STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G269	A. BUILDING _____ B. WING _____	C 02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY TERRACE	**43 BROADWAY CHICAGO HEIGHTS, IL 60411**

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W 368	Continued From page 8 by the doctor. 2. R1, per the Individual Profile General Data Sheet dated 11/2002, has diagnoses that include Severe Mental Retardation, Chronic Obstructive Pulmonary Disease and Panic Disorder. R1 is dependent on facility staff for the administration of his medications. On review of the most recent Physician's Order Sheet for February 2012, R1's medication orders included an order for Atrovent 0.02%, 1 vial via nebulizer three times a day, scheduled at 7 AM, 4 PM and 8 PM. On review of the Medication Administration Record, it was documented that R1 received all of his scheduled medications on the morning of 2/1/12, except for the 7 AM dose of Atrovent. During an interview on 2/1/12 at approximately 7:30 AM, E3 (Direct Service Person) confirmed that R1 did not received the Atrovent. E3 stated, "They (pharmacy) don't sent the Atrovent vial anymore; it comes mixed in with the Albuterol." E3 further stated, "That order needs to be changed." E3 was later observed asking another staff member how she administers the Albuterol and the Atrovent. The surveyor asked E3 if she had the physician's order to reflect the change in the order for Atrovent. E3 acknowledged that she did not administer the Atrovent as ordered by the physician. E3 stated, That's my medication error."	W 368		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	W9999		

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W9999	Continued From page 9 LICENSURE VIOLATIONS 350.620a) 350.1230d)2) 350.3240a) 350.3240e) 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 350.1230 Nursing Services 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. 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) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome	W9999		

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of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on record review and interview, the facility failed to implement the policy and procedure for abuse prevention for 1 of 3 clients in the sample (R1) by failing to 1) ensure that staff named in an allegation of staff-to-resident abuse is immediately removed from direct contact with clients during the investigation and 2) ensure that staff named in an allegation of abuse and neglect is provided with the necessary training prior to returning to the work place.

Findings include:

On review of an Allegation of Abuse Neglect Report dated 12/13/11, facility staff documented that on 12/12/11, the facility was made aware of an allegation of resident abuse. Facility staff documented in the report that on 12/12/11, the Facility Representative was contacted by the facility Resident Services Director with an allegation of abuse involving a staff member (E3). E1 documented in the report that E3, "was suspended pending the outcome of the investigation."

During an interview on 1/31/12 at approximately 2:00 PM, E2 (Resident Services Director) stated that she was made aware of an allegation of resident abuse on 12/12/11. E2 stated that E3 (Direct Service Person) approached her and stated that she got a telephone call from staff who

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work at a sister facility, informing E3 she had been named in an allegation of resident abuse. E2 stated she instructed E3 to write a statement related to this allegation of abuse. E2 stated that she called the Facility Representative (E1) on 12/12/11 and informed her of the allegation of abuse towards E3.

During an interview on 1/31/12 at 2:10 PM, E1 (Facility Representative) confirmed that E2 notified her of the allegation of resident abuse involving E3 on 12/12/11. E1 stated that facility staff are required to report all allegations of abuse directly to the Facility Representative. According to the facility Abuse/Neglect Reporting and Investigation Procedure, alleged abusive/neglectful acts must be reported immediately to facility management in the following order: facility representative, executive director and then the director of operations. E3 failed to follow the facility procedure for reporting an allegation of resident abuse, when she reported the allegation of abuse involving herself to the Resident Services Director (E2), instead of reporting it to the Facility Representative (E1).

On 12/13/11, E1 sent the State Agency a letter confirming that she was made aware of the allegation of abuse involving E3 on 12/12/11. E1 stated in the letter, "On 12/12/11, the Facility Representative was contacted by the Resident Services Director of facility regarding an allegation of abuse involving a staff member (E3)."

During the interview on 1/31/12, E1 stated that facility staff promptly initiated an investigation. E1 stated that it was determined that R1 was the

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client who was allegedly abused by E3; and that the alleged incident occurred on 12/1/11. However, the allegation of abuse was not reported to facility staff until 12/12/11, when E3 reported to the Resident Services Director (E2) that she had been named in an allegation of abuse. E1 stated that every staff member was interviewed and that all of the clients in the home were interviewed as well.

R1, per the Individual Profile General Data Sheet dated 11/2002, has diagnoses that include Severe Mental Retardation, Chronic Obstructive Pulmonary Disease, Schizophrenia, Depression and Panic Disorder. The Individual Service Plan (ISP) dated 3/11/2011 states that R1, "needs assistance with wiping himself properly after using the restroom." The ISP also documents that R1, "has occasional toileting accidents and uses protective underwear to assist him in this area." The ISP also documents that R1 requires sedation for dental procedures.

During a confidential telephone interview on 1/31/12 at approximately 9:50 AM, Z3 stated that R1 was neglected by facility staff when he returned to the home following a dental appointment on 12/1/11. Z3 stated that the client had three teeth extracted and required sedation for this procedure. R1 was observed several hours after his appointment wearing clothing that was "soaked in urine and stool." Z3 stated that the client was wearing a shirt with large blood stains; and that he was still bleeding from his mouth. Z3 stated that R1 attempted to change his incontinence brief, but was having difficulties because he had been previously sedated. Z3 stated that R1 did not receive any assistance

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from any of the staff in the home with changing his bloody shirt, changing his clothing or assisting him with changing his incontinence brief. Z3 stated that facility staff neglected to provide the necessary care to R3.

The Allegation of Abuse Final Report dated 12/16/11, states E1 interviewed Z3 who identified a situation where E3 abused a client in the facility. According to the interview with Z3, it "Was about two weeks ago, I came in to work, (E3) was outside having a cigarette, she was the only one here (at the home). She said (R1) was home and she just gave him a rag which to wipe the blood from his face due to he had just got some teeth pulled. So then I asked how he was? She said he was still bleeding and she said oh by the way R1 is wet and I'm having him change. He was soaking wet and was trying to get out of his clothes by himself.....Blood was on his shirt from the dental appointment."

On further review of the Allegation of Abuse Final Report dated 12/16/11, E1 documented an interview with E3. During the interview, E3 stated, "1:30 pm - 2:00 pm he came out of his room I gave him a rag and told him to wipe his face.....I was in there when he went to the bathroom and gave him a fresh diaper." E1 documented that E3, "told him when he changed to come out and get something to eat." According to the documentation, E3 did not provide R1 with any assistance with changing his incontinence brief, cleaning the blood from his face or changing his clothing.

The Allegation of Abuse Final Report dated 12/16/11 was sent to the state agency on

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12/17/11. According to the Final Report, facility staff determined that "(R1) had been observed to be wet." The Final Report also stated, "The following recommendations were made by the investigative committee: All staff members should be retrained on investigative committee Policy 5.24. All staff members who were aware of this situation should be disciplined for failure to follow company protocol regarding reporting abuse neglect immediately when observed."

On review of the Attendance Archive Time Card for E3, the documentation supports that she worked on 12/12/11 and 12/13/11. E3 was not immediately suspended and/or removed from the work place, when the allegation was reported to E2. The suspension for E3 did not start until 12/14/11. During an interview on 1/31/12, E2 confirmed that E3 worked with clients on 12/13/11. E2 stated, "E3 worked the entire shift on 12/13/11; she was out to a doctor's appointment with a client and not in the facility." During an interview on 1/31/12, E1 stated that she and E2 were both responsible for ensuring that E3 was removed from the schedule and was not to return to work until the investigation was completed.

The Attendance Archive Time Card states that E3 was suspended from 12/14/11 to 12/17/11. E3 had regularly scheduled off days on 12/18/11 and 12/19/11; and returned to work 12/20/11. On review of the In-Service Education/Meeting Report for training on Policy 5.24 for Reporting and Documenting Allegations, it was documented that E3 was not trained or in-serviced on the proper procedures for reporting and documenting abuse until 12/30/11. E3 was allowed to returned

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W9999	Continued From page 15 to the workplace without having the necessary training for reporting an allegation of abuse. This resulted in the facility's failure to ensure client safety. On review of the Facility Investigative Committee Policy 5.24, "If the allegation is that an employee committed an act of abuse or neglect, the employee shall be suspended from duty until such time as the: 1) Investigation is complete and 2) the Administrator considers the report and takes administrative action." (B)	W9999		