STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G349	A. BUILDING _____ B. WING _____	10/20/2011

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SEYMOUR TERRACE	1504 16TH STREET NORTH CHICAGO, IL 60064

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W 000	INITIAL COMMENTS Annual Certification Survey - Fundamental to Extended. Annual Licensure Survey. Inspection Of Care.	W 000		
W 316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drugs used for behavior have been reduced at least annually for R2, 1 of 2 residents in the sample who take drugs for behavior. Findings include: R2 is a 60 year old female with diagnoses including Severe Mental Retardation, Bipolar Disorder-Hypomania according to her October 2011 Physician's Orders Sheet (POS). R2's October 2011 POS validate the following orders: 1. Clozapine 50 mg every morning and Clozapine 75 mg every evening (order date of) 4/13/10 2. Seroquel 150 mg every bedtime (order date of) 5/6/10. R2's Behavior Management/Resident Rights Committee (GP-17) dated 01/11/10, 4/12/10 and 7/11/11 validates R2 has been on Clozapine at a total dose of 125 mg a day and Seroquel 150 mg a day since 01/11/10.	W 316		11/24/11

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

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 316	Continued From page 1 E2 (Qualified Mental Retardation Professional, QMRP) was asked on 10/4/11 approximately at 11:00 AM regarding R2's annual attempt at reducing medication used for behavior. E2 (QMRP) showed surveyor the undated hand written entry on the second page of R2's GP-17 dated 4/12/10 which reads "R2 had a failed reduction in the past quarter. Continue present care and medication regimen. Review in three months." E2 was asked to show surveyor the reduction that occurred in the past quarter for R2. E2 showed R2's GP-17 dated 01/11/10 that validates her Clozapine was at 125 mg a day and Seroquel 150 mg a day as of 01/11/10. E2 validated R2 has not had an attempt at reducing drug taken for behavior in the past year.	W 316		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to prevent medical neglect when they failed to adequately monitor and intervene the serious medical condition for 1 of 1 resident who expired in the last six months (R6) when: - R6 was not responding to staff, had abnormal breathing and staff did not immediately call 911. - Facility did not investigate the significant event involving R6 on 6/05/11. - Facility did not ensure re-training of staff or ensuring safeguards are in place for the remainder of the residents in the facility (R1, R2, R4 and R5). These failures resulted in an Immediate Jeopardy.	W 318		11/24/11

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W 318	Continued From page 2 Findings include: On 10/06/11 at 2:30 PM an Immediate Jeopardy was identified to have begun on 6/05/11 for R6 when: - R6 was not responding to staff, had abnormal breathing and staff did not immediately call 911. - Facility did not investigate the significant event involving R6 on 6/05/11. - Facility did not ensure re-training of staff or ensuring safeguards are in place for the remainder of the residents in the facility (R1, R2, R4 and R5). E1 (Facility Representative) was notified of the Immediate Jeopardy on 10/06/11 at 2:30 PM. On 10/11/11 at 2:35 PM, E1 (Facility Representative) was notified that the Immediate Jeopardy was removed. Refer to deficiency cited at: W 331 - Nursing services are provided in accordance with resident needs and facility policy and procedure.	W 318		
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 prevent medical neglect when they failed to adequately monitor and intervene the serious medical condition for 1 of 1 resident who expired in the last six months (R6) when: - R6 was not responding to staff, had abnormal	W 331		11/24/11

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W 331	Continued From page 3 breathing and staff did not immediately call 911. - Facility did not investigate the significant event involving R6 on 6/05/11. - Facility did not ensure re-training of staff or ensuring safeguards are in place for the remainder of the residents in the facility (R1, R2, R4 and R5). These failures resulted in an Immediate Jeopardy. Findings include: On 10/06/11 at 2:30 PM an Immediate Jeopardy was identified to have begun on 6/05/11 for R6 when: - R6 was not responding to staff, had abnormal breathing and staff did not immediately call 911. - Facility did not investigate the significant event involving R6 on 6/05/11. - Facility did not ensure re-training of staff or ensuring safeguards are in place for the remainder of the residents in the facility (R1, R2, R4 and R5). E1 (Facility Representative) was notified of the Immediate Jeopardy on 10/06/11 at 2:30 PM. Resident's level of function according to the Facility Resident Roster provided on 10/03/11 confirm R1 is a 49 year old male with Moderate MR (Mental Retardation), R2 is a 60 year old female with Severe MR, R4 is a 44 year old female with Profound MR, and R5 is a 36 year old female with Severe MR. R6 was a 57 year old male with diagnoses including Profound Mental Retardation, Seizure Disorder and Spastic Quadriplegia according to his June 2011 Physician's Orders Sheet. R6's ISP (Individual Service Plan) dated 12/20/10	W 331		

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W 331	Continued From page 4 validates a Functional Assessment conducted on 12/21/10 with a result of five years and 10 months. The Medical History section reports "R6 has no physical limitations and uses no adaptive equipment. R6 and his representative do not wish to put a DNR (Do Not Resuscitate) order in place at this time." The Other Medical Comments section includes "Ambulatory with a steady gait. R6 is continent of bladder and bowel." The Communication section validates R6's communication skills at 5 years, 1 month. R6's Language Comprehension Skills at 6 years, 6 months. R6's Language Expression Skills at 3 years, 2 months. Review of reports from the local hospital R6 was transported to on 6/05/11 prior to his death on 6/06/11: - "Final Report of the CT Scan of the Abdomen and Pelvis (Exam date of 6/05/11 at 11:17 AM), Impression: 1. Mechanical obstruction secondary to sigmoid volvulus. - Consultation on 6/05/11 (at 1:55 PM), Physical Examination: Abdomen - Distended and firm. Bowel sounds are absent. Assessment: The patient is status post arrest, acute abdomen. Await surgical opinion. The patient's prognosis is guarded at this point. - Neurology Consultation on 6/05/11 (at 5:13 PM), Impression: Coma and seizures/status epilepticus due to anoxic encephalopathy. - History And Physical (6/06/11 at 9:12 AM), History Of Present Illness: Apparently, the patient had been found unresponsive with a cardiac arrest and EMS has been called...The patient had a CT of the abdomen which demonstrated sigmoid volvulus. All labs and clinical presentation have demonstrated the patient was in anoxic	W 331		

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W 331	Continued From page 5	W 331		

encephalopathy with multiorgan failure. Physical Examination: Gastrointestinal - Abdomen extremely protuberant. No bowel sounds. Disposition: The patient unfortunately has multiorgan failure, had a cardiac arrest at home, has anoxic encephalopathy, and is resuscitated on a ventilator, IV support fluids, and two pressors. The outcome is extremely poor. Will have to talk to the state guardian regarding medical plans."

R6's Certification of Death Record validates date of death on 6/06/11, time of death at 4:33 PM. Cause of Death listed include a. Septic Shock, b. Decubitus Ulcers, c. Bacteremia, Multiorgan Failure.

Progress Notes (GP-15) dated 6/5/11 for R6 includes the following written by E3 (Direct Support Person, DSP):
"Around 8:10 AM, R6 brought his breakfast plate into the kitchen. Staff (E3) was in the dining room and heard (R6) scream and drop his plate. (E3) ran to investigate and saw R6 trying to hold himself up on the trash can. (E3) tried to hold (R6) up but he collapsed against the wall. (R6) was breathing very heavy and slow. (R6) looked up slightly, but was not responding to (E3). E3 contacted the RN (E7) who said to call 911. R6's breathing and pulse was very feint (sic), and he was completely limp."

E1(Facility Representative) was asked on 10/05/11 approximately at 12:15 PM regarding investigation into the events involving R6 on 6/05/11. E1 validated there is no investigation but E1 made sure E3 was asked if R6 had a pulse and was breathing. E1 added that E3 is adamant

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W 331	Continued From page 6 R6 was breathing and had a pulse. E3 did all of the steps to determine if CPR is needed. No CPR was initiated. On 10/05/11 approximately at 11:00 AM, the Emergency Medical Services Field Report completed on 6/5/11 for R6 was obtained from the local hospital for review and includes the following information: "Unit Notified: 0834 (8:34 AM) Unit Enroute: 0834 Arrived Scene: 0836 (8:36 AM) At Patient: 0836 Enroute Destination: 0850 (8:50 AM) Aid Prior to Arrival: none Illness/Injury: Unresponsive Assessment: (Pain, LOC, GCS, LMP) 000 No Pulse Vitals Signs: Time: 0836 (8:36 AM) and 08:50 (8:50 AM) B/P: 0, HR: 0, RR: 0, SP02: 0, Lung Sounds: Left 0, Right 0, Pupils: Left 0, Right 0, Temp: Cool, Skin Parameters: Pale. Patient Narrative: 57 y/o male is found unresponsive and not breathing, moved to MICU while starting CPR, EKG=Asystole, established IV 20 g R AC, ET 71/2 with good placement, suction fluid out of mouth, BVM @14 LPM o2, gave EPI, 1:10,000 1mg followed by Atropine 1 mg, continued CPR, still no pulse, 2nd round of EPI and Atropine continued CPR, patient converted to V-fib outside ER, defib at 200 jewels (sic), Patient converted to PEA and was turned over to ER staff." Approximately at 12:08 PM on 10/05/11, E7 (Nurse Consultant) was asked regarding Progress Note by DSP (E3) on R6 dated 6/05/11.	W 331		

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W 331	Continued From page 7	W 331		

E7 validated E3 called her about R6 and E7 told E3 to call 911 and then call E2 (QMRP). E7 stated E3 told her he had already called E2 (QMRP) prior to calling E7 and 911.

On 10/05/11 approximately at 2:00 PM, E1 (Facility Representative) was asked when E3 (DSP) called 911. E1 was informed of the different times noted in E3's Progress Note and the EMS Field Report. E1 stated that E3 called 911 right away.

On 10/06/11 approximately at 1:00 PM (Time print from fax was 12:48), E1 faxed surveyor a note written by E3 (DSP) dated 10/05/11. This note was written on an unlabeled form. The note includes the following:
"8:10 am was a rough guess. According to the report the ambulance was notified at 8:34. There was nowhere near a 24 minute time gap between R6's collapse and me calling 911. A more accurate estimation would be that he collapsed around 8:30. I did not have time to write a GP 15 until around 9:30, so my estimation was likely wrong. I called the nurse before 911 because that morning I have given R6 a PRN medication, for constipation, and my first thoughts on his collapse was that he was possibly having a very difficult bowel movement, since there was a loud flatulant (sic) sound. I did not immediately think that it was an emergency. Although R6 raised his head and made eye contact at first, he began losing responsiveness as I was beginning to call the nurse. R6 was breathing heavily for the first minute or so of the situation, I was able to hear it and see his chest rise. He still appeared to be breathing when I called 911. His chest movement was slower and lighter. The last point I was able

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W 331	Continued From page 8 to check his breathing was about a minute before the ambulance arrived. I checked by placing my ear near his mouth. I saw some movement in his chest. I also checked his pulse near his right wrist." E1 (Facility Representative) also faxed on 10/06/11 at 12:48 PM a one-page document from First Aid/CPR/AED Participant's Manual page 72 titled Sudden Illness. E1 stated on 10/06/11 at 2:20 PM that the page sent from Participant's Manual is what staff were trained on. This document includes the following information: "Sudden Illness. What to Look For: When a person becomes suddenly ill, he or she usually looks and feels sick. Common signals include: -Changes in level of consciousness, such as feeling lightheaded, dizzy, drowsy or confused, or becoming unconscious -Breathing problems (i.e., trouble breathing or no breathing) -Signals of a stroke, including sudden weakness on one side of the face; sudden weakness, often on one side of the body; sudden slurred speech or trouble forming words, or a sudden severe headache -Signals of shock, including rapid breathing, changes in skin appearance and cool, pale or ashen (grayish) skin -Persistent abdominal pain or pressure. When to Call 9-1-1 -Unconsciousness or altered level of consciousness -Breathing problems -Persistent abdominal pain or pressure... Remember if you cannot sort out the problem quickly and easily (cut out) if you have any doubts	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G349	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 331	Continued From page 9 about the severity of the illness (cut out) make the call for help. What to Do Until Help Arrives -First care for life-threatening conditions such as unconsciousness; trouble breathing; no breathing;... -Watch for changes in consciousness and breathing..." On 10/06/11 approximately at 2:20 PM, E1 (Facility Representative) was asked if an investigation was done regarding events on 6/05/11 involving R6. E1 stated "E3 (DSP) did everything according to policy and procedure. E3 checked for breathing and pulse. I did not see anything that E3 did not do according to procedure. Nothing that I noted or that was brought to my attention with regards to E3's handling of situation that morning. E1 and E7 (Nurse Consultant) looked at R6's records and did not see anything that indicated anything needing further investigation." E3 (Direct Support Person) was interviewed on 10/11/11 at 2:30 PM and validated he called E7 on 6/05/11 two times. First call was due to R6 not having a bowel movement and to ask what PRN to give. Second call was regarding R6 collapsing, losing responsiveness. E3 was asked for signals of responsiveness and stated "ask for name and if no answer, no responsiveness. I believe now I'm supposed to call 911. I was panicked and I did not know what to do. I was unsure of what to do. I called the nurse." E3 was asked when he is supposed to administer CPR and stated "when no breathing and pulse at all." E3 was asked to describe what happened on 6/05/11 to R6 and validated the notes he wrote on 6/05/11 and	W 331		

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 331	Continued From page 10	W 331		

10/05/11 were his account of what happened to R6 on 6/05/11. E3 clarified that R6 did not fall but E3 assisted R6 to sit on the floor. E3 added he could hear R6 inhaling and see chest rising. To determine responsiveness, E3 validated he tapped R6 on the shoulder and R6 did not look up when tapped or name called.

E3 was asked on 10/12/11 at 12:05 PM regarding R6's pulse and breath. E3 remembers checking R6's pulse at least once. E3 was asked to describe R6's breathing and validated R6's breathing seemed heavier than his usual normal breathing. E3 was asked if he called the QMRP (E2) prior to calling 911. E3 validated he was not sure, he might have.

Review of the Facility Policy No: 5.57 Physical Injury and Illness/Individual Medical Emergencies (Revised: 09/09) includes: "Policy - Individuals served by the agency shall receive timely and effective medical service for physical injuries and medical emergencies. Definitions - Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Staff Responsible - E. Direct Support Person (DSP). Procedure - In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following: A. As soon as the injury or illness is determined to be a medical emergency, the DSP is to call 911 and follow the steps in F of this policy. F. In case of a medical emergency, 1. Notify the local emergency service to transfer (use 911 or local emergency number), 2. Follow instructions of operator if available, and administer CPR/First Aid, as needed. I. The QMRP/Administrator shall

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	14G349	A. BUILDING _____ B. WING _____	10/20/2011

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SEYMOUR TERRACE	1504 16TH STREET NORTH CHICAGO, IL 60064

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W 331	Continued From page 11 conduct any necessary interviews or inquiries to establish the probable cause of the injury and document the finding on the Progress Note (Form #GP-15)." Review of the Facility Policy No: 5.24 Investigative Committee (Revised 5/11) includes: "Definitions: Neglect - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Purpose: The Investigative Committee shall be responsible for the following: A. To identify, review and determine if alleged violations of any individual's rights, including abuse and neglect have occurred. B. To investigate allegations in a professional and impartial manner. C. To protect individuals from further harm." Review of the First Aid/CPR/AED Participant's Manual (provided on 10/12/11), page nineteen, includes the following information: "If an adult is not breathing or is not breathing normally and if the emergency is not the result of non-fatal drowning or other respiratory cause such as a drug overdose, assume that the problem is a cardiac emergency. What to Do Next - If an unconscious person is breathing normally, keep the person lying face up and maintain an open airway with the head-tilt/chin-lift techniques... -If an unconscious adult has irregular, gasping or shallow breaths (agonal breathing) or is not breathing at all, begin CPR." On 10/11/11 at 2:35 PM, E1 (Facility Representative) was notified that the Immediate Jeopardy was removed when the surveyor confirmed through interview and review of the	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G349	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 331	Continued From page 12 facility plan that the facility took the following actions to remove the Immediate Jeopardy: - Discussed with Direct Support Personnel the duties to observe residents' conditions, look for and observe signs and symptoms of medical problems and duress, report any medical issues to the facility's consultant nurse for further evaluation. - Staff will be in-serviced to initiate CPR when an individual is found not to be breathing or having a pulse and 911 will be called. - Nursing and DSP staff will be in-serviced on polices on Physical Injury and Illness/Individual Medical Emergencies, Nursing Services, Medical Appointment, Medical Services, Diagnostic Service and Registered Nurse Consultant Job Description - Retrain all staff in Basic Health and Safety to recognize signs and symptoms of serious diseases. While the Immediate Jeopardy was removed on 10/11/11, the facility remains out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan.	W 331		
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 did not ensure medications are given to residents according to physician's orders affecting R6, 1 of 1 resident outside of the sample who did not	W 368		11/24/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G349	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR TERRACE	1504 16TH STREET NORTH CHICAGO, IL 60064

(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 368	Continued From page 13 receive the correct dose of Acetaminophen. Findings include: R6 was a 57 year old male with diagnoses including Profound Mental Retardation, Seizure Disorder and Spastic Quadriplegia according to his June 2011 Physician's Orders Sheet (POS). R6's June 2011 POS and MAR (Medication Administration Record) validates an order of Acetaminophen (Tylenol) 650 mg every 4 hours as needed for pain/fever above 100 (Notify RN if used more than 72 hrs). Medication Notes section on the back of R6's June 2011 MAR, with Diphenhydramine PRN as the first entry, validates the following hand-written entries: 6/2/11 - 1:30 PM Tylenol 325 mg 3 pills for pain 6/2/11 - 5:30 PM Tylenol 325 mg 3 pills for pain 6/2/11 - 6:00 PM Tyleno(l) 325 mg, 3 pills for pain 6/3/11 - 11:30 (PM) Tylenol 325 mg x3 for pain 6/4/11 - 6 am Tylenol 325 mg x3 pain. The correct dosage would be 2 tablets for pain. R6 was administered an additional 325 mg at each of these times. E7 (Nurse Consultant) was asked on 10/5/11 approximately at 1:45 PM regarding the hand-written entries of Tylenol on 6/2/11, 6/3/11 and 6/4/11. E7 validated the written entries were for three pills each 325 mg, total dose given is 975 mg. E7 stated "maybe they gave extra-strength." Surveyor asked E7 regarding the order for the 975 mg. Review of R6's June 2011 POS validates an order for Acetaminophen 650 mg every four hours for pain PRN (as needed).	W 368		

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 385	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility did not maintain an accurate record of the receipt and disposition of all controlled drugs for R6, 1 of 1 resident outside the sample. Findings include: R6 was a 57 year old male with diagnosis of Profound Mental Retardation according to his June 2011 Physician's Orders Sheet.. On 6/0/211, E7 (Nurse Consultant) received twelve Ativan 0.5 mg tablets and thirty Tylenol #3 tablets. R6's Controlled Drug Receipt/Record/Disposition Form validates R6 received five Ativan and six Tylenol #3 from 6/02/11 through 6/05/11. The final count should be seven Ativan and twenty-four Tylenol #3. Instead the count was six Ativan and twenty-three Tylenol #3. On 10/05/11 approximately at 12:08 PM, E7 was asked about the discrepancies in the count on the Controlled Drug Receipt/Record/Disposition Forms for R6's Ativan and Tylenol #3. E7 did not have an answer for the discrepancies in the count. On 10/13/11 approximately at 2:45 PM, E7 was asked about the missing tablet of Ativan and Tylenol #3. E7 stated "I can't say what happened	W 385		11/24/11

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 385	Continued From page 15 to it. My theory would be someone did not record a tablet given. I was aware but didn't register that there was missing sign out of drug. All that registered was what was destroyed matches the last count." R6's Controlled Substance Destruction Form emailed by facility to the Department on 10/07/11 validate destruction of six Ativan and twenty-three Tylenol #3. There is one missing Ativan and one missing Tylenol #3 that was not accounted for.	W 385		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230d)2)3) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services	W9999		

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W9999	Continued From page 16 d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. 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 prevent medical neglect when they failed to adequately monitor and intervene regarding the serious medical condition for 1 of 1 resident who expired in the last six months (R6) when: - R6 was not responding to staff, had abnormal breathing and staff did not immediately call 911. - Facility did not investigate the significant event involving R6 on 6/05/11. - Facility did not ensure re-training of staff or ensuring safeguards are in place for the remainder of the residents in the facility (R1, R2, R4 and R5). Findings include: Resident's level of function according to the Facility Resident Roster provided on 10/03/11 show that R1 is a 49 year old male with Moderate MR (Mental Retardation), R2 is a 60 year old female with Severe MR, R4 is a 44 year old	W9999		

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W9999	Continued From page 17	W9999		

female with Profound MR, and R5 is a 36 year old female with Severe MR. R6 was a 57 year old male with diagnoses including Profound Mental Retardation, Seizure Disorder and Spastic Quadriplegia according to his June 2011 Physician's Orders Sheet.

R6's ISP (Individual Service Plan) dated 12/20/10 validates a Functional Assessment conducted on 12/21/10 with a result of five years and 10 months. The Medical History section reports "R6 has no physical limitations and uses no adaptive equipment. R6 and his representative do not wish to put a DNR (Do Not Resuscitate) order in place at this time." The Other Medical Comments section includes "Ambulatory with a steady gait. R6 is continent of bladder and bowel." The Communication section validates R6's communication skills at 5 years, 1 month. R6's Language Comprehension Skills were at 6 years, 6 months. R6's Language Expression Skills were at 3 years, 2 months.

Review of reports from the local hospital shows R6 was transported to the hospital on 6/05/11 prior to his death on 6/06/11:
- "Final Report of the CT Scan of the Abdomen and Pelvis (Exam date of 6/05/11 at 11:17 AM), Impression: 1. Mechanical obstruction secondary to sigmoid volvulus.
- Consultation on 6/05/11 (at 1:55 PM), Physical Examination: Abdomen - Distended and firm. Bowel sounds are absent. Assessment: The patient is status post arrest, acute abdomen. Await surgical opinion. The patient's prognosis is guarded at this point.
- Neurology Consultation on 6/05/11 (at 5:13 PM), Impression: Coma and seizures/status epilepticus

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	14G349	A. BUILDING _____ B. WING _____	10/20/2011

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W9999	Continued From page 18	W9999		

due to anoxic encephalopathy.
- History And Physical (6/06/11 at 9:12 AM), History Of Present Illness: Apparently, the patient had been found unresponsive with a cardiac arrest and EMS has been called...The patient had a CT of the abdomen which demonstrated sigmoid volvulus. All labs and clinical presentation have demonstrated the patient was in anoxic encephalopathy with multiorgan failure. Physical Examination: Gastrointestinal - Abdomen extremely protuberant. No bowel sounds. Disposition: The patient unfortunately has multiorgan failure, had a cardiac arrest at home, has anoxic encephalopathy, and is resuscitated on a ventilator, IV support fluids, and two pressors. The outcome is extremely poor. Will have to talk to the state guardian regarding medical plans."

R6's Certification of Death Record validates date of death on 6/06/11, time of death at 4:33 PM. Cause of Death listed includes a. Septic Shock, b. Decubitus Ulcers, c. Bacteremia, Multiorgan Failure.

Progress Notes (GP-15) dated 6/5/11 for R6 includes the following written by E3 (Direct Support Person, DSP):
"Around 8:10 AM, R6 brought his breakfast plate into the kitchen. Staff (E3) was in the dining room and heard (R6) scream and drop his plate. (E3) ran to investigate and saw R6 trying to hold himself up on the trash can. (E3) tried to hold (R6) up but he collapsed against the wall. (R6) was breathing very heavy and slow. (R6) looked up slightly, but was not responding to (E3). E3 contacted the RN (E7) who said to call 911. R6's breathing and pulse was very feint (sic), and he

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	14G349	A. BUILDING _____ B. WING _____	10/20/2011

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SEYMOUR TERRACE	1504 16TH STREET NORTH CHICAGO, IL 60064

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W9999	Continued From page 19 was completely limp." E1 (Facility Representative) was asked on 10/05/11 at approximately 12:15 PM regarding investigation into the events involving R6 on 6/05/11. E1 validated there is no investigation but E1 made sure E3 was asked if R6 had a pulse and was breathing. E1 added that E3 is adamant R6 was breathing and had a pulse. E3 did all of the steps to determine if CPR is needed. No CPR was initiated. On 10/05/11 approximately at 11:00 AM, the Emergency Medical Services Field Report completed on 6/5/11 for R6 was obtained from the local hospital for review and includes the following information: "Unit Notified: 0834 (8:34 AM) Unit Enroute: 0834 Arrived Scene: 0836 (8:36 AM) At Patient: 0836 Enroute Destination: 0850 (8:50 AM) Aid Prior to Arrival: none Illness/Injury: Unresponsive Assessment: (Pain, LOC, GCS, LMP) 000 No Pulse Vitals Signs: Time: 0836 (8:36 AM) and 08:50 (8:50 AM) B/P: 0, HR: 0, RR: 0, SP02: 0, Lung Sounds: Left 0, Right 0, Pupils: Left 0, Right 0, Temp: Cool, Skin Parameters: Pale. Patient Narrative: 57 y/o male is found unresponsive and not breathing, moved to MICU while starting CPR, EKG=Asystole, established IV 20 g R AC, ET 71/2 with good placement, suction fluid out of mouth, BVM @14 LPM o2, gave EPI, 1:10,000 1mg followed by Atropine 1 mg, continued CPR, still no pulse, 2nd round of EPI	W9999		

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W9999	Continued From page 20	W9999		

and Atropine continued CPR, patient converted to V-fib outside ER, defib at 200 jewels (sic), Patient converted to PEA and was turned over to ER staff."

At approximately 12:08 PM on 10/05/11, E7 (Nurse Consultant) was asked regarding Progress Note by DSP (E3) on R6 dated 6/05/11. E7 validated E3 called her about R6 and E7 told E3 to call 911 and then call E2 (QMRP). E7 stated E3 told her he had already called E2 (QMRP) prior to calling E7 and 911.

On 10/05/11 at approximately 2:00 PM, E1 (Facility Representative) was asked when E3 (DSP) called 911. E1 was informed of the different times noted in E3's Progress Note and the EMS Field Report. E1 stated that E3 called 911 right away.

On 10/06/11 at approximately 1:00 PM (Time print from fax was 12:48), E1 faxed surveyor a note written by E3 (DSP) dated 10/05/11. This note was written on an unlabeled form. The note includes the following:
"8:10 am was a rough guess. According to the report the ambulance was notified at 8:34. There was nowhere near a 24 minute time gap between R6's collapse and me calling 911. A more accurate estimation would be that he collapsed around 8:30. I did not have time to write a GP 15 until around 9:30, so my estimation was likely wrong. I called the nurse before 911 because that morning I have given R6 a PRN medication, for constipation, and my first thoughts on his collapse was that he was possibly having a very difficult bowel movement, since there was a loud flatulant (sic) sound. I did not immediately think that it was

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	14G349	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 21	W9999		

an emergency. Although R6 raised his head and made eye contact at first, he began losing responsiveness as I was beginning to call the nurse. R6 was breathing heavily for the first minute or so of the situation, I was able to hear it and see his chest rise. He still appeared to be breathing when I called 911. His chest movement was slower and lighter. The last point I was able to check his breathing was about a minute before the ambulance arrived. I checked by placing my ear near his mouth. I saw some movement in his chest. I also checked his pulse near his right wrist."

E1 (Facility Representative) also faxed, on 10/06/11 at 12:48 PM, a one-page document from First Aid/CPR/AED Participant's Manual page 72 titled Sudden Illness. E1 stated on 10/06/11 at 2:20 PM that the page sent from Participant's Manual is what staff were trained on. This document includes the following information:
"Sudden Illness. What to Look For:
When a person becomes suddenly ill, he or she usually looks and feels sick. Common signals include:
-Changes in level of consciousness, such as feeling lightheaded, dizzy, drowsy or confused, or becoming unconscious
-Breathing problems (i.e., trouble breathing or no breathing)
-Signals of a stroke, including sudden weakness on one side of the face; sudden weakness, often on one side of the body; sudden slurred speech or trouble forming words, or a sudden severe headache
-Signals of shock, including rapid breathing, changes in skin appearance and cool, pale or ashen (grayish) skin

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	14G349	A. BUILDING _____ B. WING _____	10/20/2011

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W9999	Continued From page 22 -Persistent abdominal pain or pressure. When to Call 9-1-1 -Unconsciousness or altered level of consciousness -Breathing problems -Persistent abdominal pain or pressure... Remember if you cannot sort out the problem quickly and easily (cut out) if you have any doubts about the severity of the illness (cut out) make the call for help. What to Do Until Help Arrives -First care for life-threatening conditions such as unconsciousness; trouble breathing; no breathing;... -Watch for changes in consciousness and breathing..." On 10/06/11 at approximately 2:20 PM, E1 (Facility Representative) was asked if an investigation was done regarding events on 6/05/11 involving R6. E1 stated "E3 (DSP) did everything according to policy and procedure. E3 checked for breathing and pulse. I did not see anything that E3 did not do according to procedure. Nothing that I noted or that was brought to my attention with regards to E3's handling of situation that morning. E1 and E7 (Nurse Consultant) looked at R6's records and did not see anything that indicated anything needing further investigation." E3 (Direct Support Person) was interviewed on 10/11/11 at 2:30 PM and validated he called E7 on 6/05/11 two times. First call was due to R6 not having a bowel movement and to ask what PRN to give. Second call was regarding R6 collapsing, losing responsiveness. E3 was asked for signals of responsiveness and stated "ask for name and	W9999		

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	14G349	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 23	W9999		

if no answer, no responsiveness. I believe now I'm supposed to call 911. I was panicked and I did not know what to do. I was unsure of what to do. I called the nurse." E3 was asked when he is supposed to administer CPR and stated "when no breathing and pulse at all." E3 was asked to describe what happened on 6/05/11 to R6 and validated the notes he wrote on 6/05/11 and 10/05/11 were his account of what happened to R6 on 6/05/11. E3 clarified that R6 did not fall but E3 assisted R6 to sit on the floor. E3 added he could hear R6 inhaling and see chest rising. To determine responsiveness, E3 validated he tapped R6 on the shoulder and R6 did not look up when tapped or name called.

E3 was asked on 10/12/11 at 12:05 PM regarding R6's pulse and breath. E3 remembered checking R6's pulse at least once. E3 was asked to describe R6's breathing and validated R6's breathing seemed heavier than his usual normal breathing. E3 was asked if he called the QMRP (E2) prior to calling 911. E3 validated he was not sure, he might have.

Review of the Facility Policy No: 5.57 Physical Injury and Illness/Individual Medical Emergencies (Revised: 09/09) includes: "Policy - Individuals served by the agency shall receive timely and effective medical service for physical injuries and medical emergencies. Definitions - Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Staff Responsible - E. Direct Support Person (DSP). Procedure - In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G349	A. BUILDING _____ B. WING _____	10/20/2011

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SEYMOUR TERRACE	1504 16TH STREET NORTH CHICAGO, IL 60064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 24 A. As soon as the injury or illness is determined to be a medical emergency, the DSP is to call 911 and follow the steps in F of this policy. F. In case of a medical emergency, 1. Notify the local emergency service to transfer (use 911 or local emergency number), 2. Follow instructions of operator if available, and administer CPR/First Aid, as needed. I. The QMRP/Administrator shall conduct any necessary interviews or inquiries to establish the probable cause of the injury and document the finding on the Progress Note (Form #GP-15)." Review of the Facility Policy No: 5.24 Investigative Committee (Revised 5/11) includes: "Definitions: Neglect - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Purpose: The Investigative Committee shall be responsible for the following: A. To identify, review and determine if alleged violations of any individual's rights, including abuse and neglect have occurred. B. To investigate allegations in a professional and impartial manner. C. To protect individuals from further harm." Review of the First Aid/CPR/AED Participant's Manual (provided on 10/12/11), page nineteen, includes the following information: "If an adult is not breathing or is not breathing normally and if the emergency is not the result of non-fatal drowning or other respiratory cause such as a drug overdose, assume that the problem is a cardiac emergency. What to Do Next - If an unconscious person is breathing normally, keep the person lying face up and maintain an open airway with the head-tilt/chin-lift techniques... -If an unconscious	W9999		

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W9999	Continued From page 25 adult has irregular, gasping or shallow breaths (agonal breathing) or is not breathing at all, begin CPR." (A)	W9999		