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W 460	Continued From page 56 Based on observation, interview and record review, the facility failed to ensure 2 of 2 clients in the sample (R2 and R3) received skim milk as per their dietary order. Findings include: R2 and R3 were observed at their DT (Day Training) program on 4/4/12 at 10:55am. At 10:55am R2 was observed to receive her sack lunch. R2's lunch contained a carton of 2%milk. At 11:10am R3 was observed to receive her sack lunch. R3's lunch contained a carton of 2%milk. R2's POS (Physician's Order Sheet), dated 3/26/12 to 4/25/12 was reviewed. R2's dietary order includes, "skim milk only." R3's POS, dated 3/26/12 to 4/25/12 was reviewed. R3's dietary order includes, "skim milk." E11 (cook) was interviewed on 4/4/12 at 1:40pm. E11 stated that there was no skim milk available this week for lunches. E11 stated that only 2% milk was available.	W 460		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210 350.1220j) 350.1220k) 350.1230c) 350.1230d)2) 350.1420a) 350.3240a) 350.3750	W9999		

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W9999	Continued From page 57 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. k) At the time of an accident, immediate first aid treatment shall be provided by personnel trained in medically approved first aid procedures. Section 350.1230 Nursing Services c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. 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 350.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the	W9999		

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W9999	Continued From page 58 licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time. 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 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These regulations are not met as evidenced by the following: Based on interview and record review, the facility failed to ensure nursing needs were met for 1 of 1 client outside the sample (R6) who sustained a	W9999		

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closed fracture of the proximal tibia when staff was performing a transfer from the shower bed to the wheelchair. The facility also failed to ensure nursing obtained a written physician order for a clarification of a supplement order for 1 of 1 client (R4) in the sample who developed a decubitus ulcer. The facility also failed to address with the physician that 1 of 1 client (R6) who was scheduled for surgery, that she was on a blood thinning medication.

The facility failed to:

1) Ensure a safe transfer procedure was implemented.

2) Ensure nursing physically assessed and documented the assessment of R6 after staff fell while carrying client.

3) Ensure on-going nursing assessment, including monitoring of pain control.

4) Ensure on-going communication between nursing staff was implemented.

5) Notify the physician of a change in condition.

6) Ensure medication is given as ordered.

Findings include:

R6, per review of her 3/26/12 to 4/25/12 POS (Physician's Order Sheet), has diagnoses that include Profound Mental Retardation, Cerebral Palsy, Scoliosis and Status Post Baclofen Pump Insertion.

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R6's 9/13/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies that R6 is essentially non-verbal, although she can verbalize some words. R6 communicates her wants and needs through facial expressions and gestures.

On 4/3/12 at approximately 9:30am, E1 (Administrator) informed surveyor that R6 was not present at the facility as she was hospitalized after sustaining an injury that occurred during a transfer procedure.

The facility's Incident Report, written on 4/2/12 by E6 (RN - Registered Nurse), noted the following occurred on 4/1/12 at 7pm: "CNA (Certified Nursing Assistant) transferring resident from shower bed to w/c (wheelchair) and foot slipped and fell backward while holding resident, ? (sic) resident bumped (left) leg."
Injury described as, "(Left) knee and foot tender to touch at times."
The physician was contacted on 4/2/12 at 8:45am and ordered X-Ray of the left knee and ankle.
The results of the portable X-Ray include the following diagnosis: "Acute non-displaced interspinous and intra articular of lateral tibial condyle. Gracile bones. Patellar alta is noted."

E1 (Administrator) was interviewed on 4/3/12 at 2:33pm regarding R6's fracture. E1 was asked how R6 was being transferred when she sustained her fracture on 4/1/12. E1 stated that R6 is generally a 1 person transfer and that E10 (CNA) was transferring R6 from the shower bed to her wheelchair (inside the tub room) when E10 slipped and fell. E1 stated that E10's feet were wet due to just giving R6 a shower.

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W9999	Continued From page 61 E10 was interviewed on 4/3/12 at 2:37pm and was asked to demonstrate how she was transferring R6 when she fell on 4/1/12. E10 stated that she was in the tub room with R6 and then carried her, like a baby (demonstrating a cradle hold with her hands) approximately 8 to 10 feet to put her in her wheelchair that was located outside of the tub room. E10 stated that she slipped and fell while carrying R6. E10 stated that the floor was wet and that she was carrying R6 by herself. E10 stated that she has always transferred R6 like this. E9 (Physical Therapist) completed a Physical Therapy evaluation of R6 on 9/7/11. In the area of "Transfer" E9 documented the following regarding R6's transfer needs: "Wheelchair to bed and bed to wheelchair - 2 person transfer: resident able to bear weight, limited." "Sit to stand and stand to sit - 2 person transfer, resident able to bear weight, limited." E9 was interviewed on 4/6/12 at 9:50am. E9 stated that R6 can bear weight long enough to do a pivot transfer (for approximately 10 to 20 seconds). E9 was asked how R6 should be transferred from the shower bed to her wheelchair. E9 stated that R6 should be either a 2 person transfer or a mechanical lift. E9 stated that since R6 sustained a fracture she is now a mechanical lift only. E9 was asked if it was appropriate for staff to carry R6 "like a baby" (or cradle transfer) from the shower bed to the wheelchair. E9 stated that it is not correct to use a cradle transfer for R6. E9 stated that staff have never been instructed to transfer R6 using a cradle transfer.	W9999		

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R6's nursing progress notes were reviewed. The first documentation that R6 was involved in an incident in which staff fell while transferring R6 was on 4/2/12 at 8:30am. E6 (RN - Registered Nurse) documented that yesterday (4/1/12) staff was transferring R6 from the shower bed to the wheelchair and slid to the floor with staff. A body check was done and tenderness to the left knee and possibly ankle is noted. The physician, guardian and administrator were notified. Orders were received from the physician for an X-Ray of the left knee and ankle. E6 documented that PRN (as needed) Tylenol was given.

E4 (LPN - Licensed Practical Nurse) was interviewed on 4/5/12 at 3:00pm. E4 stated she was the nurse on duty on 4/1/12 working from 3:00pm until 11:00pm. E4 stated that when she was arriving to the facility she received a page from E10 (CNA). When she entered the facility E10 told her that while she was transferring R6 from the shower bed to the wheelchair she fell while holding R6. E4 stated that she asked E10 if R6 touched the floor and E10 told her that R6 never touched the floor when she (E10) fell. E4 stated that she assessed R6 in her bed and that her ROM (Range of Motion) to her knee and ankle was fine. E4 stated that R6 did not moan and had no other signs of pain. E4 stated that E10 denied that R6 ever touched the floor. E4 was asked if she completed an Incident Report or documented in R6's nursing progress notes that staff fell while transferring R6; and/or if she documented that she assessed R6 after the fall. E4 stated that she did not document anything because she was told by E10 that R6 never touched the floor. E4 was asked if she communicated with the on coming nurse

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(11:00pm to 7:00am) to monitor R6. E4 stated she did not communicate this to the on coming nurse either verbally or in writing. E4 was asked if she notified the physician that staff fell to the floor while transferring R6. E4 stated that she did not notify the physician.
E4 stated that she told the CNA's that if R6 moans they are to call the nurse.

The CNA communication log was reviewed. There is no documentation that E4 told the CNA's to monitor R6 and/or to notify nursing if she moans.

E6 documented, on 4/2/12 at 11:30am, in R6's nursing notes that a portable X-Ray was done.

E1 (Administrator) was interviewed on 4/5/12 at 1:25pm. E1 was asked if a nursing assessment was completed on R6 on Sunday 4/1/12. E1 stated that no nursing assessment is documented as being completed. E1 was asked if the physician should have been notified on 4/1/12 when staff fell while transferring R6. E1 stated, for falls, the physician should have been called.

E4 documented the following in R6's nursing notes:
- 4/2/12 at 3:35pm "(R6) moaning Lt. (left) knee swelling when touching, telling discomfort ... Tylenol 650mg (milligrams) PO (by mouth) given, continue monitoring."
- "8pm Called the X-ray department result was not ready. They will call back. Waiting for call."
- "10pm X-ray result received acute non-displaced fracture interspinous and intra articular of lateral tibial condyle gracile bones. Patellar alta is noted. Left ankle, there is no

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gross acute fracture. Severe pes planus deformity of foot is noted."
- "10:05pm Called Administrator and notified. Called E7 (Physician) notified and faxed X-ray result. TO (Telephone Order) receive. Send out her hospital for (follow up) and evaluation."
- "10:10pm Called mother and notified. Mother want sent her (to specific hospital)."
- "10:15pm Called (Ambulance company) coming 30 minutes."
- "11:30pm Ambulance arrived all information given resident out."

E4 documented that R6 was given Tylenol on 4/2/12 at 3:35pm as she was moaning and her left knee was observed to have swelling. E4 did not administer another dose of Tylenol.

R6's POS, dated 3/26/12 to 4/25/12, notes that R6 has the following order: Acetaminophen 325mg tab (Tylenol) - 2 tabs (650MG by mouth every 4 hours PRN indefinitely for pain and temp (temperature) ...

E4 was interviewed on 4/5/12 at 3:00pm. E4 stated that she worked from 3:00pm until 11:00pm on 4/2/12. E4 stated that when she assessed R6 at 3:35pm, R6's knee was reddish and blue and she moaned when touched. E4 was asked if she notified R6's physician of R6's change in condition. (discomfort, pain and swelling) E4 stated that she did not call the physician because an X-Ray was already ordered.

E7 (physician) was interviewed on 4/6/12 at 9:45am via a phone call. E7 stated that she was contacted by E6 (nurse) and was told that the

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patient (R6) fell. E7 stated she was told that R6 never hit the ground and there was no injury and no signs of pain. E7 was asked if she would have wanted to be notified when R6's condition changed (swelling to knee, discoloration and moaning when area was palpated). E7 stated that she should have been notified and she would have ordered R6 to be sent out (to the hospital).

R6's portable X-Ray results, dated 4/2/12, were reviewed and noted the following: "Acute non-displaced fracture interspinous and intra articular of lateral tibial condyle. Gracile bones. Patellar alta is noted."

E8 (CNA) was interviewed on 4/5/12 at 2:25pm. E8 stated that she worked on 4/2/12 starting at 2:00pm. E8 stated when she arrived at 2:00pm she was made aware (by other CNA's) that R6 had a fall on 4/1/12. E8 stated when she saw R6, shortly after 2:00pm, she did not look like herself. E8 stated that R6 responded "yes" when asked if she was in pain. E8 stated that R6's left leg was swollen and her leg was warm to the touch. E8 stated that R6 was up in her wheelchair and she used a mechanical lift to put her in her bed. E8 stated that R6 grimaced as if she was in excruciating pain. E8 stated that she told E4, around 3:00pm, that R6 was in a lot of pain. However, E4 insisted that R6 was fine.

R6's hospital records were reviewed. R6 was admitted to the hospital on 4/2/12 and discharged on 4/4/12.R6's discharge medication orders included the following order: "Heparin 5,000 unit SQ (sub cutaneous) every 12 hours, 7am and 7pm"

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W9999	Continued From page 66 Review of R6's MAR (Medication Administration Record) initiated 4/4/12 was reviewed. R6 did not receive her first dose of Heparin on 4/4/12 at 7:00pm as ordered. R6's MAR was reviewed with E1 on 4/5/12 at 1:25pm. E1 verified that R6 did not receive her first dose of Heparin as ordered. E1 also verified that the physician was not notified that R6 did not receive her first dose of Heparin as ordered. 2) R4, per review of Physicians Order Sheet dated 3/26/12 - 4/25/12, is a male client whose diagnoses include Profound Mental Retardation, Failure to Thrive, and Cerebral Palsy. R4 was observed in the home, non-ambulatory, but mobile through use of his powered wheel chair. The Incident Report involving R4, dated and timed 3/5/12 at 8:00pm was reviewed. Under Describe Incident, it reads, "During shower time noted lt(left) hip open sore 1 cm(centimeter) dia(diameter). Clean(ed) with normal saline and applied(applied) exudrem(Exuderm)." Under physician orders, it reads, "Lt hip apply Exuderm every three days, and prn(as needed) until healed." The Accident/Incident Management Meeting Resident Review Form involving R4, with the date of occurrence of 3/5/12, was reviewed. Under changes in the plan of care/interventions to be initiated, it reads in part, "Obtained consultation from dietician for low protein. Recommendation made for an order for additional protein supplement." The progress note written by E14 (Dietician) on	W9999		

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3/7/12 was reviewed. It reads, but is not limited to, "Follow up on change with skin integrity. Left hip, left ischial tuberosity open sore, 1 cm per nursing notes...I would suggest a multivitamin mineral supplement for health healing as well. P(plan) multivitamin mineral supplement, clarify supplement to resource (liquid nutritional supplement)."

The Physician's Order Sheet for 3/26/12 - 4/25/12 for R4 was reviewed. Under dietary orders, the house supplement 4 0z was changed from BID (twice daily) to TID (three times daily), in addition to (nutritional drink) or Nutrition Shake with Q(every) meal.

R4 was observed at his Day Training location beginning at 9:20am on 4/4/12. At 11:00am, R4 was observed beginning to eat his lunch, which consisted of a peanut butter and jelly sandwich, cucumber salad, peaches, water, and peach (nutritional drink). No 4 oz supplement was observed in R4's lunch, as per his current physician order sheet.

During an interview with E1 on 4/4/12 at 1:30pm., E1 was asked why R4 did not receive his 4 ounce supplement, as per his physician orders, when he was at Day Training on this same day. E1 stated that she thinks that the supplement order should have been discontinued, and that the (nutritional drink) should be three times per day, because he likes the (nutritional drink), and in the past had been known to refuse the supplement. E1 stated that the supplement added was the multivitamin tablet with minerals, not the 4 ounce supplement. E1 stated that it does seem confusing, and that she will need to have the nurse clarify the order

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with the physician.

The physician order sheet for R4 was again reviewed. The dietary order for the house supplement now had a line through it, with a d/c (discontinued) next to it, dated 4/4/12. The (nutritional drink) order also had a line through it with the verbage of (nutritional drink) 8 ounces c(with) every meal. This change was also dated 4/4/12. There was no order on the Physician's Order Sheet reflecting these changes to the above supplements. During an interview with E1 on 4/5/12 at 11:30am, E1 was asked where the order was to make the changes on the Physician Order Sheet. E1 verified that there was no order. E1 stated that E15 (nurse) took the order from the physician. E1 stated that she will ensure that E15 writes the order on the Physician's Order Sheet as per what the physician told her on 4/4/12.

3) R6, per review of her 3/26/12 to 4/25/12 POS (Physician's Order Sheet), has diagnoses that include Profound Mental Retardation, Cerebral Palsy, Scoliosis and Status Post Baclofen Pump Insertion. R6's 9/13/11 IPP (Individual Program Plan) was reviewed. R6's IPP identifies that R6 is essentially non-verbal, although she can verbalize some words. R6 communicates her wants and needs through facial expressions and gestures.

The Physician's Consulting Report for R6 dated 4/16/12 was reviewed. It reads, but is not limited to, "Left Tibial Plateau Fx (fracture). Recommend surgery for operative fix to improve ADL's (Activities of Daily Living). The nursing note for R6 dated 4/16/12 at 12:30pm was reviewed. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G370	A. BUILDING _____ B. WING _____	05/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TRAILS	273 ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(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 69	W9999		

reads, "Resident returned from orthopedic appt. Left tibial plateau fx - recommend surgery. Prep work scheduled by mom for 4/19/12. Mom to call c(with) time."

A second entry for the same date, timed at 2:05pm was reviewed. It reads, "PA(Physician's assistant) returned call and was informed about orthopedic consult and recommended surgery scheduled for 4/20/12 c(with) preop work scheduled 4/19/12." R6 was currently on Heparin at the time this call was made, with the nurse knowing that R6 was on Heparin, and would be going to surgery. The nursing note did not address this finding with the physician, as per review of documentation. These nursing notes were authored by E6 (Registered Nurse).

During an interview with E6 via the telephone on 4/19/12 at 9:30am, E6 was asked if she was aware that R6 was on Heparin, when she found out that R6 was scheduled for surgery on 4/16/12. E6 stated that she was aware that R6 was on Heparin. E6 was asked why she did not address this finding with the physician, since being on Heparin will increase your risk of bleeding, knowing that R6 would be going to surgery at the end of the week. E6 stated that she just did not think about that. E6 was asked if she was aware that Heparin will interfere with clotting times during surgery. E6 stated that she was aware, but she just did not think to address this fact with the physician.

During an interview with E16 (Registered Nurse) on 4/18/12 at 2:00pm, E16 was asked if she was the nurse that addressed the fact that R6 was on Heparin, and was scheduled to go for surgery on

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W9999	Continued From page 70 4/20/12. E16 stated that she did call the physician when she saw the paperwork for R6 related to her going to surgery. E16 stated that E6 did not endorse to her to follow up on addressing the Heparin with the physician. E16 stated that E6 should have addressed this fact with the physician on the 16th when she was made aware of the scheduled surgery. E6 stated that she did pass this information onto E1 (Administrator), and that E6 did not report this information to the physician. During an interview with E1(Administrator) on 4/19/12 at 10:05am, E1 was asked if she was aware that E6 did not address the fact of R6 being on Heparin prior to going to surgery with the physician. E1 stated that she was made aware by E16. E1 was asked if she was aware that Heparin is a medication that should be stopped, prior to going to surgery, since it will interfere with clotting times. E1 stated that she was not aware at the time it was brought to her attention, but that she does realize that now. E1 was asked who the nursing staff reports to, and who monitors the nursing staff. E1 stated that she was responsible. E1 stated that she realizes that she needs a nursing consultant on a more consistent basis to monitor the nursing staff, and documentation, since she is not a Registered nurse herself. (A)	W9999		