that R3 is still on 30 minute checks with his level of supervision.

The Interim Staffing/IDT Meeting/CST Meeting involving R3 dated 6/16/11 was reviewed. Under

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{W 149}	Continued From page 34 Residential, it reads, "R3 is in a wheelchair during all waking hours. He is able to transfer only with staff assistance/observation." Under Recommendations by IDT, it reads, but is not limited to, "The IDT will meet again and will discuss the appropriateness of a 15 minute roll call, if R3 falls again. A toileting schedule will be implemented for R3 to eliminate his falls and to better assist him with his everyday needs." During an interview with E1 (Administrator) on 6/30/11 at 10:30am, E1 was asked what process they have in place to prevent clients who are at risk for falls, from sustaining future falls, after they have demonstrated a known history/pattern of falling. E1 stated that of these three clients, R8, R12, and R3, they all have similarities. E1 stated that all three clients are losing their abilities to walk independently. E1 stated that they are trying alarms on wheelchairs, but that much of the time, the falls are occurring at night, when no staff are around. E1 stated that it is an issue that they are struggling with. E1 confirmed that they have called in Physical Therapy in the past for guidance/assistance, but that they have not been very helpful.	{W 149}		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	W 153		

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W 153	Continued From page 35 Based on interview and record review, the facility failed to ensure that an allegation of potential neglect was immediately reported to the Administrator and to IDPH (Illinois Department of Public Health) for 1 of 1 client in the sample (R6) who consumed another clients' medication. Findings include: R6, per review of his 6/9/11 to 7/8/11 POS (Physician's Order Sheet), is a 30 year old male whose diagnoses include Profound Mental Retardation, Autism and Bowel Retention Syndrome. R6's 1/6/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies that R6 is ambulatory and essentially non-verbal. R6's nursing progress notes were reviewed and the following entry was made by E18 (nurse): "6/27/11 Late entry - On 6/13/11 client (R6) consumed medication belonging to another resident. No injury or changes in condition noted upon assessment. (Physician) notified and states medication ingested will not harm client. Will continue to monitor. Vitals - BP (blood pressure)128/78, P(pulse) 68, R(Respirations) 20, T(Temperature) 97.7. Supervisor made aware and Guardian notified." On 6/28/11 E1 (Administrator) was interviewed at 10:30am. E1 was asked if he had any further information about R6 "consuming" another resident's medication on 6/13/11. E1 stated, "That's the first I've heard of it." On 6/28/11 E2 provided a medication error incident report. The report is dated 6/13/11 and the explanation of the medication error is, "Client	W 153		

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ate another's client food containing medication." The medication that R6 consumed includes: Synthroid 75mcg, Loratadine 10mg and a Multivitamin.

E1 and E2 were interviewed on 6/28/11 at 1:38pm. E1 stated that R6 consumed 3 medications that are prescribed for R17.

E1 was interviewed on 6/28/11 at 1:38pm. E1 verified he was not made aware of this incident of potential neglect until 6/28/11. E1 verified the incident occurred on 6/13/11.
E1 also verified that IDPH was not notified of the 6/13/11 incident of potential neglect of R6. E1 stated that IDPH should have been notified.

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483.420(d)(3) STAFF TREATMENT OF CLIENTS

The facility must have evidence that all alleged violations are thoroughly investigated.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that an allegation of potential neglect was investigated for 1 of 1 client in the sample (R6) who consumed another clients' medication.

Findings include:

R6, per review of his 6/9/11 to 7/8/11 POS (Physician's Order Sheet), is a 30 year old male whose diagnoses include Profound Mental Retardation, Autism and Bowel Retention Syndrome.
R6's 1/6/11 IPP (Individual Program Plan) was

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reviewed. R6's IPP identifies that R6 is ambulatory and essentially non-verbal.

R6's nursing progress notes were reviewed and the following entry was made by E18 (nurse): "6/27/11 Late entry - On 6/13/11 client (R6) consumed medication belonging to another resident. No injury or changes in condition noted upon assessment. (Physician) notified and states medication ingested will not harm client. Will continue to monitor. Vitals - BP (Blood Pressure)128/78, P (Pulse)68, R(Respirations) 20, T (Temperature) 97.7. Supervisor made aware and Guardian notified."

On 6/28/11 E1 (Administrator) was interviewed at 10:30am. E1 was asked if he had any further information about R6 "consuming" another resident's medication on 6/13/11. E1 stated, "That's the first I've heard of it."
On 6/28/11 E2 provided a medication error incident report. The report is dated 6/13/11 and the explanation of the medication error is, "Client ate another's client food containing medication." The medication that R6 consumed includes: Synthroid 75mcg, Loratadine 10mg and a Multivitamin.

E1 and E2 were interviewed on 6/28/11 at 1:38pm. E1 stated that R6 consumed 3 medications that are prescribed for R17.

E1 and E2 were interviewed on 6/28/11 at 1:38pm. E1 and E2 were asked if the facility completed an investigation of this incident of potential neglect. E2 stated that she was going to get a written statement from E18 (nurse).

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W 154	Continued From page 38 E1 was again interviewed on 6/30/11 at 2:30pm. E1 verified the facility has not yet investigated the incident of potential neglect of R6.	W 154		
{W 227}	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: REPEAT Based on interview and record review, the facility failed to ensure objectives necessary to meet the client's needs were developed for - 1. 1 of 1 client (R6) with a known history of PICA behavior and; 2. 1 of 1 client (R1) with a history of pulling out her G-tube (Gastrostomy tube) Findings include: 1) R6, per review of his 6/9/11 to 7/8/11 POS (Physician's Order Sheet), is a 30 year old male whose diagnoses include Profound Mental Retardation, Autism and Bowel Retention Syndrome. R6's 1/6/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies that R6 is ambulatory and essentially non-verbal. On 6/21/11 at approximately 10am E1 (Administrator) was interviewed regarding the current census at the facility. E1 stated that 1 client was hospitalized. E1 identified that client	{W 227}		

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as R6. E1 stated the reason for R6's hospitalization was a possible Bowel Obstruction.

R6's nursing progress notes were reviewed. On 6/18/11 at 8pm, nursing staff documented that R6 was sent to the Emergency Department due to change in mental status and dehydration. Nursing staff also documented that a nurse at the hospital stated the hospital is awaiting test results to rule out a bowel obstruction.

On 6/24/11 at 10am, E1 told surveyor that there was information to share regarding R6. E1 stated that R6 had surgery on 6/23/11 at approximately 4pm. E1 stated that when R6 was opened up, plastic was found in his colon. E1 stated that R6 must have ingested something.

On 6/24/11 E1 provided surveyor a copy of R6's surgical report. The surgical report includes the following:
On 6/23/11 an Exploratory Laparotomy with Bowel Resection was performed on R6. R6 was diagnosed with a Small Bowel Obstruction.
A foreign body, also known as a "bezoar", was identified and removed from R6's small bowel. The foreign body is described as: "The specimen is labeled "small bowel bezoar." Received in bile stained formalin are multiple fragments of black - tan to red, plastic, membranous folded material aggregating 6.9 X 4.9 X 2.9 cm (centimeter) in aggregate. No tissue is grossly identified. Gross description only."

E1 stated, on 6/24/11 at 10am, that R6 has a history of PICA behavior. E1 also stated that R6 has mouthing behaviors - he chews on towels. E1 stated that R6 would eat the plastic off of a

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sandwich if it was given to him wrapped.

R6's 1/6/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies the following:
- "(R6) needs to work on food foraging, the pace at which he consumes his food, and refraining from placing inedible objects in his mouth."
- "The removal of his comforter is due to history of chewing threw his bed mattress."

R6's monthly QMRP program progress notes, dated 5/20/11 were reviewed. There is no documentation that R6 has an objective to address his PICA behavior.

R6's behavior program, implemented on 2/1/11, was reviewed. R6's behavior program notes the following:
"Due to past incidents of Pica and eating his comforter and top sheet, (R6's) comforter and top sheet will be removed during non-sleep hours."

E7 (QMRP) was interviewed on 6/29/11 at 10:35am. E7 confirmed that she was made aware that R6 was hospitalized on 6/18/11 and diagnosed with a Small Bowel Obstruction. E7 stated she was also aware that R6 had surgery and a foreign object was found and removed.
E7 verified that R6 currently has a behavior program that was implemented on 2/1/11. E7 stated R6's targeted maladaptive behaviors are; anxiety, agitation and insomnia.
E7 was asked if R6 has an objective to address his PICA behavior - ingesting inedible items. E7 stated that R6 does not have an objective for PICA or ingestion of inedible items.
E7 was asked if she was aware of R6's PICA behavior. E7 stated she was aware and that is why R6's comforter and top sheet are removed

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{W 227}	Continued From page 41	{W 227}		

from his bed after he gets out of bed in the morning.
E7 stated that in the past year R6 grabbed a sandwich that was wrapped in plastic. E7 stated she does not remember the specific details, or when the incident occurred. E7 stated the sandwich was wrapped in plastic, but she does not think that R6 ingested the plastic.

2) R1, per review of her 2/1/11 IPP (Individual Program Plan), is a 37 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy and Diabetes Insipidus.
R1, observed on 6/21/11 at 5:15pm, is non-ambulatory. R1 can verbalize a few words / short sentences.

The facility's Incident Reports were reviewed and on the following dates R1 pulled out her G-tube (Gastrostomy Tube) and was transported to the hospital for reinsertion of her G-tube:
- 6/3/11
- 1/22/11
- 11/27/10
- 10/22/10

E4 (RSD - Residential Services Director) documented, per 6/3/11 Incident Report, the following:
"It was reported by the nurse on duty at (R1's) day program that (R1) had pulled out her G-Tube during lunch." ..."(R1) has a history of pulling out her G-tube while in the shower or being fed, often laughing or stating, "I get to go out now.". (R1) wears a binder over the G-tube area to prevent her from pulling it out that must be removed for proper showering and feeding. This behavior appears to be attention seeking so that (R1) can

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{W 227}	Continued From page 42 go to the hospital." E14 (QMRP) was interviewed on 6/29/11 at 10:20am. E14 was asked how often R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder 24 hours a day except during bathing. E14 was asked why R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder, "So she won't pull out her G-tube." E14 was asked if R1's use of the abdominal binder is incorporated into her IPP. E14 stated that R1 does not have an objective or behavior plan to address the use of the abdominal binder.	{W 227}		
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: REPEAT Based on record review, observation, and interview, the facility failed to: 1. Implement a feeding program for 1 of 1 client observed with a known behavior of stealing food (R11), 2. Provide continuous active treatment for 7 of 13	{W 249}		

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clients observed in the facility's day training program (R1, R19, R31, R44, R45, R46, R47).

Findings include:

1) R11, per review of the Behavior Program dated 7/1/11, is a 31 year old male whose diagnoses include Profound Mental Retardation, Tourette's Disorder, Stereotypic Movement Disorder, Down's Syndrome, and Visual Loss.

R48, per review of Inspection of Care Record dated 6/30/11, is a 48 year old male whose diagnoses include Severe Mental Retardation and Cerebral Palsy.

R11 was observed in the Red Hall dining room on the morning of 6/22/11 from 6:45am through 8:30am. At 7:30am, R11 was observed seated at a table next to R48. R11 reached over to R48's plate with his spoon, and scooped a spoonful of R48's hot cereal off of his plate, and ate it. R11 continued to eat cereal off of R48's plate for a total of three times, without any staff monitoring or re-direction. This surveyor told E8(Direct Care Staff) that R11 had stole food directly off of R48's plate. E8 said he was not watching closely, and was not aware that R11 was eating from R48's plate. E8 stated that he will just move R11 away from R48, so that he could not reach R48's plate, to prevent him from stealing more food from R48. E8 did not bring R48 a new plate of food to eat, even though R11 ate directly off of R48's plate three times with his spoon.

During an interview with E8 on 6/22/11 at 8:20am, E8 was asked if R11 has a behavior of stealing food from other clients. E8 stated that R11 does

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steal food from time to time. E8 stated that when R11 steals food from other clients, he moves R11 away from that client, and sits between them so they can be separated. E8 stated that he could bring R11 into the second seating for breakfast, if he thought R11 would do better because it is a quieter seating with fewer clients who eat at that time.

R11's Behavior Plan dated 7/1/11 was reviewed. R11 has a behavior plan for Inappropriate Social Behavior. The methodology reads that any time R11 is observed stealing food, his behavior should be blocked, and R11 should be directed away from the area. A special note was added that dishes should be cleaned and/or plasticware should be disposed of. It also notes that whenever possible, R11 should be the last one in the kitchen for meals to help deter him from the behavior of stealing food.

During an interview with E6 (Qualified Mental Retardation Professional) on 6/28/11 at 11:40am, E6 was asked what staff should do when R11 steals food from other clients. E6 stated that the best thing for direct care staff is to position R11 at a space of his own. E6 explained that even though it would work better for R11 to be at the second seating because it is quieter, it is difficult, because R11 wants to eat during the first seating. E6 explained that R11 has a hard time waiting. E6 stated that when R11 did steal food from R48, E8 should have removed R11 from the dining area, because it is inappropriate behavior. E6 stated that staff should be watching R11 during the meal time, to ensure that if R11 does attempt to steal food from others, staff can redirect him from doing so. E6 also confirmed

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{W 249}	Continued From page 45 that E8 should have brought R48 a new plate of food to eat, since R11 ate off of R48's plate on three different occasions. 2) R1, per review of Inspection of Care Record dated 6/30/11, is a 37 year old female, whose diagnoses include Profound Mental Retardation, and Cerebral Palsy. R19, per review of Inspection of Care Record dated 6/30/11, is a 52 year old male whose diagnoses include Profound Mental Retardation, and Cerebral Palsy. R31, per review of Inspection of Care Record dated 6/30/11, is a 41 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy, and Seizure Disorder. R44, per review of Inspection of Care Record dated 6/30/11, is a 45 year old male whose diagnoses include Profound Mental Retardation, Cerebral Palsy, and Seizure Disorder. R45, per review of Inspection of Care Record dated 6/30/11, is a 51 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy, and Seizure Disorder. R46, per review of Inspection of Care Record dated 6/30/11, is a 48 year old female whose diagnoses include Profound Mental Retardation, and Seizure Disorder. R47, per review of Inspection of Care Record dated 6/30/11, is a 39 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy, and Seizure Disorder.	{W 249}		

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{W 249}	Continued From page 46 Morning observations were conducted at the facility's day training location from 10:30am through 11:30am., in area FG. At 10:30am, R1 was observed seated in her wheelchair, unengaged. At 11:00am, R1 was observed being toileted, and at 11:10am, R1 was observed playing a hand game with a staff member for about one minute. R44 was observed at 10:30am, holding a boom box, seated at a table. At 10:50am, R44 was moved to a new table, where staff were building with blocks. R44 just sat and observed. At 11:00am, staff walked by, and blew a small fan on him. At 10:30am, R45 was observed sitting in her wheelchair. During the one hour observation, staff was observed taking R45 to the bathroom. No other activity occurred during the hour time frame. At 10:30am, R46 was observed in a chair, rocking back and forth. Staff would occasionally ask R46 a question, to which R46 would yell very loudly. No activity occurred with R46 during this hour time frame. At 10:30am, R19 was also observed in a chair. Staff gave R19 a ball to hold for about 30 seconds at 11:00am. That was the extent of R19's programming during this hour time frame. R31 was also observed at 10:30am, sitting in her wheelchair, with her shoes off. R31 was toileted at 10:50am. No other activity was observed during this hour time frame. At 10:30am, R47 was observed sleeping under a blanket, with her head covered as well, on a sleeping mat/bag. During the entire hour, not one staff approached R47 to engage her in any activity. During an interview with E10 (Direct Care Staff at Day Training) on 6/22/11 at 11:30am, E10 was	{W 249}		

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{W 249}	Continued From page 47 asked about the lack of activity that was observed in area FG from 10:30am through 11:30am. E10 stated that some of the clients will refuse to participate, especially R46. E10 stated that many of the clients do not like to be touched, R19 in particular. E10 continued to explain that some clients are tired, but that they do try to wake them up. E10 stated that she did go around and provide a massage to some of the clients, but it is just that many of the clients will refuse. E10 stated that with R47, that she has been having headaches, and has not been sleeping well at the facility. That is why R47 had been sleeping while at Day Training.	{W 249}		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility's HRC (Human Rights Committee) reviewed and approved the locking of the dining room / kitchen in Plum Hall affecting 15 of 15 clients (R1, R32, R33, R34, R2, R35, R3, R36, R37, R38, R39, R40, R41, R42 and R43) and; ensure the facility's HRC reviewed and approved placing a padlock on the refrigerator in Teal Hall affecting 14 of 14 clients Findings include:	W 262		

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W 262	Continued From page 48 1) Review of Inspection of Care information sheet, dated 6/30/11, noted the following diagnoses: R1 - Profound Mental Retardation R32 - Profound Mental Retardation R33 - Moderate Mental Retardation R34 - Profound Mental Retardation R2 - Profound Mental Retardation R35 - Profound Mental Retardation R3 - Profound Mental Retardation R36 - Profound Mental Retardation R37 - Severe Mental Retardation R38 - Profound Mental Retardation R39 - Profound Mental Retardation R40 - Moderate Mental Retardation R41 - Profound Mental Retardation R42 - Moderate Mental Retardation R43 - Profound Mental Retardation On 6/21/11 at 4:35pm surveyor attempted to enter the Plum Hall dining room / kitchen. At this time the door was locked. E13 (direct care) was observed in Plum Hall and was asked why the door to the Plum Hall dining room / kitchen was locked. E13 stated, "I usually lock the doors behind me, they are usually locked until dinner time." As observed on 6/21/11 at 4:35pm 15 of 15 clients (R1, R32, R33, R34, R2, R35, R3, R36, R37, R38, R39, R40, R41, R42 and R43) residing in Plum Hall did not have access to their dining room / kitchen. E1 (Administrator) was interviewed on 6/30/11 at 3pm. E1 verified the facility did not ensure the HRC reviewed and approved the locking of the dining room / kitchen door affecting the above	W 262		

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W 262	Continued From page 49 noted 15 clients residing in Plum Hall. 2) Review of Inspection of Care information sheet, dated 6/30/11, noted the following diagnoses: R21 - Profound Mental Retardation R22 - Profound Mental Retardation R23 - Severe Mental Retardation R24 - Severe Mental Retardation R25 - Profound Mental Retardation R26 - Profound Mental Retardation R27 - Moderate Mental Retardation R28 - Profound Mental Retardation R31 - Profound Mental Retardation R15 - Severe Mental Retardation R6 - Profound Mental Retardation R17 - Profound Mental Retardation R29 - Profound Mental Retardation R30 - Severe Mental Retardation On 6/28/11 at 10:45am surveyors entered the Teal dining room / kitchen and observed a padlock on the refrigerator. As observed on 6/28/11 at 10:45am 14 of 14 (R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R6, R17, R29 and R30) clients residing in Teal Hall did not have access to their refrigerator. E1 (Administrator) was interviewed on 6/28/11 at 10:52am. E1 stated that yesterday (6/27/11) he asked maintenance to put a lock on the refrigerator. E1 explained that they needed a place to put food that does not disappear. E1 verified that the HRC did not review and approve preventing access to the refrigerator for the above noted 14 clients.	W 262		
{W 263}	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE	{W 263}		

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The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.

This STANDARD is not met as evidenced by:
REPEAT

Based on observation and interview, the facility failed to ensure written informed consent was obtained prior to the locking of the dining room / kitchen in Plum Hall affecting 15 of 15 clients (R1, R32, R33, R34, R2, R35, R3, R36, R37, R38, R39, R40, R41, R42 and R43) and;
ensure written informed consent was obtained prior to placing a padlock on the refrigerator in Teal Hall affecting 14 of 14 clients (R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R6, R17, R29 and R30).

Findings include:

1) Review of Inspection of Care information sheet, dated 6/30/11, noted the following diagnoses:
R1 - Profound Mental Retardation
R32 - Profound Mental Retardation
R33 - Moderate Mental Retardation
R34 - Profound Mental Retardation
R2 - Profound Mental Retardation
R35 - Profound Mental Retardation
R3 - Profound Mental Retardation
R36 - Profound Mental Retardation
R37 - Severe Mental Retardation
R38 - Profound Mental Retardation
R39 - Profound Mental Retardation

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{W 263}		{W 263}		

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R40 - Moderate Mental Retardation
R41 - Profound Mental Retardation
R42 - Moderate Mental Retardation
R43 - Profound Mental Retardation

On 6/21/11 at 4:35pm surveyor attempted to enter the Plum Hall dining room / kitchen. At this time the door was locked. E13 (direct care) was observed in Plum Hall and was asked why the door to the Plum Hall dining room / kitchen was locked. E13 stated, "I usually lock the doors behind me, they are usually locked until dinner time."

As observed on 6/21/11 at 4:35pm 15 of 15 clients (R1, R32, R33, R34, R2, R35, R3, R36, R37, R38, R39, R40, R41, R42 and R43) residing in Plum Hall did not have access to their dining room / kitchen.

E1 (Administrator) was interviewed on 6/30/11 at 3pm. E1 verified the facility did not obtain written informed consent prior to the locking of the dining room / kitchen door affecting the above noted 15 clients residing in Plum Hall.

2) Review of Inspection of Care information sheet, dated 6/30/11, noted the following diagnoses:
R21 - Profound Mental Retardation
R22 - Profound Mental Retardation
R23 - Severe Mental Retardation
R24 - Severe Mental Retardation
R25 - Profound Mental Retardation
R26 - Profound Mental Retardation
R27 - Moderate Mental Retardation
R28 - Profound Mental Retardation
R31 - Profound Mental Retardation

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{W 263}	Continued From page 52 R15 - Severe Mental Retardation R6 - Profound Mental Retardation R17 - Profound Mental Retardation R29 - Profound Mental Retardation R30 - Severe Mental Retardation On 6/28/11 at 10:45am surveyors entered the Teal dining room / kitchen and observed a padlock on the refrigerator. As observed on 6/28/11 at 10:45am 14 of 14 (R21, R22, R23, R24, R25, R26, R27, R28, R31, R15, R6, R17, R29 and R30) clients residing in Teal Hall did not have access to their refrigerator. E1 (Administrator) was interviewed on 6/28/11 at 10:52am. E1 stated that yesterday (6/27/11) he asked maintenance to put a lock on the refrigerator. E1 explained that they needed a place to put food that does not disappear. E1 verified that the facility did not obtain written informed consent prior to preventing access to the refrigerator for the above noted 14 clients.	{W 263}		
{W 268}	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: REPEAT Based on observation, record review, and interview, the facility failed to ensure for the dignity of 3 of 10 clients in the sample observed while eating (R2, R9 and R10), and 1 of 1 client out of the sample observed with a chew toy around her neck (R20).	{W 268}		

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{W 268}	Continued From page 53 Findings include: 1) R10, per review of Physician Order Sheet dated 6/9/11-7/8/11, is a 60 year old male whose diagnoses include Profound Mental Retardation, Paraplegia, Cerebral Palsy, and Blindness. Morning observations were conducted on 6/22/11 from 6:45am through 8:30am. At 7:50am, R10 was observed entering the Red dining room, with his shirt up, leaving his entire abdomen exposed from the chest down. E9 (Direct Care Staff) was observed pushing R10 into the dining room, in his wheelchair. E9 did not attempt to pull R10's shirt down, to cover his exposed abdomen. At 8:00am, R10's abdomen was still exposed. At 8:10am, E9 began feeding R10. R10's shirt was still up at this time, and toast crumbs were noted to be falling on R10's abdomen. E9 continued to feed R10, and never once attempted to pull R10's shirt down during the entire breakfast meal, even though food crumbs and particles were noted to fall on R10's abdomen. During an interview with E9 on 6/22/11 at 8:30am, E9 was asked why he did not pull R10's shirt down while in the dining room eating his breakfast, in order to provide for his dignity. E9 stated that R10 likes to put his hands down his pants, so in order to prevent him from doing this behavior, he just lets R10's shirt up, and then that way R10 will not place his hands in his pants. E9 explained that if he does pull R10's shirt down, then R10 will immediately put his hands down his pants. During an interview with E1 (Administrator) and	{W 268}		

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{W 268}	Continued From page 54 E4 (Residential Services Director) on 6/22/11 at 2:40pm, E1 and E4 were informed that R10 came into the dining room with his abdomen exposed because E9 stated that if he pulls down his shirt, then R10 will begin his behavior of placing his hands in his pants. E1 stated that he is not sure if R10 has a program for public masturbation, but stated that if he did, he didn't think it would be ok to leave his shirt up to prevent him from doing so. E4 confirmed that R10 does have a program for masturbation, and leaving his shirt up, with his abdomen exposed is not the way his program reads. Both E1 and E4 confirmed that it is not appropriate to leave R10's abdomen exposed to prevent him from engaging in another type of behavior. R10's Behavior Program dated 4/30/10 was reviewed. Under Goal Maladaptive, it states that staff should immediately re-direct R10 to stop masturbating, and direct him towards an activity. If R10 should refuse, he should be directed to an appropriate area, such as but not limited to the bathroom and/or bedroom. The plan does not mention anything about leaving the clients shirt up, in order to prevent him from masturbating in public. 2) R2, per review of Physician Order Sheet dated 6/9/11-7/8/11, is a 31 year old female whose diagnoses include Profound Mental Retardation, and Cerebral Palsy. Evening observations were conducted on 6/21/11 in the Plum Hall dining room. At 5:15pm, R2 was observed seated at a dining room table, with the adaptive equipment of a built up spoon and a divided plate. At 5:30pm, R2 was observed	{W 268}		

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{W 268}	Continued From page 55	{W 268}		

eating with her hands. Staff would occasionally prompt R2 to use her spoon, but R2 continued to eat her stewed tomatoes with her hands. There was no consistent follow through from staff for R2 to use her spoon, instead of her hands.

R2's Individual Support Plan dated 9/28/10 was reviewed. R2's current dining goal is to hold her cup with a beverage inside it.

During an interview with E14 (Qualified Mental Retardation Professional) on 6/29/11 at 10:30am, E14 was asked if R2 is capable of using her built up spoon. E14 explained that R2 has the capability of feeding herself. E14 stated that R2 will eat with her hands at times, but staff should re-direct R2 to use her spoon. E14 clarified that staff should continually prompt R2 to use her spoon. E14 stated that R2 does not need hand over hand assistance. E14 explained that after R2 is set up, she can eat independently.
3) R9, per review of 10/18/10 IPP (Individual Program Plan), is a 49 year old female whose diagnoses include Profound Mental Retardation, Pervasive Developmental Disorder and Down Syndrome.

R9 was observed on 6/21/11 at 4:43pm in the living room area of Peach Hall. R9 was observed sitting on a couch. R9 was barefoot and her toenails were observed to be long, with some of the nails curling over the skin of her toes. The bottoms of R9's feet were observed to be dirty.

E5 (RSD - Residential Services Director) was interviewed on 6/21/11 at 5:05pm regarding R9's long toenails. E5 stated that R9 did not always cooperate in having her toenails trimmed. E5

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{W 268}	Continued From page 56 stated she thought that R9 had to have a podiatrist trim her toenails. E5 was again interviewed on 6/30/11 at 10:15am. E5 stated that on the evening of 6/21/11 E11 (nurse) cut R9's toenails. E5 stated that it was not necessary for a podiatrist to cut R9's toenails. 4) R20, per review of IOC (Inspection of Care) information sheet dated 6/30/11, is a 44 year old female diagnosed with Profound Mental Retardation. R20 was observed on 6/22/11 at 3:10pm. R20 was observed wearing the following around her neck: Clear plastic tubing with a light blue plastic T shaped object attached to the tubing. R20 was observed, 6/22/11 at 3:10pm, biting / chewing on the tubing and plastic object. E6 (QMRP) was interviewed on 6/22/11 at 3:10pm. E6 was asked why R20 was wearing the plastic tubing (with attached object) around her neck. E6 stated that R20 bites her hands, so the plastic tubing is to prevent R20 from biting her hands.	{W 268}		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by:	W 289		

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Based on interview and record review, the facility failed to ensure the use of an abdominal binder to prevent pulling out a G-tube (Gastrostomy tube), was incorporated into the IPP (Individual Program Plan) for 1 of 1 client (R1) in the sample that utilizes an abdominal binder.

Findings include:

R1, per review of her 2/1/11 IPP (Individual Program Plan), is a 37 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy and Diabetes Insipidus.
R1, observed on 6/21/11 at 5:15pm, is non-ambulatory. R1 can verbalize a few words / short sentences.

The facility's Incident Reports were reviewed and on the following dates R1 pulled out her G-tube and was transported to the hospital for reinsertion of her G-tube:
- 6/3/11
- 1/22/11
- 11/27/10
- 10/22/10

E4 (RSD - Residential Services Director) documented, per 6/3/11 Incident Report, the following:
"It was reported by the nurse on duty at (R1's) day program that (R1) had pulled out her G-Tube during lunch." ..."(R1) has a history of pulling out her G-tube while in the shower or being fed, often laughing or stating, "I get to go out now.". (R1) wears a binder over the G-tube area to prevent her from pulling it out that must be removed for proper showering and feeding. This behavior appears to be attention seeking so that (R1) can

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go to the hospital."

E14 (QMRP) was interviewed on 6/29/11 at 10:20am. E14 was asked how often R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder 24 hours a day except during bathing.
E14 was asked why R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder, "So she won't pull out her G-tube."
E14 was asked if R1's use of the abdominal binder is incorporated into her IPP. E14 stated that R1 does not have an objective or behavior plan to address the use of the abdominal binder.

E1 (Administrator) was interviewed on 6/23/11 at 3:30pm. E1 was asked why R1 wears an abdominal binder. E1 stated, "To keep from pulling out G-tube."

An interim staffing, to discuss R1's G-tube was held on 6/16/11. The staffing was attended by a nurse, a DT (Day Training) staff and an RSD (Residential Services Director). The recommendations made by the IDT (Inter Disciplinary Team) include:
- R1 is to wear her binder at all times, excluding showers.
- Staff are to put a light weight sheet under R1's arms in order to avoid R1 "ripping out her g-tube."

R1's 2/1/11 IPP (Individual Program Plan) was reviewed. There is no documentation, in the IPP, that identifies that R1 wears an abdominal binder to prevent her from pulling out her G-tube. There is no documentation that R1 has a behavior program to address her behavior of pulling out her G-tube.

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W 301	483.450(d)(4) PHYSICAL RESTRAINTS	W 301		

A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure 1 of 1 client (R1) who wears an abdominal binder to prevent pulling out her G-tube (Gastrostomy tube) is checked at least every 30 minutes by staff trained in the use of restraints.

Findings include:

R1, per review of her 2/1/11 IPP (Individual Program Plan), is a 37 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy and Diabetes Insipidus.
R1, observed on 6/21/11 at 5:15pm, is non-ambulatory. R1 can verbalize a few words / short sentences.

The facility's Incident Reports were reviewed and on the following dates R1 pulled out her G-tube and was transported to the hospital for reinsertion of her G-tube:
- 6/3/11
- 1/22/11
- 11/27/10
- 10/22/10

E4 (RSD - Residential Services Director) documented, per 6/3/11 Incident Report, the following:
"It was reported by the nurse on duty at (R1's) day program that (R1) had pulled out her G-Tube

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W 301	Continued From page 60 during lunch." ..."(R1) has a history of pulling out her G-tube while in the shower or being fed, often laughing or stating, "I get to go out now.". (R1) wears a binder over the G-tube area to prevent her from pulling it out that must be removed for proper showering and feeding. This behavior appears to be attention seeking so that (R1) can go to the hospital." E14 (QMRP) was interviewed on 6/29/11 at 10:20am. E14 was asked how often R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder 24 hours a day except during bathing. E14 was asked why R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder, "So she won't pull out her G-tube." E14 was asked how often R1 is checked, by staff trained in the use of restraints. E14 stated that R1 is on a 30 minute roll call. E14 was asked if staff specifically check R1 and the use of her abdominal binder. E14 stated staff, trained in the use of restraints, do not check R1 every 30 minutes. R1's 2/1/11 IPP (Individual Program Plan) was reviewed. There is no documentation that R1 is monitored every 30 minutes, by staff trained in the use of restraints.	W 301		
W 302	483.450(d)(4) PHYSICAL RESTRAINTS A client placed in restraint must be released from the restraint as quickly as possible. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 client (R1) who wears an	W 302		

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W 302		W 302		

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abdominal binder to prevent pulling out her G-tube (Gastrostomy tube) is released from the restraint as quickly as possible.

Findings include:

R1, per review of her 2/1/11 IPP (Individual Program Plan), is a 37 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy and Diabetes Insipidus.
R1, observed on 6/21/11 at 5:15pm, is non-ambulatory. R1 can verbalize a few words / short sentences.

The facility's Incident Reports were reviewed and on the following dates R1 pulled out her G-tube and was transported to the hospital for reinsertion of her G-tube:
- 6/3/11
- 1/22/11
- 11/27/10
- 10/22/10

E4 (RSD - Residential Services Director) documented, per 6/3/11 Incident Report, the following:
"It was reported by the nurse on duty at (R1's) day program that (R1) had pulled out her G-Tube during lunch." ..."(R1) has a history of pulling out her G-tube while in the shower or being fed, often laughing or stating, "I get to go out now.". (R1) wears a binder over the G-tube area to prevent her from pulling it out that must be removed for proper showering and feeding. This behavior appears to be attention seeking so that (R1) can go to the hospital."

E14 (QMRP) was interviewed on 6/29/11 at

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W 302	Continued From page 62 10:20am. E14 was asked how often R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder 24 hours a day except during bathing. E14 was asked why R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder, "So she won't pull out her G-tube." An interim staffing, to discuss R1's G-tube was held on 6/16/11. The staffing was attended by a nurse, a DT (Day Training) staff and an RSD (Residential Services Director). The recommendations made by the IDT (Inter Disciplinary Team) include: - R1 is to wear her binder at all times, excluding showers - Staff are to put a light weight sheet under R1's arms in order to avoid R1 "ripping out her g-tube." Per interview of E14 and review of R1's staffing, held on 6/16/11, R1 wears an abdominal 24 hours a day (except during bathing). R1's abdominal binder is not released as indicated by her behavior.	W 302		
W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a record of staff checks and documentation of usage of a restraint is kept for 1 of 1 client (R1) who wears an abdominal binder to prevent pulling out her G-tube (Gastrostomy tube).	W 303		

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W 303	Continued From page 63	W 303		

Findings include:

R1, per review of her 2/1/11 IPP (Individual Program Plan), is a 37 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy and Diabetes Insipidus.
R1, observed on 6/21/11 at 5:15pm, is non-ambulatory. R1 can verbalize a few words / short sentences.

The facility's Incident Reports were reviewed and on the following dates R1 pulled out her G-tube and was transported to the hospital for reinsertion of her G-tube:
- 6/3/11
- 1/22/11
- 11/27/10
- 10/22/10

E4 (RSD - Residential Services Director) documented, per 6/3/11 Incident Report, the following:
"It was reported by the nurse on duty at (R1's) day program that (R1) had pulled out her G-Tube during lunch." ..."(R1) has a history of pulling out her G-tube while in the shower or being fed, often laughing or stating, "I get to go out now.". (R1) wears a binder over the G-tube area to prevent her from pulling it out that must be removed for proper showering and feeding. This behavior appears to be attention seeking so that (R1) can go to the hospital."

E14 (QMRP) was interviewed on 6/29/11 at 10:20am. E14 was asked how often R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder 24 hours a day except during bathing.

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W 303	Continued From page 64 E14 was asked why R1 wears an abdominal binder. E14 stated that R1 wears the abdominal binder, "So she won't pull out her G-tube." E14 was asked if there is any documentation of staff monitoring R1 every 30 minutes, and a record of when the abdominal binder is applied and removed. E14 stated that is no documentation that R1 is checked every 30 minutes by staff. E14 also verified there is no documentation as to when R1's abdominal binder is applied and when it is removed. An interim staffing, to discuss R1's G-tube was held on 6/16/11. The staffing was attended by a nurse, a DT (Day Training) staff and an RSD (Residential Services Director). The recommendations made by the IDT (Inter Disciplinary Team) include: - R1 is to wear her binder at all times, excluding showers. - Staff are to put a light weight sheet under R1's arms in order to avoid R1 "ripping out her g-tube."	W 303		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 10 clients in the sample (R1) was provided with necessary nursing services after an incident of incontinence. Findings include: R1, per review of her 2/1/11 IPP (Individual Program Plan), is a 37 year old female whose	W 331		

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W 331	Continued From page 65 diagnoses include Profound Mental Retardation, Cerebral Palsy and Diabetes Insipidus. R1, observed on 6/21/11 at 5:15pm, is non-ambulatory. R1 can verbalize a few words / short sentences. The facility's Incident Reports were reviewed. On 5/20/11 staff were alleged to neglect R1, by not changing her brief after a bowel movement, for approximately 1 hours and 45 minutes. The alleged neglect was investigated and on 5/27/11 E4 (RSD - Residential Services Director) documented that staff did neglect R1 on 5/20/11. E4 documented that R1 was examined by E11 (nurse) and R1 did not have any redness or other signs of skin breakdown. R1's nursing progress notes were reviewed. There is no documentation, by E11 or any other nurse, that R1 was examined and assessed after not having her brief changed for approximately 1 hour and 45 minutes. E11 did document the following: "5/20/11 9A Annual physical done by (attending physician)." There is no evidence that a nursing assessment was completed after R1 was alleged to be neglected. E2 (DON - Director of Nursing) was interviewed on 7/6/11 at 2pm. E2 verified that E11 did not document that R1 was assessed after allegedly being neglected.	W 331		
{W 340}	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to	{W 340}		

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{W 340}		{W 340}		

Continued From page 66
training clients and staff as needed in appropriate health and hygiene methods.

This STANDARD is not met as evidenced by:
REPEAT

Based on observation and interview, the facility failed to ensure for the health and hygiene measures for:

1. 1 of 1 client with nasal discharge on his hands, who poured a pitcher of juice without having his hands sanitized, and who had a client eat off of his breakfast plate (R48), and for

2. 3 of 4 clients attending the second seating in the Red Hall dining room (R8, R10 and R12), who did not have the table cleaned before they sat down to eat their meal.

Findings include:

1) R11, per review of Behavior Program dated 7/1/11, is a 31 year old male whose diagnoses include Profound Mental Retardation, Tourette's Disorder, Stereotypic Movement Disorder, Down's Syndrome, and Visual Loss.

R48, per review of Inspection of Care Record received on 6/30/11, is a 48 year old male whose diagnoses include Severe Mental Retardation, and Cerebral Palsy.

R11 was observed in the Red Hall dining room on the morning of 6/22/11 from 6:45am through 8:30am. At 7:30am, R11 was observed seated at a table next to R48. R11 reached over to R48's

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{W 340}	Continued From page 67 plate with his spoon, and scooped a spoonful of R48's hot cereal off of his plate, and ate it. R11 continued to eat cereal off of R48's plate for a total of three times, without any staff monitoring or re-direction. This surveyor told E8 (Direct Care Staff) that R11 had stole food directly off of R48's plate. E8 said he was not watching closely, and was not aware that R11 was eating from R48's plate. E8 stated that he will just move R11 away from R48, so that he could not reach R48's plate, to prevent him from stealing more food from R48. E8 did not bring R48 a new plate of food to eat, even though R11 ate directly off of R48's plate three times with his spoon. At 7:00am, R48 was observed seated at the far right dining table in Red Hall. R48 was observed sneezing, with nasal discharge over his hands and mouth. E8 was observed handing the pitcher of juice to R48 to pour, with the nasal discharge still over his hands and mouth. E8 was observed handing the pitcher to R11, without wiping R48's hands or cleaning the pitcher handle of the juice. This surveyor informed E8 that R48 had sneezed over his hands, and had nasal discharge over them, which has now contaminated the handle of the juice pitcher. E8 stopped passing the pitcher of juice from client to client, and washed the handle of the pitcher. E8 also washed R48's hands. During an interview with E8 on this same date and time, E8 was asked why he allowed the clients to handle the same pitcher that R48 had touched, after he had contaminated it with his nasal discharge. E8 stated that he was not aware, and did not notice the nasal discharge on his hands. 2) Morning observations continued on 6/22/11.	{W 340}		

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{W 340}	Continued From page 68 The second seating of breakfast started at 7:50am. At this time, R10 was observed being seated at a table setting, where another client had been seated during the first seating. R10's setting was placed on the table, without having the table washed in between clients. R8 came into the dining room at this same time with R12. Both clients sat down at a table where another client had previously ate, without having the table washed in between the two clients. During an interview with E1(Administrator) on 6/22/11 at 2:45pm, E1 was informed that three clients did not have the table washed prior to them eating, after the first sitting for breakfast was completed. E1 acknowledged that staff should clean the tables in between seating's of breakfast.	{W 340}		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain an accurate MAR (Medication Administration Record) for 4 of 4 clients (R12, R13, R14 and R15) residing on the West wing of the facility. Findings include: The following was obtained from IOC (Inspection of Care) information sheet, dated 6/30/11: R12 is a 71 year old male diagnosed with Severe Mental Retardation.	W 365		

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W 365	Continued From page 69 R13 is a 64 year old male diagnosed with Profound Mental Retardation. R14 is an 82 year old male diagnosed with Severe Mental Retardation and Cerebral Palsy. R15 is a 48 year old male diagnosed with Severe Mental Retardation and Cerebral Palsy. R12's nursing progress notes were reviewed. E2 (DON) made the following entry: "1/4/11 9:25 / A Late Entry for 12/30/10 @ 2:45 / P. Notified (on call physician) to report that resident's Fosamax had not been given regularly as ordered. This writer added that the situation has been rectified and the resident is now receiving the medication as ordered." On 6/29/11 at 1:20pm surveyor received an investigation regarding R12 not receiving his medication Fosamax. The investigation completed on 1/6/11 by E1(Administrator), includes the following: On 12/30/10, while re-ordering medication for R15, the ADON (Assistant Director of Nursing) discovered that 4 clients (R12, R13, R14 and R15) may not have received their prescribed dose of Fosamax as ordered. The Fosamax is to be given one time per week on Monday morning. The medication is delivered from the pharmacy in a 4 dose package. The packages for R12, R13, R14 and R15 were over a month old and there were still pills in each package. The ADON and the DON (Director of Nursing) contacted the pharmacy regarding the dates the Fosamax was dispensed for R12, R13, R14 and R15. The pharmacy produced documents	W 365		

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W 365	Continued From page 70 indicating the Fosamax has not been reordered / dispensed for these 4 clients since September 2010. The facility's investigation concluded that R12, R13, R14 and R15 did not receive their prescribed Fosamax since 9/13/10 (a 4 month period). The facility's conclusion notes the following: "It is apparent that (E20) (former nurse) did not administer Fosamax each time it was ordered (1 X (time) per week) for four individuals, however she documented in the Medication Administration Record that she did so. ... It is clear that (E20) did not pass the medications to the four individuals one time per week as ordered, and the documentation she entered into the Medication Administration Records is false." E1 was interviewed on 6/29/11 at 2:10pm. E1 verified that E20 falsified the MAR when she charted that R12, R13, R14 and R15 received their prescribed medication Fosamax. E1 verified that E20 falsified her entries into the MAR's for a 4 month period for R12, R13, R14 and R15.	W 365		
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 interview and record review, the facility failed to ensure all drugs were administered in compliance with physician's orders for 2 of 10 clients in the sample (R4 and R6); and 4 of 4 clients (R12, R13, R14 and R15) residing on the West side who are prescribed	W 368		

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Fosamax.

Findings include:

The following was obtained from IOC (Inspection of Care) information sheet, dated 6/30/11:

R4 is a 36 year old female diagnosed with Profound Mental Retardation, Seizure Disorder and Hypothyroidism.

R6 is a 30 year old male diagnosed with Profound Mental Retardation and Autism.

R12 is a 71 year old male diagnosed with Severe Mental Retardation.

R13 is a 64 year old male diagnosed with Profound Mental Retardation.

R14 is an 82 year old male diagnosed with Severe Mental Retardation and Cerebral Palsy.

R15 is a 48 year old male diagnosed with Severe Mental Retardation and Cerebral Palsy.

1) The facility's Incident Reports were reviewed. R4 did not receive her medication as prescribed on 11/25/10, 11/26/10 and 11/27/10. E16 (former RSD - Residential Services Director) completed an investigation and concluded the following:
E15 (former nurse) provided R4's family with the incorrect medication. The medication provided to R4's family was another clients medication. Video surveillance confirms that E15 gave the incorrect medication to R4's family.
The facility's "Sign Out / Sign In" sheet notes that R4's family picked R4 up from the facility on

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Thursday 11/25/10 at 11:50am. R4 returned to the facility on Saturday 11/27/10 at 6:50pm.

The facility's investigation includes the following interview of E17 (nurse):
E17 was interviewed and stated that on 11/27/10 she was on duty when R4 returned to the facility. R4 was accompanied by her parents. R4's parents told E17 that R4 had 2 seizures on Friday (11/26/10) and 2 seizures today (Saturday 11/27/10). R4's father told E17 that he thought R4's seizure medications had changed without him being notified. E17 looked at the medication that was returned and noticed that it had belonged to another client. E17 told R4's father that her medication had not changed but that she was given the wrong medication to take home.

The facility's investigation identifies that R4 was sent home with the following medications:
- Levothyroxine 125mcg (for thyroid)
- Omeprazole 20mg (for GERD - Gastro Esophageal Reflux Disease)
- Lasix (Diuretic)
- Tizanidine 2mg (for muscle spasms)

R4 should have received the following medications:
- Lamotrigine 350mg twice daily (to control seizures)
- Vimpat 200mg twice daily (Anti epileptic / seizure control)
- Levothyroxine 50mcg (for thyroid)
- Topamax 200mg three times a day (for seizures)

R4's POS (Physician's Order Sheet) dated 11/1/10 thru 11/30/10 was reviewed. R4 had the

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following medications prescribed:
- Multi-vitamin 7am
- Levothyroxine 50mcg 7am
- Miralax Powder 7am
- Lamotrigine 350mg 7am and 9pm
- Oyster Shell with calcium 5pm and 9pm
- Vimpat 200mg 7am and 9pm
- Topamax 200mg 7am, 5pm and 9pm
- Docusate Sodium 100mg 9pm

Review of the above noted that R4 left on a home visit on 11/25/10 at 11:50am. R4 returned to the facility on 11/27/10 at 6:50pm. R4 had 2 seizures on 11/26/10 and 2 seizures on 11/27/10.
R4 did not receive her Multi-vitamin for 2 days.
R4 did not receive her correct dose of Levothyroxine for 2 days.
R4 did not receive her Miralax Powder for 2 days.
R4 did not receive 4 doses of her Lamotrigine (seizure medication).
R4 did not receive 4 doses of her Oyster shell.
R4 did not receive 4 doses of her Vimpat (seizure medication).
R4 did not receive 7 doses of her Topamax (seizure medication).
R4 did not receive her Docusate Sodium for 2 days.

Review of R4's "Seizure Report Log", dated 9/1/10 thru 6/16/11, noted that during this time period R4 averaged 2 seizures per month.

E2 (DON - Director of Nursing) was interviewed on 6/23/11 at 2:30pm. E2 stated that E15 (former nurse) packaged the wrong medications for R4 when she went on a home visit on 11/25/10. E2 verified that R4 did not receive any of her seizure medications when she was on this home visit.

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2) R6's nursing progress notes were reviewed and the following entry was made by E18 (nurse): "6/27/11 Late entry - On 6/13/11 client (R6) consumed medication belonging to another resident. No injury or changes in condition noted upon assessment. (Physician) notified and states medication ingested will not harm client. Will continue to monitor. Vitals - BP 128/78, P68, R20, T 97.7. Supervisor made aware and Guardian notified."

On 6/28/11 E1 (Administrator) was interviewed at 10:30am. E1 was asked if he had any further information about R6 "consuming" another resident's medication on 6/13/11. E1 stated, "That's the first I've heard of it."
On 6/28/11 E2 provided a medication error incident report. The report is dated 6/13/11 and the explanation of the medication error is, "Client ate another's client food containing medication." The medication that R6 consumed includes: Synthroid 75mcg, Loratadine 10mg and a Multivitamin.

E1 and E2 were interviewed on 6/28/11 at 1:38pm. E1 stated that R6 consumed 3 medications that are another client's.

3) R12's nursing progress notes were reviewed. E2 (DON) made the following entry:
"1/4/11 9:25 / A Late Entry for 12/30/10 @ 2:45 / P. Notified (on call physician) to report that resident's Fosamax had not been given regularly as ordered. This writer added that the situation has been rectified and the resident is now receiving the medication as ordered."

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W 368	Continued From page 75 On 6/29/11 at 1:20pm surveyor requested, from E1 (Administrator),and received an investigation regarding R12 not receiving his medication Fosamax. The investigation completed on 1/6/11 by E1, includes the following: On 12/30/10, while re-ordering medication for R15, the ADON (Assistant Director of Nursing) discovered that 4 clients (R12, R13, R14 and R15) may not have received their prescribed dose of Fosamax as ordered. The Fosamax is to be given one time per week on Monday morning. The medication is delivered from the pharmacy in a 4 dose package. The packages for R12, R13, R14 and R15 were over a month old and there were still pills in each package. The ADON and the DON (Director of Nursing) contacted the pharmacy regarding the dates the Fosamax was dispensed for R12, R13, R14 and R15. The pharmacy produced documents indicating the Fosamax has not been reordered / dispensed for these 4 clients since September 2010. The facility's concluded that R12, R13, R14 and R15 did not received their prescribed Fosamax since 9/13/10 (a 4 month period). E3 (ADON) was interviewed on 6/29/11 at 2:15pm. E3 stated that the pharmacy sent a notice with a medication delivery identifying that Fosamax had not been refilled for a "disturbing" time period. E3 stated she checked the all of the Fosamax meds and checked the date dispensed on each box. E3 stated she then notified the DON that R12, R13, R14 and R15 may not be getting their Fosamax. E3 verified that R12, R13, R14 and R15 did not received their Fosamax, as	W 368		

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W 368	Continued From page 76 prescribed, for a 4 month period.	W 368		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060e) 350.1210 350.3240a) Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to prevent neglect for 1 of 1 client (R6) who was hospitalized and a foreign body was surgically removed from his bowel, when the facility failed to ensure sufficient	W9999		

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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
W9999	Continued From page 77 safeguards and supervision to prevent injuries are in place. Findings include: R6, per review of his 6/9/11 to 7/8/11 POS (Physician's Order Sheet), is a 30 year old male whose diagnoses include Profound Mental Retardation, Autism and Bowel Retention Syndrome. R6's 1/6/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies that R6 is ambulatory and essentially non-verbal. On 6/21/11 at approximately 10:00am, E1 (Administrator) was interviewed regarding the current census at the facility. E1 stated that 1 client was hospitalized. E1 identified that client as R6. E1 stated the reason for R6's hospitalization was a possible bowel obstruction. R6's nursing progress notes were reviewed. On 6/18/11 at 8:00pm, nursing staff documented that R6 was sent to the Emergency Department due to change in mental status and dehydration. Nursing staff also documented that a nurse at the hospital stated the hospital is awaiting test results to rule out a bowel obstruction. On 6/24/11 at 10:00am, E1 told surveyor that there was information to share regarding R6. E1 stated that R6 had surgery on 6/23/11 at approximately 4:00pm. E1 stated that when R6 was opened up, plastic was found in his colon. E1 stated that R6 must have ingested something. E1 stated that R6 has a history of PICA behavior. E1 stated that R6 might eat the plastic off of a sandwich if it was given to him wrapped in plastic.	W9999		

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	14G102	A. BUILDING ______ B. WING ______	R 08/09/2011

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W9999	Continued From page 78 The facility's policy, titled "Client Treatment Policy," dated 2/05 was reviewed. The policy includes the following: "Under no circumstances shall any abuse or neglect of a client be tolerated. All staff shall receive training regarding the rights of clients and concerning proper staff behavior when dealing with different aspects of client care. Training is included in the initial orientation and Developmental Disabilities Aide course and is also an annual training requirement for staff. Training includes such topics as neglect, respect, dignity of the client during personal care and privacy...." R6's nursing progress notes were reviewed. The following was documented by nursing staff: - "6/17/11 5:20p Resident was not behaving as usual (post) fun fest today. He acted very sedate. Checked to make sure he could swallow which he did. B/P (blood pressure) 101/84, P(pulse) 94, T (temp) 97.2, R (respiration)16, BS (bowel sounds) + 4. Abdomen rounded and firm. ... (on call physician notified)..." - "6/18/11 0735 Resident had a good night. Sleep was monitored throughout the night. Vital signs remain stable, still acting unusual very quiet, refused to eat dinner..." - "6/18/11 2000 Continued to monitor client VS (vital signs) 135/70, P80, R18, T97.9, BS normoactive to hypoactive. Abdomen rounded and very firm. Skin is pale, dry and cool. Eyes appear sunken in. Very lethargic, not eating. Refused breakfast, lunch, and afternoon snack, which is very uncharacteristic behavior for this client. Gave the client 240ml of water, 120ml of Resource 2.0, and 500ml juice (Hab aide gave at dinner). Client had 2 wet diapers and 2 loose	W9999		

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BM's since this morning. Paged MD on call with results. Per (physician) (telephone order): Send client to (local) hospital ED (Emergency Department) for change in mental status and dehydration. Client taken to ED via (facility) van accompanied by (facility) employee. Per (nurse) at hospital, client stable receiving IV fluids, awaiting results of CT scan of abdomen to R/O (rule out) bowel obstruction (@1730). Client admitted to hospital; spoke to nurse (at hospital) at 2020...."

- "6/21/11 1005 Spoke with (nurse) at (local hospital). States 'R' (resident) has confirmed Dx. (diagnosis) of SBO (small bowel obstruction). ... (Nurse) also states that 'R' has unconfirmed diagnosis of pneumonia...."

On 6/24/11 E1 provided surveyor a copy of R6's surgical report. The surgical report includes the following:
On 6/23/11 an Exploratory Laparotomy with bowel resection was performed on R6. R6 was diagnosed with a Small Bowel Obstruction.
A foreign body, also known as a "bezoar," was identified and removed from R6's small bowel. The foreign body is described as: "The specimen is labeled "small bowel bezoar." Received in bile stained formalin are multiple fragments of black - tan to red, plastic, membranous folded material aggregating 6.9 X 4.9 X 2.9 cm (centimeter) in aggregate. No tissue is grossly identified. Gross description only."

R6's 1/6/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies the following:
- "(R6) needs to work on food foraging, the pace at which he consumes his food, and refraining from placing inedible objects in his mouth."

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- "The removal of his comforter is due to history of chewing (through) his bed mattress."

R6's behavior program, implemented on 2/1/11, was reviewed. R6's behavior program notes the following:
"Due to past incidents of Pica and eating his comforter and top sheet, (R6's) comforter and top sheet will be removed during non-sleep hours."

E7 (QMRP) was interviewed on 6/29/11 at 10:35am. E7 confirmed that she was made aware that R6 was hospitalized on 6/18/11 and diagnosed with a small bowel obstruction. E7 stated she was also aware that R6 had surgery and a foreign object was found and removed. E7 verified that R6 currently has a behavior program that was implemented on 2/1/11. E7 stated R6's targeted maladaptive behaviors are anxiety, agitation and insomnia.
E7 was asked whether R6 has an objective to address his PICA behavior - ingesting inedible items. E7 stated that R6 does not have an objective for PICA or ingestion of inedible items. E7 was asked if she was aware of R6's PICA behavior. E7 stated she was aware and that is why R6's comforter and top sheet are removed from his bed after he gets out of bed in the morning. E7 stated that in the past year R6 grabbed a sandwich that was wrapped in plastic. E7 stated she does not remember the specific details, or when the incident occurred. E7 stated the sandwich was wrapped in plastic, but she does not think that R6 ingested the plastic. E7 was asked to identify R6's level of supervision. E7 stated that R6's level of supervision was a 15 minute roll call. E7 stated that staff are to check on R6 every 15 minutes. E7 stated that R6's

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level of supervision is every 15 minutes due to his behavior of wandering and insomnia. E7 stated that R6 does not receive any specific monitoring due to his PICA behavior.

E21 (Dietary Food Service Manager) was interviewed on 6/28/11 at 10:33am. E21 was asked to describe R6's current dietary orders. E21 stated that R6 receives a mechanical soft diet with double portion of the entree and double portion of cereal at breakfast. E21 was asked if R6 receives sandwiches. E21 explained that R6 does receive sandwiches with soft meats (e.g. tuna salad ...). E21 stated that R6 does receive sandwiches that are served in a plastic bag. E21 was asked whether R6 receives any food items that are packaged in other types of plastic wrap. E21 showed surveyor graham crackers and other small cookies/crackers that come pre-packaged in red and / or colored plastic material.

The facility completed an investigation, dated 6/30/11, of R6's ingestion of a foreign body. The facility identified that the majority of R6's food is wrapped in clear plastic. However, a few of the snack items are packaged in red plastic. The facility determined: "Based on this information it can be potentially concluded that (R6) consumed a snack item without removing the plastic."

The facility failed to provide adequate supervision for a client (R6) with a known special need (PICA - ingesting inedible objects). The facility failed to provide adequate safeguards to ensure R6's safety. The facility's failure to provide R6 with necessary supervision and safeguards resulted in R6 being hospitalized on 6/18/11.

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W9999	Continued From page 82 E7 (QMRP) verified, on 6/29/11 at 10:35am, that R6's supervision level was not reviewed and/or revised due to R6's PICA behavior. R6 was diagnosed with a small bowel obstruction. On 6/23/11 R6 had surgery and a foreign body was noted and removed from his small bowel. (A)	W9999		