STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W 339	Continued From page 129	W 339		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1220j) 350.1230d)1)2) 350.1610e)1) 350.1610g) 350.3220f) 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 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W9999	Continued From page 130	W9999		

welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.

Section 350.1230 Nursing Services

d) Direct care personnel shall be trained in, but are not limited to, the following:

1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

2) Basic skills required to meet the health needs and problems of the residents.

Section 350.1610 Resident Record Requirements

e) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.

1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.

g) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W9999	Continued From page 131 Section 350.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 requirements are not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing services were provided and policies and procedures to prevent abuse and neglect were implemented and clients were free from the development of decubitus for 2 of 6 clients who expired with a decubitus present at the time of their death (R3,R6), and for 5 of 5 clients who currently have active decubitus present at this time, that developed while under the care of this facility (R8,R9,R10,R11,R12). Findings include: R3, per review of face sheet dated 3/13/12, was a male client with the documented diagnoses of Profound Mental Retardation, and Cerebral Palsy.	W9999		

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	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W9999	Continued From page 132	W9999		

R6, per review of Physician's Order Sheet dated 12/15/11 - 1/14/12, was a female client with the documented diagnoses of Profound Mental Retardation, Down Syndrome and Seizure Disorder.

R8, per review of face sheet dated 3/13/12, is a male client whose diagnoses include Severe Mental Retardation, Cerebral Palsy, and Cerebral Vascular Accident.

R9, per review of face sheet dated 3/13/12, is a female client whose diagnoses include Severe Mental Retardation, and Alzheimer's Disease.

R10, per review of face sheet dated 3/13/12, is a male client whose diagnoses include Profound Mental Retardation, and Down Syndrome.

R11, per review of face sheet dated 5/2011, is a female client whose diagnoses include Moderate Mental Retardation, Down Syndrome, and Dementia.

R12, per review of Physician's Order Sheet dated 4/15/12 - 5/14/12, is a female client whose diagnoses include Severe Mental Retardation, Cerebral Palsy, and Vision Impairment.

The Policy and Procedure entitled, "Abuse and Neglect of Persons Receiving Services " , with a revision date of 2/5/12 was reviewed. It reads, but is not limited to, " Purpose: There are multiple purposes of this policy. Chief of these is to assure that persons with disabilities are served by the facility in a manner that allows them from fear of abuse or neglect...The facility accepts zero tolerance for abuse and neglect....All allegations

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	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W9999	Continued From page 133	W9999		

are reported to the Office of Inspector General or to the Department of Public Health, as appropriate, based on Administrative rules to the program in which the allegation is reported."

The Definition of Neglect is defined as follows, " Neglect: The failure to provide adequate medical or personal care or maintenance; which failure results in physical or mental injury to an individual or in the deterioation of an individual ' s physical or mental condition. "

The Policy and Procedure entitled, " Skin Integrity Protocol " , with a revision date of 8/11/11 was reviewed. It reads, but is not limited to, " Purpose: Promoting healthy skin integrity is of utmost importance to all residents of the Facility. By preventing skin impairment, residents are able to maintain usual daily activities and enjoy the level of participation to which they are accustomed. Goal: To maintain the skin integrity of all residents. To treat skin impairment with a systematic and multidisciplinary approach. It is the responsibility of all staff working at the facility to report changes in skin integrity to the Nurse on duty...The nurse on duty will assess the skin. Initiate the Pressure Ulcer Assessment Guide. Take appropriate action depending on the stage of the skin impairment. All nurses are responsible for: monitoring staff positioning of resident to prevent further pressure on the site...Health Services Adminstrator responsibilities: Institute additional training as needed. "

The Skin Integrity Protocol Directive #83 undated, was reviewed. Under #7, it reads, ' Reposition every two hours, or at least every 1 hour if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 134	W9999		

impairment is present. Inform the nurse immediately if a red area is noted. Resident will then be held back, remain at home and repositioned at least every hour. "

R3's Discharge Summary dated 3/26/12 was reviewed. Under Date of Expiration it reads, "3/26/12 at 12:30pm." Under Cause of Death, it reads, "Respiratory Failure, End Stage Dementia, and Alzheimer's."

The Physician's Order Sheet dated 3/15/12 - 4/14/12 was reviewed. An entry dated 3/23/12 reads, "Wound Vac, Change drsg(dressing) q(every) 3 days. If drsg comes off or becomes inoperable, apply wet to dry drsg until wound vac drsg can be replaced." The Pressure Ulcer Assessment Guide for R3 was reviewed. The nursing notes from 1/2/12 was reviewed, and it states that client has no open areas, with warm and dry skin. R3 had just returned from a hospitalization, and the facility assessed R3's skin at this time. R3's entry dated 2/7/12, notes his R buttock decubitus status as being a Stage 2, that measures 4 cm x 3 cm, with a narrative description that reads, "Wound bed c(with) white tissue c pink edges, hard induration." The 2/20/12 entry describes the R buttock decubitus as a Stage 2, which measures 8cm x 3.3 cm, with a depth of 0.3cm. The description of the wound is as follows, "R buttock wound c whitish tissue, slight redness around wound, hard induration." The entry of 3/20/12 notes the location of the decubitus to be on the right buttock, Stage 3, measuring 9.5 x 7.5 x 1(centimeters). The Description of the Ulcer reads, "R(right) buttock area noted c(with) yellowish fatty tissue to wound bed, edges noted c dark red tissue. Wound c

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	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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W9999	Continued From page 135 clear-yellowish drainage noted on old dressing." R3's nursing notes entry from 1/19/12 reads,"Per Day Training staff, client has a red area to R buttock. Per Day Training nurse, has a R(red) area to R buttock slightly raised. Staff informed to reposition off buttock." The next entry, dated 1/20/12 reads, "R buttock slightly raised, decreased redness. Repositioned off buttock." The next entry in R3's nursing note is from 1/29/12, which reads, "8-4 staff reported pt(patient) Rt buttock reddened, went to observe, Rt buttock cheek reddened and felt hard, mass like. No discharge to site. Has Stage 2 decub. Called MD c new orders." Per review of nursing notes, R3 went out to the hospital for evaluation of his R buttock, and was admitted with cellulitis. At the time of discovery on 1/19/12, no entry was noted on the measurement guide, nor was a call placed to the physician to update on the new decubitus/hard mass/reddened area on his R buttock. Md was not notified until 10 days later, on 1/29/12. Resident returned from the hospital on 2/6/12, with a diagnosis of R buttock (abscess s/p I&D(Incision and Drainage), appox size 1cm x .5cm). The first Pressure Ulcer Assessment Guide that notes any breakdown of skin is dated 2/7/12, measuring 4cm x 3cm. There is no entry for the date of 1/19/12, when the redness was first discovered. Nursing notes were reviewed for on- going documentation of the progression, description, and pressure relief measures implemented for R3's decubitus; No documentation is noted on 2/11, 2/15-2/16, 2/18-2/22, 2/24-2/26, 2/28,3/2-3/5, 3/16-3/18 on these issues. On 3/19, an entry is noted for required debridement scheduled for 3/22, 3/23 wound vac recommendation, 3/25- Hospice	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W9999	Continued From page 136 evaluation received, 3/26- still waiting for final consents from Hospice, 3/26 at 12:25pm, client stopped breathing, call placed to MD, is a DNR, 911 called, and R3 was pronounced expired at 12:30pm. R3's Reposition Sheets were reviewed for a three week period from March 1st. until client expired on 3/26/12. Reposition sheets were missing for all three shifts for the dates of 3/2,3/4.3/6,3/10,3/15,3/21,3/22,3/25,and 3/26. For the remaining days of March when reposition sheets were accounted for, multiple sheets were missing for each shift. During an interview with E3(Director of Nursing) on 5/3/12 at 1:45pm, E3 asked what needs to be in place as per their Skin Care Policy. E3 stated that the Pressure Ulcer Assessment Guide needs to be implemented upon discovery(R3's wound was not documented until 2/7/12, when it was discovered on 1/19/11). When asked what is the expectation of how often the nurses should be documenting about the decubitus in the nursing notes, E3 stated that their policy is not clear on that, but that they chart by exception, meaning it is not normal to have skin breakdown, so they should be documenting at least daily. E3 was also asked about the Reposition Sheets, how many dates are missing, and many shifts are missing for the dates that are accounted for. E3 stated that there should be a log for every shift, of every day, and that they should be filled out completely. E3 was asked how she can be sure the staff is assessing, and repositioning as per their policy, when documentation does not reflect this. E3 stated that she thinks the staff are following their policy, but without the	W9999		

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	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W9999	Continued From page 137	W9999		

documentation, she understands that it is difficult to prove that they are.

The Policy entitled, "Skin Care Policy and Procedure, with the latest revision date documented as 10/19/10, was reviewed. It states, upon discovery of a stage 1 decubitus, nursing staff will initiate the Pressure Ulcer Assessment Guide, and initiate turning the resident every hour, keeping pressure off the area. If a stage 2 or greater, staff will notify the physician, document the orders, initiate the treatment prescribed by the Physician, and hold Special Team Meetings when warranted. All nurses are responsible for documenting on the Pressure Ulcer Assessment Guide, monitoring of staff to ensure positioning of residents, to prevent further pressure on the site, and communicating changes or concerns in a resident's skin. The undated Skin Integrity Protocol was reviewed. Under number 7, it states that clients should be repositioned every two hours, or more often if breakdown is present(every 1 hour). Inform the nurse immediately if a red area is noted. Resident will then be held back home, and repositioned every hour until clear.

During a second interview with E3 on 5/4/12 at 10:15am, E3 was asked if she was aware that the documentation for R3 was inconsistent in both the nursing notes, and repositioning logs. E3 stated that she was not aware until now. E3 stated that they thought the wound was initially an abscess when it started, and that they eventually did an I&D on the area, and cellulitis developed. E3 stated that they should have initiated the Pressure Ulcer Assessment Guide upon first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 138	W9999		

discovery, and that staff should be documenting at least daily in the nursing notes on the progress of the decub/wound, possibly even every shift.

R6's Resident Discharge Summary dated 1/6/12 was reviewed. Reason for discharge is documented as expired at 3:30am. Cause of Death is documented at Respiratory Failure (End Stage Dementia). R6's Physician Order Sheets were reviewed. An entry dated 7/28/11 reads, "R Coccyx - Cleanse, Apply Duoderm every 3 days and PRN(as needed) until healed." Dressing change orders were noted periodically, from the initial order on 7/28/11 through 1/5/12. An order for a wound vac was obtained on 12/22/11, with an order for a Hospice consult on 12/23/11.

The Pressure Ulcer Assessment Guide sheets for R6 were reviewed. Even though R6's wound was documented to have been discovered on 7/28/11, the first Assessment Guide Sheet was not implemented until 8/8/11, when the wound was documented as a stage 2, which measured 2cm x 2cm. By 8/22/11, the measurement had now progressed to 4.5cm x 4.5cm. By 9/5/11, the wound measurements increased to 5cm x 7cm, with documentation indicating white tissue in the wound bed. Documentation on 10/24/11 indicates the wound now measures 4 x 5.9cm, with white tissue to upper edges. Documentation dated 11/23/11 indicates the wound is now a stage 3, with 2 areas of necrotic tissue. By 12/15/11, the wound now measures 6cm x 4.5cm with undermining of 2.5cm., and tunneling of 4.5cm. The wound at this point is now a stage 4. The last entry from 1/3/12 documents the wound as a stage 4, with wound vac therapy in progress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 139	W9999		

Nursing notes for R6 were reviewed. An entry dated 7/28/11 notes new skin breakdown to left buttock. An entry dated 8/4/11 notes new open area on coccyx which measures 2.5cm x 1cm. (No Pressure Ulcer Assessment Guide was implemented until 8/8/11). On 8/8/11, documentation notes the left buttock is now healed, but breakdown is noted to the right coccyx. The next mention of the coccyx breakdown is not until 8/11/11, when the physician came to see R6. The next entry that mentions anything about coccyx breakdown is on 8/15/11. The next entry is on 8/18/11, followed by 8/22/11, and 8/25/11. No new entry about the wound was not documented until 9/1/11, with no charting in between this date and 9/8/11, when the physician assessed the wound. No documentation is present regarding the wound on 9/14/11. On 9/15/11, the physician saw the client, but no mention of the wound again until 9/22/11. Again no documentation is noted from 9/28/11 - 10/6/11. The physician saw the client on 10/6/11, and than there is not documentation noted on the wound until 10/13/11, when the physician was in again to see the client. Again a lack of documentation on the wound from 10/14/11 - 10/19/11, with the physician seeing the patient on 10/20/11. From 10/25/11 - 11/2/11, no mention of the wound. Also noted a break in documentation from 11/18/11 - 11/22/11. The dates of 11/24/11 as well as 11/26/11 lack documentation on the wound progression. By 11/27/11 documentation notes necrotic tissue, with undermining present by 12/15/11. On 1/4/12 received a new air mattress through Hospice. On 1/5/12 the wound vac is discontinued. Nursing notes documentation notes the resident expired on 1/6/12.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 140 The Repositioning Sheets for R6 were reviewed from a period of 12/23/11 - 1/6/12. Sheets were missing for the following dates: 12/27 and 1/3/12. All dates that sheets are present are either missing one or two shifts for that individual day. When being repositioned, on occasion the client is being repositioned back to the same area she was just repositioned from. During an interview with E3 on 5/4/12 at 10:40am, E3 stated that she does not know why there is inconsistent charting on the wound, and repositioning measures. E3 stated that the nurses just need to make the time to document. E3 was asked how she can be sure the staff did in fact reposition R6. E3 stated with the lack of documentation, she cannot be sure. R8's Physician Order Sheets were reviewed. An order dated 4/30/12 reads, "Cleanse R coccyx area c(with) NSS(normal saline), then apply Duoderm q(every) 3 days and PRN(as needed) until healed." R8's Pressure Ulcer Assessment Guide was reviewed. An entry dated 4/30/12 documents a stage 2 measuring 4.5cm x 1.3cm x 0.1cm to the right coccyx. The nursing notes for R8 were also reviewed. An entry from 4/30/12 reads, "Client with new open area to R coccyx." The next note is from 5/3/12, when the physician came in to assess the coccyx. There is no nursing note documentation on the decubitus in between 4/30/12 through the 5/3/12. The Repositioning Sheets for R8 were reviewed. Charting indicates that on some days client is to be repositioned every 2 hours, and other days, to be repositioned every 1 hour.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 141 R8 was observed in his bedroom on 5/3/12 at 2:30pm. R8 has a reposition clock up in his room, indicating that he needs to be repositioned every 1 hour. E3(Director of Nursing) was present during this observation. R8 was lying on his back, when the repositioning clock indicated that he should be repositioned on his right side. E3 confirmed that the staff should have repositioned him 30 minutes ago. E3 confirmed that R8's decubitus developed here while under the care of their facility. R9's Physician Order Sheet dated 2/15/12 - 3/14/12 was reviewed. An order dated 3/13/12 reads, but is not limited to, "....Elevate foot and ankle of cast to keep pressure off of posterior cast." R9's Patient Information and Transfer Form dated 3/31/12 was reviewed. Under Major Diagnoses it reads, "Skin ulceration, early cellulitis." Under Patient Information, it reads, Right inner thigh cellulitis - open to air. R heel - stage 2 - OTA(open to air)." R9's Physician Order Sheet dated 3/15/12 - 4/14/12 was reviewed. An order dated 4/1/12 reads, "Rt heel sore, clean c saline and apply bacitracin ointment. Cover c 4 x 4 dressing BID(twice daily). Elevate Rt leg on pillows. Wear big spongy boot. No pressure on Rt heel." R9's Physician Order Sheet dated 4/15/12 - 5/14/12 was reviewed. An order dated 4/12/12 reads, "R foot heel - cleanse wound bed c(with) NSS(normal saline) or wound cleaner, gently pat dry. Apply Santyl to wound bed, cover c Hydrogel guaze and non-adherent foam dressing - secure c bulk roll guaze and medfix tape q day and PRN(as needed) until healed." R9's Pressure Ulcer Assessment Guide was reviewed. The entry from 4/2/12 states R9 has a stage 2 to her	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 142	W9999		

R heel which measures 3.5cm x 2.5 cm. R9's Repositioning Sheets from 4/1/12 - 4/10/12 were reviewed. R9 is missing sheets for the dates of 4/1, and for the dates of 4/6 - 4/9. For the dates when repositioning sheets were available, there was only one sheet for one shift of the day, not all three shifts.

During observations with E3(Director of Nursing) on 5/3/12 at 1:45pm, R9 was observed lying in her bed, with her R heel directly touching the mattress, without any pressure relief as is ordered from her physician. There also is no reposition clock posted by her bed. During an interview with E3 at this time, E3 was asked why there is no clock by R9's bed, even though she has an active decubitus to her R heel. E3 stated that R9 can reposition herself, so they do not use a clock for her. E3 also stated that because R9 can reposition herself, that she moves around so much in bed, and it is difficult for the staff to monitor if her R heel is free from pressure. E3 stated that R9 had surgery for a quadricept repair, and that when they took her cast off, they discovered that she had a stage 2 on her heel. Documentation in the nursing notes, and lack of repositioning sheets makes it difficult to discern if staff were keeping pressure off the R heel to prevent the development of skin breakdown.

R10's Physician Order Sheet dated 4/15/12 - 5/14/12 was reviewed. An order dated 4/19/12 reads, "Tx(treatment): sacral crease/inner buttock, cleanse c(with) NSS(normal saline), then apply Full Dakin's wet to dry drsg BID(twice daily) and PRN(as needed) until healed." The nursing note dated 5/7/12 for R10 was reviewed. It reads, but is not limited to, "Client awake, alert

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 143	W9999		

and responsive to verbal stimuli. Sacral crease wound c pinkish-red tissue, some white tissue, bone exposure. Size 4.5cm x 1.8 x 2.8cm with undermining 2*(o'clock) 2cm, 11 o'clock, 2cm and 12 o'clock, 1cm...some purulent, light green drainage. MD informed." Per review of nursing notes for the month of April, there is inconsistent documentation, with missing days of no documentation on the progression of the wound, repositioning, or even mention that a decubitus is present. R10's Pressure Ulcer Assessment Guide sheets were reviewed. The entry from 3/19/12 notes the decubitus measures 4.3 x 2 x 1cm to the inner buttock, which is a stage 2 at this time. The entry from 4/3/12 documents the wound to the inner buttock is now a stage 3, which measures 5cm x 3cm x 0.5cm. Undermining is now present in the wound. On 5/7/12 the wound to the site is now noted as being present to the sacral crease, and has progressed to a stage 4, with undermining at 3.4cm. R10's repositioning sheets were reviewed starting on 4/19/12 for a ten day period. The dates of 4/20-4/22, 4/24, 4/25, and 4/27 had no repositioning sheets available. On the dates that reposition sheets were located, they lacked inconsistent documentation, and did not have a sheet representing each shift, making it difficult to prove that staff had been repositioning R10 as per their policy.

R10 was observed lying in his bed on 5/3/12 at 2:30pm, while doing rounds with E16(Assistant Director of Nursing). Per his reposition clock posted at R10's bedside, R10 should have been lying on this Right side. R10 was found lying on his left side, 30 minutes late from when he should have been repositioned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 144 R11's Pressure Ulcer Assessment Guide sheets were reviewed. An entry dated 2/13/12 states the area to R11's R buttock is healed, when it had been a stage 2 on 1/28/12 measuring .1cm x .1cm. On 4/2/12, the R buttock is now open again, as a stage 2 which measures 2cm x 1 cm x 0.1cm. R11's nursing notes were reviewed. The entry from 2/13/12 reads, "R buttock area healed." From the dates of 2/13/12 - 4/2/12, only two entries are present, one on 3/29/12 and one on 3/30/12, both talking about an intermittent cough. On 4/2/12, documentation reads, "Client has open area to R inner buttock, size 2cm x 1cm., pinkish red tissue, scant amt(amount) of serous drainage. New order Duoderm, q every 3 days and PRN until healed." On 4/5/12, the next entry reads that the physician was in to assess the R inner buttock area. The next nursing note is not until a week later, on 4/12/12, when again the physician came to see the physician, but it did not mention the status of the wound at this time. The next time the wound was mentioned was on 5/1/12, which mentions that R11's Duoderm is intact to her R buttock. The client(R11) had a hospital visit from 4/28/12 - 4/30/12 for UTI and dehydration. Her return nursing note still did not mention her skin status at that time. R11's Reposition Sheets were reviewed for the month of April, starting on April 1st. R11 only had reposition sheets for the following dates(excluding 4/28-4/30 when client was in the hospital): 4/1, 4/7, 4/13, 4/14, 4/17, 4/18, 4/19, 4/25, and 4/26. These dates only had one sheet, only representing one shift of each day. During observation of R11's room on 5/3/12 at 1:45pm with E3(Director of Nursing), R11 did not	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 145	W9999		

have a reposition clock posted at her bedside. R11 also had a regular mattress on her bed, instead of the air mattress that E3 stated should be on her bed. E3 was asked how the staff know to ensure R11 needs to be repositioned, since she has no clock posted at her bedside. E3 stated that R11 moves around in bed, and when the staff change R11, they would notice that she had a decubitus. E3 also stated that the nursing staff can also write a note on the Log Sheet, under nursing concerns, to alert direct care staff if a resident needs to be repositioned. The logs from 5/2 and 5/3 were reviewed. There is documentation on the 5/2 log, stating that R11 needs to be repositioned off of her buttock, but there is no documentation on the 5/3 log indicating that R11 needs to be repositioned.

R12's Physician Order Sheet dated 4/15/12 - 5/14/12 was reviewed. An order dated 4/13/12 reads, "Cleanse inner buttocks/sacral area and R buttock, and apply Duoderm dressing every M-W-F and as needed." The nursing notes for R12 were reviewed. An entry dated 2/13/12 reads, "Inner buttock and R buttock healed." The next entry, dated 2/22/12 reads, "R and inner buttock c open area pink tissue in wound bed. Slight bleeding. R buttock size 1.5cm x 0.5cm, inner buttock 2cm x 0.5cm. Order for duoderm every 3 days and PRN until healed." On 2/24/12, MD in to see patient, and assessed buttock area. The decubitus area is next mentioned in the nursing notes on 2/27/12, and than is not mentioned until 3/29/12, when the physician was in to see the patient, and assessed the buttock area. The next nursing entry regarding the buttock area is noted on 4/12/12, when the physician was in to see the patient and assessed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 146	W9999		

the decubitus area, which is followed by a note a week later on 4/19/12, when again the MD was in to see the patient, with no new orders received. On 4/23/12, an note is entered, which addressed the Duoderm treatment being every M-W-F, and PRN. The decub is again documented on 4/24, 5/3/12, and 5/7/12. R12's Pressure Ulcer Assessment Guide Sheets were reviewed. The entry from 5/7/12 notes the R buttock decubitus to measure 2cm x 1.5cm/stage 1, with a second decub on the Sacral/inner buttock being a stage 2, measuring 1.5cm x 0.5cm x 0.1cm. R12's Repositioning Sheets were reviewed from the time frame of 4/18/12 - 5/2/12. R12 is missing repositioning sheets for the dates of 4/21, 4/22, 4/26, and 4/30. For the dates when a reposition sheet is available, it is only for one shift, missing documentation for all three shifts.

R12 was observed lying in her bed at 2:30pm, while doing a tour with E3(Director of Nursing) on 5/3/12. At this time, R12 was observed lying on her back, when the reposition clock indicated R12 should be on her right side. R12 also had a 2 hour reposition clock posted at her bedside. E3 confirmed that R12 should have a 1 hour reposition clock, as she requires to be repositioned every hour. E3 confirmed that R12's decubitus developed while in the facility.

During an interview with E14(Physician) on 5/3/12, E14 was made aware that staff were not always reporting immediately to him a new development of a decubitus. E14 was also made aware that the staff were not always repositioning as per their policy, and documenting inconsistently. E14 stated that even though these clients are compromised, and are getting more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 147 fragile, it is a problem if the staff are not catching the wound soon enough, and not repositioning ,and following their policy as it is written. E14 stated that they should be documenting appropriately as well. (A) 350.700a) 350.1210 350.3240a) Section 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident 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. These regulations are not met as evidenced by the following:	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 148	W9999		

Based on record review and interview, the facility failed to ensure all clients were transferred safely and without injury, for 1 of 5 clients in the facility who requires a mechanical lift for transfers(R18). R18 fell from the sling attached to the lift, and was diagnosed one day after the fall with a fracture to her proximal left tibia, and neck of her left fibula.

Findings include:

R18, per review of Face Sheet dated 3/13/12, is a female client whose diagnoses include Severe Mental Retardation, Seizure Disorder, Cerebral Palsy, and Morbid Obesity.

The fax to Public Health dated 5/6/12 was reviewed. It reads, "Patient fell from lift used to assist pt(patient) up in w/c(wheel chair). C/o(complaints of) pain to lower legs. Sent to hospital to eval." The fax to Public Health dated 5/8/12 was reviewed. It reads, "Reviewing incident when resident fell to determine if neglect occurred. Staff members involved in incident put on administrative leave pending investigation. Full report to follow."

The Incident Report involving R18, dated 5/6/12 at 8:00am was reviewed. E17(Direct Care Staff) was the staff that was being interviewed. It states, but is not limited to, "E17 assisted E18(Direct Care Staff) with hooking the sling to the lift, and suggested that the straps crisscross and position between her legs or underneath and to the outside of the legs, to secure her real well in the sling. E18 suggested a totally different hook up that she felt more comfortable with, and proceeded with her method. E18 felt more at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 149	W9999		

ease with the straps not crisscrossing, and positioned on the outside of R18's legs. She(E18) told E17 that R18 well be fine, because this is the way that she has been doing her. E17 proceeded to transfer R18 the way E18 suggested. While R18 was being lifted and moved to her wheelchair, E17 stood behind her wheelchair in order to grab the straps on the sling. R18 operated the lift and had to turn R18's body to position it squarely over her wheelchair. E17 pulled upward on sling using the straps on back of the sling, which caused her body to lean forward. R18 slid out of the sling, and fell to the floor on her left side."

E18's statement dated 5/6/12 was reviewed. R18 was in the lift and staff was getting read(ready) to lower R18 to the chair and R18 roll(rolled) to the left and fall(fell) to the floor. I, (E18) put R18 in the sling and ask(asked) E17 to help put R18 in her chair. We lift(lifted) R18 up and I was on the left and E17 was behind R18, positioning her to the chair, and she move(moved) to the left, and fall(fell) to the floor."

Under Describe location of Injury on Body, it reads, "Resident c/o pain to lf(left) arm and lower extremities." The Hospital Transfer Form for R18 dated 5/6/12 was reviewed. Under reason for transfer/additional information, it reads,"Pt(patient) fell out of lift, fell on L side. C/o pain to lower extremities, L arm."

During an interview with E3(Director of Nursing) on 5/11/12 at 1:00pm, E3 was asked if she could describe what happened during the transfer with R18 on 5/6/12. E3 explained that through investigation, E17 felt that E18 had the sling the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 150	W9999		

wrong way, and that it was not hooked up right, but that E18 stated that this was how she always hooked up the sling. E3 stated that both E17 and E18 proceeded with the transfer, and as E17 pulled back on the sling to align R18 over the wheelchair, R18 slid out of the sling, and fell. E3 was asked if R18 sustained any injuries during the fall. E3 stated that she fell onto her left side, and had a scrape on her right elbow. E3 stated that R18 was sent to the ER. We feel the superficial scratch on her elbow was from scraping the wheelchair as she fell. R18 came back from the hospital with just a diagnosis of an abrasion to her Rt forearm. E3 stated that the next day, R18 complained on pain on her lower extremity, so she was sent back out, and was admitted with cellulitis of her left leg. E3 stated that R18 has a chronic history of osteomyelitis, so that is probably what it is related to. E3 was asked if she has any other injuries, or paperwork from the hospital, since today is the last day for her report to be finalized. E3 stated that she could call the hospital to find out. During a second interview with E3 this same day at 2:15pm, E3 stated that she just spoke with E14(physician) to inquire if the cellulitis development was related to R18's fall, and E14 told E3 that it probably was not, but did let E3 know that R18 does have a fracture on her left leg. E3 stated that they just found that out now. E3 stated she is not sure which bone is fractured. E3 stated they will have to get the hospital paperwork first.

The final investigation report for R18 dated 5/11/12 was reviewed. It reads, but is not limited to, "R18 was taken via ambulance to ER on 5/6/12 for evaluation after staff reported she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 151	W9999		

slipped from the sling during a transfer. She returned to the facility the same day with a diagnosis of abrasion on right forearm and spastic paresis left side(previous diagnosis)....Following initial review of the Incident reports/statements from the staff present during the incident, an investigation was initiated to determine if any improper procedures occurred. E17 and E18 were placed on administrative suspension until the investigation was completed....Improper procedures were followed during the transfer for R18 on 5/6/12. The improper placement of the sling for the safe transfer(criss-crossing the sling legs behind her legs) was not completed resulting in R18 slipping out of the sling to the floor...R18 was sent to ER on 5/7/12 due to complaint of pain in her legs, redness, warmth, and swelling. She was admitted with the diagnosis of cellulitis....Upon consultation with E14(Physician), R18's primary care physician, on 5/11/12, 2012, he felt the cellulitis was not directly related to the fall that occurred on 5/6/12, however, he at this point reported to the facility nurse that R18 had fractured her left tibia and fibula....Review of the requested imaging reports from hospital confirmed the doctor's verbal report."

R18's hospital paperwork was reviewed. X-ray reports obtained from films taken on 5/7/12 were reviewed. The image report from R18's left tibia and fibula was reviewed. It reads, "Fracture proximal left tibia extending to the metaphysis with no significant displacement. Fracture neck of the left fibula."

R18's nursing notes were reviewed. The entry dated 1/30/12 was reviewed. It reads, but is not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 152	W9999		

limited to, "6:30am - 7:30am. Staff reported that resident "slipped" to the floor while being transferred from the bed to w/c on 1/29/12 at 8:30am. Asked why she was reporting this late, she said the nurse has to write a report. I asked why if she told the nurse on duty, she said negative. At 9:30am, 1/30/12, I assessed resident....She(R18) denied pain anywhere; not even the buttocks she landed on. A (P5) incident report is filled out, even if it's about 24 hours later."

During an interview with E3 at 2:15pm, E3 was asked if she was aware that R18 fell during a transfer from her bed to her wheelchair back in January. E3 stated that she was not aware. E3 stated that she cannot find an incident report for this incident, and does not recall an investigation being completed as to how this fall occurred. E3 stated she is not sure if R18 fell from her sling, or not. E3 was asked if staff were in-serviced after this fall occurred. E3 stated that she is not sure, but she did find an in-service from 2/1/12 on transfers, that could have been a result of R18's fall. E3 was asked if staff were re-trained after the fall R18 sustained on 5/6/12. E3 stated that staff were retrained by E19(Habilitation Coordinator). E3 stated that E19 just trained all of the staff on 5/9/12.

During an interview E13(Direct Care Staff) on 5/11/12 at 12:45pm, E13 was asked if she knew which sling to use for which client. E13 stated that there are about 4 or 5 clients who require a sling to be transferred, and she said she just knows what sling to use for which client. E13 also stated that they have two mechanical lifts to use, and that she is aware which sling and lift to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 153 use with each client. E13 was asked what if you are a new staff member, how would a new staff member know which sling, or lift to use. E13 stated that usually they are paired with a staff member who has been working here a long time, and they could ask them. E13 stated they do receive education when they are hired too. E13 was asked what the new staff would do if a more seasoned staff was not working that day, and they forgot which sling or lift to use. E13 stated that would be difficult, because as far as she was aware, there was no place where it is documented for the staff, so they would know which sling to use for which client. E13 stated that she wished there was a place it was documented. E13 stated that in this circumstance, she did not know what the new staff would do. E13 was asked if she just received an in-service about transfers and mechanical lifts. E13 stated that she did just receive mechanical lift training. During an interview with E19 on 5/11/12 at 1:35pm, E19 was asked if she was the staff member who was responsible for the mechanical lift training that was just held on 5/9/12. E19 confirmed that she was the staff member. E19 was asked if there is any place the staff can go as a reference as to which sling is to be used on which client. E19 stated that she didn't think so, but stated that all staff are trained on mechanical lift transfers when they are hired. E19 stated that the slings are universal. E19 stated that she places less experienced staff with more seasoned staff, and if they are not available, then she will schedule herself to work. E19 later recalled that they do have a list which she presented, entitled,	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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W9999	Continued From page 154 "Recommended Transfer List." E19 was asked where she found this list, and E19 stated it is in the clients goal books. E19 was informed that the direct care staff did not know that this list was available. E19 was also made aware that the OT assessment does not specify which sling to use for the client on their assessment form. E19 stated that she was not aware that staff did not know about the transfer list. R18's Occupational Therapy Assessment 7/20/11 was reviewed. Under adaptive equipment, it reads, but is not limited to, "w/c, mechanical lift..." There is no mention as to what size or technique to use, with R18's mechanical lift. (A) 350.1210 350.1220j) 350.1230d) 350.3240a) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

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W9999	Continued From page 155 Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 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 are not met as evidenced by the following: Based on record review and interview, the facility staff failed to provide timely emergency care for 1 of 6 clients who expired after a 2 day decline in her physical health(R5). Findings include: R5, per review of face sheet dated 3/13/12, was a female client whose diagnoses included Profound Mental Retardation, Cerebral Palsy, and Gastro-Esophageal Reflux Disease. R5's fax report to Public Health dated 4/5/12 was reviewed. Under reason for sending resident to	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 156	W9999		

hospital or description of incident, which requires notification, it reads, "Lethargic, resident sent to hospital for evaluation." Under admitting diagnosis, it reads, "Severe Dehydration, Acute Mental Status Change, Hypercalcemia, Hyperchloremia."

The nursing notes for R5 were reviewed. The entry dated 4/3/12 at 3pm reads, but is not limited to, "Staff called nrsg(nursing) station stating client appears to not be feeling well, assessed, T. 97.4, P.96, B/P L 88/66, R 88/61. Skin dry, warm, tenting noted to arm and abdomen. Client awake, but appears sleepy. Responsive via verbal stimuli and tactile stimuli...Called E14(Physician). Ordered push fluids. Called guardian to inquire about considering hospice. Call MD in am." The entry from 9:00pm reads, but is not limited to, "...eyes appear sunken-alert-skin cool to touch." An entry at 11:00pm reads, but is not limited to, "Voiding tea colored urine."

The nursing notes from 4/4/12 were reviewed. The entry from 5:00pm reads, but is not limited to, "...Lethargic-spoon fed per staff dysphagia diet-small portions taken." At 7:00pm, the notes read, but are not limited to, "Lethargic-assessment unchanged-skin cool/dry. No visit or calls in to Hospice care. No contact from guardian."

The nursing notes from 4/5/12 were reviewed. The entry at 12:25am reads, but is not limited to, "Nausea-emesis x1, tan, watery. Compazine suppository given....monitor." The entry from 12:45am reads, but is not limited to, "Resident found on floor in her room, by the mat, and body

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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W9999	Continued From page 157	W9999		

pillows. Body check revealed no bruises, injury, bleeding....Bed mattress removed from room and mattress placed on floor with mat beside it." The next entry at 1:50am reads, "Resident rolled to the floor from the mattress on the floor. Placed back and made comfortable." The next entry at 2:50am reads, "Resident keeps rolling out onto floor." At 4:00am, reads, "Resident in bed, awake, holding doll to herself, emesis x 1 noted. Will cont. to monitor." The next entry at 6:30am reads, "Resident had emesis again, breathing is shallow. Resp 22, B/P unable to get a reading. Resident can focus eye on you when you talk. Called MD, gave report and MD said to send to hospital." At the 7:00 entry it reads,"Resident sent to hospital via Emergency ambulance." The entry at 11:00am, it reads, "Client admitted to ICU. Dx. Severe dehydration, AMS change, hypercalcemia, hyperchloremia. An entry dated 4/5/12, "Client expired at hospital."

During an interview with E3(Director of Nursing) on 4/5/12 at 10:50am, E3 was asked by their was a delay in getting R5 out to the hospital, when she was declining. E3 stated that the physician had wanted the nursing staff to pursue Hospice with the guardian, because R5 had been declining. E3 stated that R5 had extensive workup in relationship to her frequent emesis and GI issues. E3 stated that multiple attempts were made to the guardian, but that she was extremely hard to get in contact with. E3 was asked if she was aware that the nursing staff never called the physician back for an update in the morning of 4/4/12, as was ordered per review of the nursing notes from 4/3/12. E3 stated that she is not sure why the nursing staff did not give the physician an update, but she thinks it was because they were trying to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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W9999	Continued From page 158 pursue Hospice with the guardian. E3 explained that she did not do a formal investigation, but thinks this is possibly why the nurse was not actively pursuing conversation with the physician, to try to get R5 out to the hospital sooner. (A) 350.1210 350.3240a) 350.3240b) 350.3240d) 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These regulations are not met as evidenced by the following: Based on record review and interview, the facility	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 159	W9999		

failed to ensure all clients and their physical environments are kept clean, sanitary, and dry for 1 of 1 clients in the sample (R4). R4 was found in urine soaked bed linens, with mucous on his face and pillow case. R4, per review of face sheet dated 3/13/12, was a male client whose diagnoses included Mild Mental Retardation, and Down Syndrome. The facility also failed to thouroughly investigate one of 1 client (R1) with a bruise of unknown origin.

Findings include:

The Resident Discharge Summary form involving R4 dated 4/8/12 was reviewed. Under reason for leaving, it reads, "Expired(Hospice)."

The nursing notes for R4 dated 4/4/12 was reviewed. It reads, but is not limited to, "5pm. Resident received in bed, soaked c(with) urine including bed sheet was soaked - copious tan thick mucous on Rt(right) mouth and face - on pillow case and a large amount of thick mucous on bed sheet - cleaned resident, changed all bed linens..."

During an interview with E3(Director of Nursing) on 4/5/12 at 11:15am, E3 was asked if she reported this allegation of potential neglect to Public Health. E3 stated that she did not. E3 was asked if she was made aware of the allegation of neglect, of R4 being found soaked in urine and mucous over his face and pillow case. E3 stated that the nurse did come to her about this matter, but I was just wondering if it could have been urinary retention, since he was found soaked in so much urine. E3 stated that Hospice was coming in so much at this point, and it would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 160	W9999		

be unusual for him to not be cared for. E3 was asked if she did a formal investigation or completed an incident regarding this matter. E3 stated that she did not make out an incident report, or did not complete a formal investigation. E3 stated she just asked the staff who came to her about this matter(E12, Licensed Practical Nurse) if the urine looked like it was old, indicating R4 had been left in the urine for a long time. E3 stated that E12 might have reported this to her the next day(4/6/12), when she came to work that next day. E3 confirmed that there should have been an incident report completed.

R1, per review of face sheet dated 3/31/12, is a female client whose diagnoses include Severe Mental Retardation, and Cerebral Palsy.

R1's nursing notes were reviewed. The entry dated 4/24/12 reads, "Purplish-yellow discoloration above L(left) buttock per Day Service nurse. Size 4.5cm x 5.5cm. Cause unknown." This note was signed by E16(Assistant Director of Nursing). No incident report was presented by the facility regarding this injury of unknown origin.

During an interview with E16 on 5/8/12 at 2:05pm, E16 was asked if she was the author of the above nursing note. E16 stated that she was. E16 stated that she received a call from Day Training, and they reported the injury to her. E16 was asked if she had an incident report regarding this incident. E16 stated possibly the Day Training Provider made out an incident report, but confirmed there was no incident report here at this present time. E16 was asked if she passed this information on to any one, or tried to obtain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 161 the incident report. E16 stated that she did not, but could try to get a copy from the Day Training site now, if needed. E16 was asked if an investigation was done regarding the bruising. E16 stated that E3 would do the investigation, if any was completed. (B) 350.1080c) 350.1082a)1) 350.1082b) 350.1230b)6)7) 350.3220k) 350.3240a) Section 350.1080 Restraints c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience. Section 350.1082 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; b) A physical restraint may be used only with the	W9999		

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	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 162 informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well-being. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.3220 Medical Care k) A resident shall be permitted respect and privacy in his or her medical and personal care program. Every resident's case discussion,	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 163	W9999		

consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his or her permission to be present. (Section 2-105 of the Act)

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 requirements are not met as evidenced by:

Based on record review, observation and interview, the facility failed to ensure clients were free of unnecessary restraints for 5 of 5 clients who have a seat belt attached to a toilet frame, which is fastened each time they use the toilet for elimination(R2,R13,R14,R15,R16) and failed to ensure privacy was maintained for 1 of 5 clients (R2) while using the toilet.

Findings include:

R2, per review of face sheet dated 3/13/12, is a female client with the known diagnoses of Profound Mental Retardation, and Cerebral Palsy.

R13, per review of face sheet dated 9/28/11, is a male client with the known diagnoses of Profound Mental Retardation, and Seizure Disorder.

R14, per review of face sheet dated 3/13/12, is a female client with the known diagnoses of Profound Mental Retardation, and Major Depressive Disorder(Recurrent Type).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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W9999	Continued From page 164	W9999		

R15, per review of face sheet dated 3/13/12, is a female client with the known diagnoses of Severe Mental Retardation, and Gait Disorder(Non-Ambulatory).

R16, per review of face sheet dated 3/13/12, is a male client with the known diagnoses of Profound Mental Retardation, Down Syndrome, and Epilepsy.

1. Per interview with Z1(guardian) on 4/26/12 at 10:05am, via the telephone, Z1 reported that on 4/18/12, R2 was observed seated on the toilet in her bathroom, with the door open, naked. Z1 stated that R2 was sitting on the toilet naked for at least 20 minutes. Z1 stated that no direct care staff was around to assist R2 with her privacy needs, and that E9(Case Manager) had to assist R2 off the toilet, and provide for her privacy.

During an interview with E9 on 5/3/12 at 11:00am, E9 was asked if she had to assist R2 off the toilet on 4/18/12. E9 stated that she did assist her off the commode. E9 was asked if R2 was naked at the time, and if she was seated on the toilet for a long time frame. E9 stated that she was naked, and that she was on the commode, naked with the door open for approximately 15 minutes. E9 stated that she helped change her clothes. E9 was asked who the direct care staff was that was assigned to her. E9 stated that E10(Direct Care staff) was the staff member assigned to R2 that particular day and shift.

During an interview with E10 on 5/8/12 at 3:15pm, E10 was asked if she was the Direct Care Staff that was assigned to R2 on 4/18/12. E10 confirmed that she was. E10 was asked why she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 165	W9999		

left R2, naked on the toilet. E10 stated that when she left her, she had a top on, and was only naked from the waist down. E10 stated that R2 must have taken her top off when she left the room. E10 was asked who took R2 off the toilet. E10 stated E9 took R2 off the toilet. E10 stated that she was assisting another family member to get towels, so she left R2 on the toilet, to assist that family member. E10 stated that she may have left R2 on the toilet unattended for 10 minutes or so. E10 was asked if it is safe to leave R2 unattended, with the door open to her bathroom for any time frame. E10 stated that R2 has a toilet frame with a seat belt attached to it, so she is safe to be left unattended while in the bathroom. E10 stated that R2 knows that I put her on the toilet, fasten the seatbelt, and then go onto the next client. R2 knows that I will be coming back to take her off the toilet. E10 stated it just took a little longer, because she had to assist with another client. E10 stated that when Z1 came into the room to get something for R1, she must have saw R2 sitting on the toilet naked, because the bathroom door was left open.

R2's bathroom was observed. Attached to a back support on her toilet, was a seatbelt that was attached to this support frame. There was also a toilet frame on either side of the toilet. E10 and E9 both confirmed that R2 was left naked on the toilet for a 10 to 15 minutes time frame, unattended, without her privacy needs being maintained.

During an interview with both E3(Director of Nursing) and E4(Director of Social Services) on 5/8/12 at 4:00pm, both staff members were asked if they are aware that R2 had a seat belt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 166	W9999		

attached to her back support on her toilet, and that staff was strapping R2 to the toilet, and then walking away to do other patient care tasks. E4 stated that she was not aware this was happening. E4 was asked if there are any other clients who have seat belts attached to their toilet. E4 stated that she does not know, but will find out from the coordinators. E4 was asked if they have an order, and consent from both the Human Rights Committee(HRC) and guardian, since this is considered a restraint. E4 and E3 stated that they did not think so, because they did not look at it as being a restraint. They both thought that is would be used as a safety measure.

During a second interview with both E3 and E4 at 6:00pm, a list was provided to this surveyor for all of the clients who have a seat belt attached to their toilet. The list provided from the facility included four additional clients, (R13,R14,R15,and R16), in addition to R2.

R2's Occupational Therapy Assessment dated 5/4/11 was reviewed. Under adaptive equipment, there is no mention of a seat belt for the toilet frame as a requirement to be used when toileted. The toileting Assessment form for R2 dated 5/4/11 was reviewed. Under assessment area, item number 4, it reads that the maximum amount of time this person can tolerate staying on the toilet is 5 minutes. R2's Resident Fall Risk Assessment form dated 4/28/11 was reviewed. Under miscellaneous/Other Interventions, it is circled toilet safety frame and grab bars, but no mention of seat belt.

2. R13's Occupational Therapy Assessment dated 3/14/12 was reviewed. Under Adaptive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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W9999	Continued From page 167	W9999		

Equipment, it mentions use of toilet safety frame or grab bar, but no mention of a seat belt that should be fastened when toileted. The Toileting Assessment for R13 was reviewed. This form is undated. Under item number 4, it states the maximum amount of time R13 should on the toilet for elimination is five minutes. Under item number 12, recommendations mention the use of a toilet frame, or grab bars, with supervision needed to prevent falls. A memo dated 3/28/12, with the subject, R13: Programming needs as of ISP 3/14/12. Item number 5 reads, but is not limited to, "...R13 uses a toilet safety frame and/or grab bar in the bathroom. He should not be left alone while toileting--to prevent falls, staff member should stay in the area, and check on R13 to ensure safety. Assist him as needed to ensure appropriate toileting hygiene." There is no mention of a seat belt that needs to be fastened around him while on the toilet.

3. R14's Resident Fall Risk Assessment form dated 11/10/11 was reviewed. Under Miscellaneous/Other Interventions, it states to use a toilet safety frame/grab bars, but without mention of an attached seatbelt. R14's Toileting Assessment dated 8/3/11 was reviewed. Under item number 4, the maximum amount of time R14 can be left on the toilet is 5 minutes. The Monthly Case Managers report for R13 dated for the month of March, 2012 was reviewed. It does mention the use of a toilet safety frame with a seatbelt for safety.

4. R15's Occupational Therapy Assessment form from 2011 was reviewed. Under Adaptive Equipment, it states to use a raised commode, and grab bars, without mention of a seat belt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W9999	Continued From page 168	W9999		

attached to the frame. The undated Toileting Assessment states under item number 4, that the maximum amount of time R15 can be seated on the toilet for one session is five minutes. Under summary of toileting programs attempted in the past, it reads, but is not limited to, "...In March of 2008, R15 fractured her left hip after falling off the toilet. Special precautions are now in place; she should never be left unattended while in the bathroom, and specialized adaptive equipment in the bathroom include a raised toilet seat and toilet support and frame." There is no mention of an attached seatbelt. R15's Resident Fall Risk Assessment dated 2/15/11 was reviewed. Under specific interventions for this resident, it reads, but is not limited to, "Not to be left unattended on a mat table or in bed s(without) side rails, or when on a toilet." The Monthly Case Manager Summary for the month of March, 2012 was reviewed. Under Appliance usage or follow up plan, for adaptive equipment, it mentions to use a toilet support and frame, but without mention of a seatbelt that needs to be fastened.

5. R16's Resident Fall Risk Assessment dated 2/27/12 was reviewed. Under Miscellaneous/Other Interventions, it states a toilet safety frame/grab bars are required. There is no mention of a toilet seat belt. R16's Toileting Assessment dated 3/30/11 states that R16's maximum time to be left on the toilet is 5 minutes. R16's March 2012 Monthly note was reviewed. It states that R16 is on a 2 hour schedule for positioning and changing, but does not mention the use of a toilet seat belt.

During an interview with E3(Director of Nursing) on 5/10/12 at 1:30pm, E3 stated that she spoke

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 06/19/2012

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W9999	Continued From page 169	W9999		

with E14(Physician) about the clients who are using toilet seat belts, and E14 stated that he will provide for an order for the use of a toilet seat belt for all of these clients, except for R2. E3 stated that they have already discontinued R2's seat belt on her toilet. E3 stated they will also go and get HRC and Guardian consent for all of these clients, except R14, who already has consents from both. When asked why the facility still feels it is necessary to use the seat belts while seated on the toilet, E3 stated that it is for their safety. E3 stated that they did not look at the seat belt as being a restraint. E3 was asked if they tried other measures before going to the seat belt to provide for their safety, for the least restrictive measure. E3 stated that they did not. E3 stated that they will address each client to see if it is really necessary for them to have the seat belt on while being toileted. E3 confirmed that when a client is fastened to the toilet with the seat belt, staff should not leave the client unattended, but should remain with them in the immediate vicinity. The aide may stand outside the door, so they can hear them, with the door cracked open just a bit.

During an interview with E15(Certified Nursing Assistant) on 5/10/12 at 11:00am, E15 was asked if he uses the seat belt for any of the above clients when they are being toileted. E15 stated that both R13 and R16 are in his group, and he does use the seat belt on the toilet for both clients. E15 stated that when he toilets R13, he fastens the seat belt, and then opens the door of the bathroom, turns his television on so he can watch sports, and then walks out of the bathroom, and waits inside of the bedroom area for him to be finished. E15 stated that for R16,

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W9999	Continued From page 170 he will wait in the bathroom with R16, after he makes sure the seat belt is applied nice and snug. During an interview with E13(Direct Care Staff) on 5/10/12 at 11:10am, E13 was asked if she works with any of the clients who utilize a seat belt while being toileted. E13 stated that she works with R2, R14, and R15, and all three of these ladies use a seat belt while being toileted. E13 was asked if she can describe the process of applying the seat belt with all three clients. E13 stated that with R15, she applies the seat belt, and stays with R15 because she goes right away. E13 stated that R15 is pretty steady on the toilet. For R2, E13 stated that R2 is not a fall precaution, but does use a seat belt. E13 stated that she applies the belt, and then goes to gather her clothes. E13 stated that she is always watching her, even when she is gathering her clothes and shoes for the day. E13 stated that for R14, she doesn't always use the toilet, as she wears a brief, and is incontinent at times. E13 stated that for all three clients, you can never leave the bedroom that the client is in, but you can be outside of the bathroom, as long as you keep an eye on them. During a confidential interview with Z2 on 5/11/12 at 10:45am, Z2 stated that in the morning, the facility is in complete chaos. Z2 stated that clients are left on the toilets, in their seat belts or up to an hour at a time. Z2 stated that during this time they are not being watched or monitored for safety. Z2 stated that he wanted me to be aware of that. (B)	W9999		