STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

(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	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 350.620a) 350.670e) 350.670f)3) 350.810a) 350.1060e) 350.1080a) 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 350.670 Personnel Policies e) All personnel shall have either training or experience, or both, in the job assigned to them. f) Orientation and In-Service Training 3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. Section 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. At a minimum, there shall be at least one staff member awake dressed and on duty at	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

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HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 46 all times. Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1080 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	W9999		

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	14G056	A. BUILDING _____ B. WING _____	09/28/2012

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HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 47 These Requirements are NOT MET as Evidenced by: Based on observation, interview and record review, the facility failed to ensure their policy to prevent neglect was implemented for 1 of 1 individual outside the sample (R9) who demonstrated risk of strangulation or entrapment while in her wheelchair when the facility failed to ensure: 1) The individual is evaluated for the most appropriate and least restrictive device to ensure this clients safety. 2) The individual is supervised as identified by her behavioral needs. 3) Each incident resulting in injury to this client is evaluated as to the effectiveness and safety for use of the restrictive device. 4) Effective implementation of safety interventions at day training and the facility as they were revised. 5) Evidence of a reproducible system to track the number and severity of behavioral occurrences. Findings include: R9 was found alone in her room half out of her chair with her seat belt still around her chest her while in behaviors resulting in red marks to her chest area and an open area to her right knee; on 7/27/12 at 8:55 pm staff found R9 alone in her	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

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HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 48	W9999		

room after behaviors with her seatbelt around her neck and redness around her neck, chest, left upper breast and a scrape to her right arm from falling to the footrest; on 8/12/12 at 10:27 pm staff witnessed R9 scoot herself out of her wheelchair during a behavior making the seat belt too tight around her ribs and possibly causing bruises to her rib area with redness present below the breasts; and on 8/30/12 at 1:30 pm R9 attempted to slide out of her wheelchair resulting in her seatbelt rubbing under her breasts. The facility did not ensure R9 is safe while in her wheelchair without risk of strangulation or entrapment.

In review of an Individualized Habilitation Plan (IHP) dated 6/28/12, R9 is a female resident who has diagnoses of Profound Mental Retardation, Impulse Control Disorder and Depression.

R9's IHP states she is prone to falls but independent in the building if her lap alarm is engaged. R9's IHP identifies consents for adaptive equipment, behavior support plan, posey vest, medication and locked closets. These are due to R9 being a fall risk or a danger to herself or others.

A section of the IHP titled "Mobility and Transportation" states R9 tends to "pop up" out of her chair and uses maladaptive behavior to get what she wants.

E1 confirmed during interview on 9/20/12 at 3:10 pm R9 wears a seatbelt to prevent her from falling due to noncompliance.

A Behavioral Support Plan provided by the facility dated 6/28/12 addresses behavior requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 49	W9999		

restrictive interventions as "attempts to throw herself from her wheelchair." This should be addressed with a "2 person escort" or "(restrictive) vest." There is no evidence of less restrictive measures to be used.

A Fall Policy titled "Fall Risk Assessment Procedure" dated 9/18/07, revised on 3/11 reads, "Section 2.0 IDT Responsibilities.

2.1 The IDT will closely review circumstances surrounding each fall and complete a fall risk assessment.

2.4 The IDT will take immediate action and put in place measures to protect the individual during the assessment phase.

2.6 The IDT will determine the specific course of action and best method to protect the individual. The IDT's action will be reflected in future service plans."

A policy titled "Handling, Investigating and Reporting Unusual Incidents" dated 8/8/91 and revised 7/10 reads, "Reports to Department of Public Health."

1.21 When the Administrator has reasonable cause to believe that mistreatment may have occurred, the Administruor must investigate the report."

1.212 Neglect is defined as failure to provide adequate personal care or maintenance resulting in physical or mental injury to a resident or in deterioration in resident's physical or medical condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 50 1.22 Administrator reports incidents of abuse or neglect to DPH by fax or phone. 1.23 Administrator will notify Executive Director of all incidents and reports. The policy states that incidents of neglect will be investigated and referred to Quality Assurance following investigation. In review of "Medical Reports" and nursing notes, there were four incidents found where R9 was found entrapped in her wheelchair seatbelt between 7/17/12 and 8/30/12. a) In a "Medical Report" dated 7/17/12 at 2:30 pm, R9 was reported to be having behaviors. R9 was found in her bedroom "half out of her chair with her seat belt still on her." R9 had an open area to her right knee. A Nursing Progress Note dated 7/17/12 at 2:30 (pm) reads, "Per staff noted individual knee touch ground but seat belt still attached to her. Individual was having behaviors upon assessment...open area to knee". R9 was placed on "fall monitoring" per nursing notes until 7/19/12 at 9 am. During an interview on 9/14/12 at 10:30 am, E1 (Administrator) was asked about R9's fall on 7/17/12. E1 was asked if this fall was reviewed per the Interdisciplinary Team according to directives of the Fall Policy dated 9/18/07 and revised 3/11. E1 stated no. E1 added that a Program Specialist entered a note on the back under the section titled "Investigation" which	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 51	W9999		

reads, "Try to keep individual out of bedroom, monitor more closely while in behaviors."

E1 was asked if this note was written 7 days after R9 was found entrapped in her seatbelt. E1 stated yes. E1 was asked if any immediate safety measures were taken during the time of assessment. E1 stated there were no measures documented other than the note written on 7/25/12.

E2, Qualified Mental Retardation Professional (QMRP), was interviewed on 9/14/12 at 11:40 am. E2 was asked if the fall which occurred on 7/17/12 involving R9 was reviewed per the Fall Policy directives. E2 stated "my signature is not on this, I didn't review it."

E2 reviewed the Investigation note dated 7/25/12. E2 was asked if any measures were taken during the 7 days after R9 was found entrapped in her seatbelt to ensure her safety during the assessment period. E2 stated , "No."

b) A "Medical Report" dated 7/27/12 at 8:55 (pm) reports R9 "was in behaviors." The report states staff entered R9's room and she was found after trying to slip out of her wheelchair. It was reported R9's "face was bright red and the seat belt was around her neck." R9 received a scrape to her right arm from falling to the footrest level. Nursing also documented R9 had red areas to her neck, chest and left upper breast.

A "Memorandum" written by E4 on 7/30/12 reads R9 was found with her seatbelt around her neck on 7/27/12 and is now to be within eye sight during all waking hours. R9 is not to be in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 52	W9999		

room alone or the back living area (as a result of her second entrapment by her seatbelt within 10 days). If R9 is in behaviors, she should be within arms reach. There is no evidence of immediate measures taken between 7/27/12 and 7/30/12.

An additional undated note from E4 states R9 was in behaviors prior to being found entrapped with the seatbelt around her neck on 7/27/12 and had required the application of a restrictive vest. "Documentation shows that the (restrictive vest) was removed from (R9) at 8:45 pm. This incident happened at 8:55 pm."

A Nursing Progress Note dated 7/27/12 at 10 pm reads, "Red areas on neck and scratches and redness to chest and (left) upper breast. Noted scratch to (right) upper arm. Having behaviors most of shift."

E1 was interviewed on 9/14/12 at 10:30 am. E1 was asked if R9 had a fall on Friday 7/27/12 where staff found her with her seatbelt around her neck. E1 stated yes.

E1 was asked if this fall was reviewed per the facility Fall Policy dated 9/18/07, revised 3/11. E1 stated E4 wrote a Memorandum on Monday 7/30/12 regarding change in supervision level. E1 was asked if any immediate measures were implemented for R9 between 7/27/12 and 7/30/12. E1 stated there is no documentation of any measures.

E2 was interviewed at 91412 at 11:40 am regarding R9's fall on 7/27/12. E2 confirmed that R9 fell on 7/27/12 and was found by staff in her room alone after having behaviors with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 53	W9999		

seatbelt around her neck. E2 also confirmed the first documentation on a increase in R9's supervision level to "within eyesight" was on 7/30/12. The IDT to address other safety measures was held 7 days after the incident on 8/2/12. There is no evidence of increased supervision to prevent R9 from becoming entrapped by her seatbelt between 7/27/12 and 7/30/12.

An "IDT" note dated 8/2/12 discusses R9's fall, subsequent eyesight supervision and the importance of R9's bedroom to her. "The IDT agreed to change her wheelchair seatbelt to a clasp since it will cinch and hold itself in place with tension." This was to be done within 48 hours at which time R9 would be taken off of eyesight supervision.

c) Ten days later a "Medical Report" documented on 8/12/12 at 10:27 (pm) that R9 "became agitated and attempted to scoot out of her wheelchair" resulting in "making the seat belt too tight around her ribs and possibly bruising herself."

Nursing Progress Notes from 8/12/12 at 10 am read, "Attempting to slide out of (wheel)chair, belt under breasts bright red."

A Nursing Progress Note from 8/12/12 at 9 pm reads, "Individual gave staff a very hard time tonight sliding out of her chair onto the floor. Staff tried several attempts to use (restrictive vest) to keep her in her chair but didn't work well."

A form titled "(Restrictive Vest) Tracking Sheet" for R9 in August 2012 has areas to be filled in for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 54	W9999		

date, time, why it was put on and why it was taken off. This form for August 2012 has no entries.

A "Frequency Count" used by direct care staff to record behaviors for August, 2012 has R9's targeted behaviors of Hitting Self, Hitting Others, Biting Self, Scratching Self, Uncooperative, and Elopement. Recordings for the date of 8/12/12 for all sections are zero.

E1 was interviewed on 9/14/12 at 10:30am. E1 was asked if R9 was still able to slide down in her wheelchair during behaviors and entrap her chest area with the intervention of the seatbelt clasp. E1 stated yes. E1 was asked if this incident was investigated or reviewed. E1 stated no.

E1 was shown the documentation on the Nursing note dated 8/12/12 stating R9 was in behaviors and staff tried several attempts to use the restrictive vest. E1 was asked how may times direct care documented this behavior on the August 2012 "Frequency Count" sheet. E1 stated, "zero."

E2 was interviewed on 9/14/12 at 11:40am. E2 was asked if R9 was able to slide down and become entrapped after the clasp closure was added to her seatbelt. E2 stated yes.

E2 was asked if this incident was investigated or reviewed per facility policy. E2 stated, "No."

E2 was asked what immediate measures were taken to ensure R9's safety. E2 stated there were no measures documented.

d) A "Nursing Progress Note" dated 8/30/12 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

(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 55	W9999		

1:30 pm reads "Individual attempt to slide out of W/C (wheelchair) seat belt rubbing under breast."

E1 was interviewed on 9/14/12 at 1030 am. E1 was asked if R9 had a fall on 8/30/12 involving her seatbelt. E1 stated, "Yes, according to nursing notes."

E1 was asked if there was a medical report or behavior report documented on this incident. E1 stated she was unsure where it was documented but could not locate a medical or behavioral report for this incident.

E1 then reviewed direct care staffs documentation of the "Frequency Count" for R9's behaviors. E1 confirmed there were zero behaviors recorded for 8/30/12. E1 was asked if there was documenation of R9's behaviors. E1 stated no.

E1 further stated during interview on 9/14/12 at 1:30 pm facility policies were not followed as she was not made aware of some of the occurences involving R9.

E2 was interviewed on 9/14/12 at 11:40 am and asked regarding R9's fall on 8/30/12. E2 stated there is no documentation to support a review or investigation of R9's fall. An IDT was scheduled for 9/12/12 as a result of the fall.

E2 was asked if there is a system in place to accurately track the number of incidents R9's has considering the absence of documentation by direct care staff. E2 stated no.

E2 was asked if the interventions put in place

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

(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 56	W9999		

kept R9 safe from falling or injury. E2 stated no.

A "Behavior IDT" written by E2 on 9/12/12 states "after the previous two incidents, (R9) was placed on 'within eyesight'." (R9 was taken off of eyesight after 8/2/12 IDT). E2 also stated a monitor would be placed if R9 was in her room. E2 reported this to be an audio monitor. E2 later clarified this monitor is a staff person who is to be in R9's room with her at all times which is effective immediately.

E2 was asked on 9/13/12 at 10:03 am during interview if there had been any modifications to address R9's Maladaptive Behaviors which pose a threat to her safety and require restrictive techniques. E2 stated, "None since June."

During observations on 9/13/12 at 1255pm, R9 was in a daytraining classroom sitting in her wheelchair with a clip alarm, lap alarm and seat belt in place. R9's seat belt was noted to have a knot tied it in near the clasp closure. R9's belt was applied loosely with approximately 6 inches of space between her abdomen and the belt.

E5 and E6 (both day training direct care staff), were asked on 9/13/12 at 1255pm why there was a knot tied in R9's seatbelt. E5 and E6 did not know. E5 stated R9 comes to day training with a knot in her seat belt every day, but he is not aware of a reason for this.

E5 and E6 were asked if there is direction on the tightness which R9's seat belt should be applied. E5 and E6 were not aware of any direction regarding R9's seatbelt. E5 stated it is just for safety, especially during transport.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

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W9999	Continued From page 57 E7, Day Training Supervisor, was interviewed on 9/13/12 at 1255 pm. E7 was asked if she was aware why R9's seatbelt has a knot in it. E7 stated no. E7 was asked what the supervision level for R9 is. E7 stated that everyone at day training is within "staff eyesight." There are no special interventions currently placed for R9 regarding supervision. There are no specific precautions for the tightness of R9's belt. On 9/13/12 at 342 pm, R9's bus arrived from daytraining. R9 was unloaded and assisted into the residence in her wheelchair. R9 was set in the front living room by staff. R9 was noted to have on a clip alarm, lap belt and seat belt with a knot in it. There were approximately 5 to 6 inches between R9's seatbelt and abdomen. E8 (Direct Care) was interviewed on 9/13/12 at 2:14 pm. E8 was asked why R9 has a knot in her seat belt. E8 stated there was a device attached to R9's seatbelt which was intended to prevent it from loosening, but R9 had broken it. The knot is intended to keep the belt from loosening when R9 rocks and thrusts during her behaviors. E8 was asked if there are guidelines as to how tight R9's belt is to be tightened to prevent the risk of entrapment or strangulation. E8 stated it should be tight enough "so she cannot slide down" but there are no specific guidelines. E8 was asked what the current supervision level is for R9. E8 stated that she is within eyesight if the restrictive vest is being used, but other than that she has freedom since the implementation of the clasp seat belt.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 58 E8 was asked if there were interventions if R9 was to be in her room. E8 stated that there are only interventions if she is out of her chair and in bed such as a mat, siderail and clip alarm. E8 was asked if there was a monitor. E8 stated there is "no monitor of any type" in R9's room. E8 confirmed she worked 2nd shift on 9/12/12 and 9/13/12. She was aware there was an IDT held on 9/12/12 but was not given new direction on new interventions for R9. E8 related staff are made aware of changes when the supervisor adds a memo to the staff book. The staff will read at the beginning of the shift and sign the changed interventions. E8 looked and confirmed there was no notification of changes to interventions in the book for R9 from the 9/12/12 IDT. E2 said in an interview on 9/13/12 at 10:03 am the monitor in the bedroom during waking hours was to be implemented "immediately" upon the determination of the IDT meeting 9/12/12. E9 (Direct Care) was interviewed on 9/13/12 at 230 pm. E9 confirmed that she worked 2nd shift on 9/12/12 and 9/13/12. E9 was asked what R9's supervision level is currently. E9 stated if R9 was in a behavior they "try to redirect her, if the behavior continues, then they apply a (restrictive vest)." E9 states R9 is within eyesight if she is in a restrictive vest, but if she is not in a restrictive vest, she is independent with a lapbelt and clip alarm.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G056	A. BUILDING _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

(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 59 E9 was asked about R9's supervision level while in her bedroom. E9 stated "it is okay (for R9) to go to her bedroom alone if she doesn't have her (restrictive vest) on and with her alarms." E9 was asked if there was any direction regarding the security of R9's seatbelt. E9 stated there were "no new instructions on her care, it is not specific, just not too loose and she is to wear her lap belt and clip alarm." E9 was asked if there had been any new memos regarding R9's care stemming from her 9/12/12 IDT. E9 stated no, she had checked the book and there were no memos regarding R9. (A)	W9999		