

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/22/2013
NAME OF PROVIDER OR SUPPLIER ST MARY'S SQUARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 239 SOUTH CHERRY GALESBURG, IL 61401		
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W 186	Continued From page 24 Of those six employees who were all Team Leaders, three were in on-the-job-training. E13 had been employed for two days, E10 had been employed for 15 days, E14 had been employed 3 weeks, E17 had been employed 7 months and E15 and E16 had been employed at least 2 years. Per an interview with E18, Residential Service Director (RSD), on 5/15/13 at 1045am, the current census of the floor on 5/15/13 was 62 residents. Of those 62, 16 residents required a mechanical lift, 13 residents require a sit to stand for transfers, 14 residents require some type of assistance, and 19 residents transfer independently. E18 also stated there is one resident on this floor which needed 1 on 1 or close monitoring while on isolation. One of the six team leaders would have been required to monitor this room.	W 186			
W9999	FINAL OBSERVATIONS LICENSURE FINDINGS 350.620a) 350.1230b)6)7) 350.1230d)2) 350.1230g 350.3240a) 350.3240c) 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	W9999			

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W9999	<p>Continued From page 25</p> <p>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.</p> <p>Section 350.1230 Nursing Services</p> <p>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:</p> <p>6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.</p> <p>7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.</p> <p>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.</p> <p>g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.</p> <p>These requirements are not met as evidence by:</p> <p>Based on record review and interview the facility failed to ensure a thorough investigation was completed for 1 of 2 individuals who were dropped from a mechanical lift while being</p>	W9999			

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W9999	<p>Continued From page 26</p> <p>transferred.(R5) Based on record review and interview the facility also failed to notify guardians of alleged abuse for 3 of 3 individuals outside the sample who were reported to be victims of abuse. (R6, R7, R8). Based on interview, observation and record review the facility also failed to implement their system/policy to prevent neglect when they failed to:</p> <p>1. Ensure 1 of 1 individual in the facility were free from potential peer abuse whose peer to peer incident resulted in a fractured humerus (R1) when they failed to:</p> <p>> Implement sufficient safeguards to prevent re-occurrence to R1 or other individuals in the facility.</p> <p>> Accurately collect, maintain and monitor data of R2's identified behavior of grabbing which resulted in R1's fractured humerus.</p> <p>2. Ensure 1 of 1 individual in the facility was free from potential of injury, whose repeated falls resulted in bilateral subdural hematomas (R3) and</p> <p>3. Ensure 2 of 2 individuals were free from potential harm, whom both fell while being transferred in a mechanical lift (R4 & R5)</p> <p>Findings include:</p> <p>1) R1's Physician Order Sheet (POS) for April 2013 states she is a 52 year old female who has diagnoses which include Profound Intellectual Disability, Cerebral Palsy, and Obsessive Compulsive Disorder.</p>	W9999			

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W9999	<p>Continued From page 27</p> <p>Per observation on 5/15/13 at 9:30 a.m., R1 is ambulatory without the use of assistive devices.</p> <p>In review of an Individual Service Plan (ISP) dated 2/27/13, R2 is a 31 year old male with diagnoses which include Profound Intellectual Disability, Schizophrenia, Autistic Tendencies, and Mood Disorder.</p> <p>R2's ISP states his IQ is 15 and his adaptive age score is 1 year 4 months.</p> <p>R2's 2/27/13 ISP has a section titled "Behavior". It states, "The following is a summary of the maladaptive behaviors which (R2) exhibits at his residential and day training facility." One of these summaries includes, "Hurtful to Others: One to 10 times a day (R2) may grab or hit others. This is moderately serious and addressed through formal programming."</p> <p>An untitled narrative statement dated "3/20" reads, "6:15 p.m. - In front of the elevators, (E1) Team Leader (TL) was talking with (R1) and (R2) was next to (R1). (R2) then grabbed (R1) for unknown reasons and pulled (R1) backward, (R1) then lost balance and fell to the floor."</p> <p>Another entry at a later date reads, "3/30 (R2) hit (an unidentified peer) X4 (four times) with open hand by the side elevator at 7:00."</p> <p>An "Incident Investigation" dated 3/26/13 and submitted to the Department reads that E1 stated she was up by the front elevators on 4th floor. E1 stated she was talking to R1 about going on a community outing when R2 grabbed R1 by her right arm and pulled her backwards. R1 lost her</p>	W9999			

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W9999	<p>Continued From page 28</p> <p>balance and fell backwards onto her right arm. The report states there were two other Team Leaders in the area who witnessed the incident.</p> <p>The investigation further states R2 "utilizes a wheelchair for mobility and is on behavior programing for aggression which includes hitting, kicking, pushing and scratching (which usually happens when he grabs)."</p> <p>Nursing was notified and upon assessment it was reported R1's right arm was bent at an "unnatural angle" and R1 was unable to move her right arm.</p> <p>R1 was taken to and admitted at a local hospital facility with the diagnosis of Fractured Right Humerus.</p> <p>A "Special Staffing" dated April 3, 2013 reports R2 takes Celexa 20mg daily and Risperidone 2mg twice daily for his behaviors. According to the Special Staffing report, R2's behaviors which are "Hurtful to others" include: "One to 10 times a day (R2) may grab or hit others, This is moderately serious and addressed through formal programming."</p> <p>The 4/3/13 Special Staffing reads, "(R2) sat quietly throughout the discussion. He reached out a few times to grab a shirt or his file on the table near him."</p> <p>The 4/3/13 Special Staffing further reads, "(Facility) staff reports when (R2) arrives home he will sit in his wheelchair near the elevator on the second floor. His behaviors consist of pulling, grabbing, pushing and hitting."</p> <p>R2's Behavior Management Program dated</p>	W9999			

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W9999	<p>Continued From page 29</p> <p>3/14/13 reads, "(R2) displays physically aggressive behaviors which consist of grabbing, hitting with an open or closed hand, and pinching."</p> <p>R2's "Maladaptive/Adaptive Behavior Recording Form for the month of March, 2013 has areas for staff to record the following behaviors: kicking, hitting with open or closed hand, scratching, pushing and hitting or slapping with open/closed hand. There is no area for staff to record R2's incidents of grabbing.</p> <p>R2's "Joint Program Form" with a start date of 6/15/12 under the title "Definition" reads, "Staff should be cautious of where (R2) is placed and where staff are standing. Staff should stand on his left side and when positioning him next to others or where others may pass by him, his left side should be on the traffic side. In this manner he cannot strike at peers that walk by."</p> <p>On 5/14/13 at 126pm, E1 (Team Leader) was interviewed and asked if she was a witness to the peer to peer incident between R1 and R2 which resulted in R1's right arm being fractured. E1 stated yes.</p> <p>E1 further stated she was standing by the elevator speaking with R1. R2 was sitting on the opposite side of R1 and suddenly reached up and pulled R1's right arm using his right arm. E1 states she attempted to prevent R1 from falling but was unsuccessful and R1 fell backwards onto her right arm.</p> <p>E1 was asked if she had special instructions as to which side R2 should be placed as his "traffic side." E1 stated, "Not that I recall."</p>	W9999			

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W9999	Continued From page 30 E1 was asked if the Team Leaders were inserviced after the peer to peer incident involving R1 and R2. E1 stated yes, they were advised to keep R2 out of crowds, especially if he is acting up. E3, Program Director (PD), was interviewed on 5/14/13 at 9:45 a.m. and asked if new safeguard measures were implemented after R2's actions resulted in the fracture of R1's arm. E3 stated the facility inserviced staff to keep R2 in less populated areas and any time he is observed to be under high stress, the staff is to remove him from the area. E3 was asked if R2's medications were changed. E3 stated, "Not that I know of." E3 was asked if R2 had any other modifications to his behavior plan. E3 stated, "Not that I know of." E2, (PD), was interviewed on 5/14/13 at 11am and asked if there was data collection and tracking for R2's identified behavior of grabbing. E2 stated, "No, because there isn't an option for grabbing so staff would just write it in the narrative notes." E2 was asked if this behavior was tracked, and E2 stated no. E3, PD was interviewed 5/14/13 at 1145am and asked if R2 has been put on a program which documents and tracks his behavior of grabbing since the incident of peer to peer which resulted in a fracture. E3 stated no. E3 was interviewed again on 5/14/13 at 310pm and she advised an inservice was held on 3/22/13	W9999			

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W9999	<p>Continued From page 31 to keep R2 and R1 out of the same areas. R2 should be in less congested areas and assisted to a place with fewer peers nearby.</p> <p>E3 was asked if R2 was targeting R1. E3 stated no.</p> <p>E3 was asked how the facility will ensure R2 doesn't injure one of the fewer peers he is around. E3 did not answer.</p> <p>E3 was asked what R2's current supervision level is. E3 stated R2 is "free to move about his home."</p> <p>E3 stated that R2 is wheelchair bound but propels himself about the floor using his legs. E3 also stated that R2 has little use of this left arm/hand and utilizes his right hand for functional tasks.</p> <p>E3 was asked if R2 had a level of supervision change since the 3/20/13 incident involving a fracture. E3 stated no.</p> <p>A facility policy titled "Administrator's Investigative Committee" and last revised 03/21/12 defines Neglect as the "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."</p> <p>Additionally, under "Procedure" this policy states, "11. If the allegation is that another individual committed an act of abuse, appropriate action will be taken to safeguard the other individuals."</p> <p>2) Per an Individual Service Plan (ISP) dated 09/27/12, R3 is a 64 year old female who has diagnoses which include Profound Intellectual Disability, Down Syndrome and Dementia.</p>	W9999			

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W9999	<p>Continued From page 32</p> <p>R3's ISP under a section titled "Functional Skills" reads, "(R3) has experienced falls in various areas of the facility and (at workshop)." It goes on to say R3 has "several safety devices are being used with (R3) to prevent falls." She uses a wheelchair full time with leg rests for mobility. She uses a shower chair for bathing. She uses a sling lift (this was handwritten) for transfers. (R3) also has a pressure alarm on the seat of her wheelchair and on her bed to alert staff if she attempts to transfer without assistance.</p> <p>An undated handwritten entry which was signed by E4, Qualified Mental Retardation Professional (QMRP), reads "There are also bolster pads on her bed and a safety mat on the floor next to her bed."</p> <p>"Quality Assurance Meeting" notes dated 03/18/13 report on 3/17/13, R3 was noted to have slid out of her wheelchair with no injury noted. There is no further documentation noted in R3's chart or nursing notes of this incident.</p> <p>Nurses notes titled "Program Progress Notes" and dated 3/20/13 at 5:30 a.m. read, "(Team Leader) notified nurse of res (resident) being on floor. Flipped chair once she fell asleep and body went forward. Very small bruise on forehead. No injuries noted." This is documented even with evidence of injury.</p> <p>A "Special Staffing" dated March 20, 2013 for R3 reads the staffing was held to discuss R3 tipping forward out of her wheelchair. "On 3/20/13 at 5:10 a.m., (R3) was found lying face-down on the floor with her wheelchair on top of her." It was assumed R3 leaned too far forward which caused her to tip.</p>	W9999			

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W9999	<p>Continued From page 33</p> <p>The report goes on to read later that evening at 5 p.m., R3 "fell face-first out of her wheelchair. She was bleeding from her nose and was sent to the emergency room."</p> <p>Nursing notes from 3/20/13 at 5pm read "TL (Team Leader) reported resident fell face first out of her W/C (wheelchair) - resident with active bleeding through both nostrils, abrasion to forehead (and) left eye - pupils left eye pin-point, right eye at 2 - both non-reactive to lite (sic)." R3 was sent to the emergency room via ambulance for evaluation.</p> <p>R3 was later returned to the facility with a negative CT and orders to follow up with her eye doctor.</p> <p>On 03/21/13 at 9am, R3 was sent back to the emergency room due to decreased level of consciousness.</p> <p>R3 returned from the emergency room with no new orders, follow up with physician in 3 days.</p> <p>R3 then went to her appointment at the eye doctor who stated her pin point pupil most likely was secondary to a previous cataract surgery.</p> <p>A "Program Progress Note" written by nurses on 5/7/13 at 1pm reads, "TL reported res (sic) fell out of bed to floor, res currently does not have a mat in front of bed. Res fell and hit head on floor and landed on lt (left) side of body. " R3 was sent to the emergency room via facility van.</p> <p>A "Program Progress Note" written by nursing on 5/9/13 at 745pm reads R3 returned from the</p>	W9999			

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W9999	<p>Continued From page 34 hospital with a diagnosis of Subdural Hematoma.</p> <p>A "Consultation" dictated by Z1, physician and dated 5/7/13 reads under a section titled History, "She was noted to having fallen out of her bed, hitting her forehead and was brought to the emergency room for an evaluation."</p> <p>The Consultation also reads, "CT scan which showed evidence of bilateral subdural hematomas which are mixed density being both subacute and only very small amounts of acute bleeding showing that she has been accumulating this for a short time."</p> <p>The Consultation reads under a section titled "Assessment, 1. Subacute subdural hematomas accumulating since March of this year by last CT scan. They are bilateral."</p> <p>A "History and Physical" dictated by Z3, Physician, on 05/07/13 reads, R3 "was brought into the emergency room today because of a couple of falls...She fell out of bed...She had been in the ER (emergency room) in March with a fall where she had a head injury and had a normal CT scan at that time. However, in the emergency room here today, she was found to have large bilateral subdural hematomas which had both acute and chronic findings on her CT scan of her head."</p> <p>The most recent "Fall Risk Assessment" for R3 was dated 9/27/12 and signed by E5, QMRP, which R3 was given a score of "8". The key on the risk assessment indicates the patient is high fall risk if they receive a score of 10 or more.</p> <p>A "Memo to DQA (Director Quality Assurance)"</p>	W9999			

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W9999	<p>Continued From page 35 dated 5/7/13 and written by E6, Team Leader reports R3 was found "laying face down on the floor."</p> <p>This Memo also reads there was a bed sensor / pad on the bed which wasn't beeping.</p> <p>During an interview with E6 on 5/14/13 at 220pm, E6 was asked if she was working when R3 was found on the floor 5/7/13. E6 stated yes.</p> <p>E6 reported R3 was "all cocooned up in her blanket and had went up and over the bolster. She was face first on the tile."</p> <p>E6 was asked if R3 had a bed alarm placed. E6 stated yes, "but it wasn't working."</p> <p>E6 was asked if R3 had a mat in place next to her bed. E6 stated no, there was only one in the room at the time and it was by R3's roommates' bed.</p> <p>E7, RN Trainer, was interviewed on 5/15/13 at 1050am and asked if R3's 5am fall on 3/20/13 was reported to the physician as per facility policy. E7 could not reach the nurse who had documented the nursing note that date.</p> <p>E7 did not provide any evidence of nursing contact with the physician or a fax to the physician from this first of two falls on 5/20/13.</p> <p>A facility policy titled "Emergency Services" and revised on 7/10/11 under the section titled "Head Injuries" reads, "2. The physician should be contacted."</p> <p>A facility policy titled "Administrator's Investigative Committee" and last revised 03/21/12 defines</p>	W9999			

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NAME OF PROVIDER OR SUPPLIER ST MARY'S SQUARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 239 SOUTH CHERRY GALESBURG, IL 61401		
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W9999	<p>Continued From page 36</p> <p>Neglect as the "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."</p> <p>3) Per an ISP dated 02/14/13, R4 is a 61 year old male with diagnoses which include Profound Intellectual Disability, Spastic Quadriplegia, Contractures of Extremities, and Thoracic Lumbar Scoliosis with Degenerative Joint Disease of L-5 Spine and T Spine.</p> <p>R4's ISP also states he has very limited communication skills and does not like to be touched. R4 requires staff assistance and utilizes a sling lift for all transfers.</p> <p>An "Incident Investigation" of an incident which occurred on 3/16/13 and reported to the Department states R4 experienced a fall from a sling lift resulting in a laceration to the back right side of the head.</p> <p>R4 was sent to the emergency room with six staples in place to the back right side of his head.</p> <p>The report goes on to state, "(The Team Leader) admitted that while utilizing the sling lift with (R4) that he did not cross the leg straps on the sling causing (R4) to slide out of the sling."</p> <p>A "Program Progress Note" written by nursing and dated 3/16/13 at 820pm reads, "TL (team leader) reports res (resident) fell out of sling lift. Upon assessment laceration noted to back right side of head, active bleeding noted."</p> <p>A CT report of R4's dated 3/16/13 from the hospital reads, "History: The patient was dropped four feet from a (mechanical) lift."</p>	W9999			

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W9999	<p>Continued From page 37</p> <p>During an interview with E9, Director of Training on 5/8/13 at 149pm, E9 was asked how long E10 had been employed with the facility. E9 stated E10's hire date was 3/1/13 and the date of occurrence was 3/16/13.</p> <p>E10 further stated trainees have 1 to 1 supervision for the first two weeks of employment and then continue their Competency Based Training Assessments (CBTA's) ongoing for up to 120 days.</p> <p>E9 was asked if E10 was in training on 3/16/13. E9 stated yes, E10 had ongoing training until his assessments were complete.</p> <p>During this interview E9 was asked if, according to records and the facility investigation, E10, Team Leader in Training, was transferring R4 using a mechanical lift alone although he was still in training and R4 was severely contracted and experiences chronic pain. E9 stated yes.</p> <p>E9 was asked if E10 had followed manufacturers directions to ensure R4's safety when he failed to cross the leg straps on R4's sling. E9 said no.</p> <p>A facility policy titled "Administrator's Investigative Committee" and last revised 03/21/12 defines Neglect as the "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."</p> <p>4) Per ISP dated 07/11/12, R5 is a 73 year old female who has diagnoses which include Osteoporosis, Chronic Low back Pain, and Severe Intellectual Disability.</p>	W9999			

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W9999	<p>Continued From page 38</p> <p>R5's ISP states she has fall prevention measures of a floor mat, low bed and doorbell in her room. She is to use the doorbell when she needs assistance to get up. R5 is on an ambulation program to maintain her ambulating skills which is done with her walker and staff assistance using a gait belt.</p> <p>The most recent Physical Therapy note on R5's chart reads, "Continues use of w/walker (wheeled walker) for ambulation (secondary to) unsteady gait."</p> <p>A "Program Progress Note" written by nursing and dated 3/30/13 at 7:30 pm reads, that the Team Leader reports resident fell backward out of sling lift while transferring from the wheelchair to bed. Resident was lying on the floor on her back. Team leader reports resident hit back of head on leg of lift."</p> <p>A "Memo to DQA" written by E8, Team Leader, on 03/30/13 at 7:20 pm reads that R5 "wouldn't sit still and kept yelling." A note at the bottom of this memo reads, "Slipped through the buttocks opening while squirming around."</p> <p>During an interview on 5/8/13 at 940am, E12, Director of Quality Assurance, was asked if the incident of R5 being dropped while in a mechanical lift on 3/30/13 was formally investigated. E12 stated no as there was no injury to the resident.</p> <p>During an interview with E9, Director of Training, on 5/8/13 at 1112am, E9 was asked if, according to records and the facility investigation, E8 was transferring R5 using a mechanical lift with only one staff person although she was said to have</p>	W9999			

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W9999	<p>Continued From page 39</p> <p>been "squirming" which contributed to her fall. E9 stated yes.</p> <p>A facility policy titled "Administrator's Investigative Committee" and last revised 03/21/12 defines Neglect as the "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."</p> <p>5) Per a Physician Order Sheet (POS) for March 2013, R6 is a 49 year old female with diagnoses which include Moderate Intellectual Disability and Diabetes.</p> <p>According to an "Investigation of Allegation of Verbal Abuse" dated 2/19/13 and reported to the Department, R6 was said to have been the alleged victim of verbal abuse by a staff member. This incident was reported to have occurred on 2/13/13.</p> <p>E11, Social Services, was interviewed on 5/8/13 at 10:45 a.m. and asked if the guardian of R6 had been notified of this allegation involving R6 or the findings. E11 stated no.</p> <p>6) Per a POS for April 2013, R7 is a 57 year old male who has diagnoses which include Profound Intellectual Disability and Obsessive Compulsive Disorder.</p> <p>Per a POS for March 2013, R8 is a 61 year old female who has diagnoses which include Hearing Impairment and Profound Intellectual Disability.</p> <p>According to an "Investigation of Allegation of Verbal Abuse" dated 2/19/13 and reported to the Department, R7 and R8 were said to be alleged victims of verbal abuse by an employee.</p>	W9999			

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W9999	Continued From page 40 E11, Social Services, was interviewed on 5/8/13 at 10:45 a.m. and asked if the guardians of R7 or R8 had been notified of the allegation of abuse or the findings of the investigation. E11 stated no. (B)	W9999		