STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G365	A. BUILDING _____ B. WING _____	10/14/2015

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ALDEN VILLAGE NORTH	7464 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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W 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY - FUNDAMENTAL EXTENDED IN HEALTH CARE SERVICES ANNUAL LICENSURE SURVEY INSPECTION OF CARE	W 000		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement and reinforce a behavior program as outlined in the Individual Program Plan (IPP) to address "mouthing" and excessive secretions during dinner for 1 individual (R11) who is outside of the sample. Findings include: Dinner observations were conducted on 10/06/15 in the "Tree House" dining room area of the facility beginning at 4:00pm. (R11) was observed seated at a table with E5; Case Manager and exhibiting self stimulating behavior of putting his right hand and fingers in his mouth. R11 was also	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249	Continued From page 1 expelling a large amount of thick "mucus" that was "Free - flowing" from his mouth. The secretions from R11's fingers and mouth were "flowing" onto the table in front of R11, onto his shirt, left black custom - made shoe, chair and floor in the area where R11 was seated. At 4:40pm, E6; Certified Nursing Assistant (CNA) began to wipe down the table where R11 was sitting and as she came near his place setting area, R11 "Waved her away ". At 4:43pm, E5; Case Manager began to wipe down the remaining tables in the dining room. At 4:55pm, E6 (CNA) tried to place the food for R11 in front of him when he "Waived her away". At 5:01pm, E7 (CNA) placed the food tray for R11 in front of him and R11 consumed his meal. E7 sat directly across from R11 at the same table while assisting another individual with feeding. Illinois Department of Public Health (IDPH) Surveyor did not observe from 4:00pm continuously until 5:30pm prompts from staff to address "Mouthing", the excessive secretions or engage R11 in any activities as outlined in R11's Individual Program Plan and Behavior program. Record review of R11's IPP dated 3/11/15 and Behavior program dated 8/17/15 state " (R11) may exhibit self-stimulating behaviors due to under stimulation. A consequence of him mouthing his hand is the big potential for skin deterioration. A consequence of him pushing his jaw is the potential to bruise his chin." "Interventions: Redirection- If (R11) is observed mouthing his hand or pushing his jaw, firmly redirect him to stop the behavior and engage him in an activity he prefers." An interview was held with E10; Residential Service Director (RSD) on 10/07/15 at 11:40am in	W 249		

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W 249	Continued From page 2 the dining room of the facility. E10 confirmed that "Mouthing" is identified in the IPP for R11 and that R11 has a behavior program to address this and "Staff should implement the behavior program across all settings at all times for (R11)." Facility failed to address "mouthing" and excessive secretions during dinner for R11.	W 249		
W 254	483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. This STANDARD is not met as evidenced by: Based on record review, interview and observation the facility failed to ensure documentation that contributes to the overall understanding of an individuals current functioning level for 1 of 1 resident, R8, who is not currently attending day training. Findings include: Observations were conducted in the residential site on 10/7/15 from 7:30am thru 8:45am. At 8:35am surveyor observed R8 in her bed. Surveyor asked E9, Case Manager, if R8 is going to day training. E9 stated R8 has not been going to day training. E9 stated R8 will not get on the bus. E9 said they are working with her and have tried to transport her on the facility's bus but she refuses to get on that bus as well. E9 stated she has an activity schedule while she is in the home for staff to follow. Observations were conducted at the day training site on 10/7/15. At 11:35am Z1, Program	W 254		

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W 254	Continued From page 3 Manager, stated regarding R8's attendance R8 currently has not been attending day training due to behavioral issues. Z1 stated R8 will try to get out of her seat or will unbuckle her belt if in a wheelchair. Z1 was asked when was the last time R8 attended day training. Z1 reviewed her records and said 9/17/15. Review of R8's file includes 2 references in Social Services Progress Notes to her not attending day training. 1 on 10/1//15 which references her refusal to get on the bus. The other on 10/3/15 which reviews her refusal with day training and how the team is meeting to formulate a plan for her to go back to day training. R8's file does not document her refusal of day training since 9/17/15 nor is there documentation as of 10/9/15 of the Interdisciplinary Team meeting to formulate a plan addressing her refusals. The file does not document the informal steps that have been tried including having her ride the facility bus without success. On 10/9/15 at 11:53am E12, Case Manager, was interviewed. E12 stated they are trying to figure out why R8 is not going to day training. "We think there is some anxiety and her Qualified Intellectual Disability Professional has left. We tried on our bus but that didn't work. We are still going to meet and figure out how to get her back to day training. The team has not met formally but we did have an informal case manager meeting if it is behavior or anxiety." E12 acknowledged that this was not documented.	W 254		
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the	W 268		

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W 268	Continued From page 4 growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure dignity was maintained for 1 of 3 clients observed during the evening medication pass, who was out of the sample(R12). Findings include: The evening medication pass was observed being performed on 10/6/15, beginning at 4:25pm. R12 was observed receiving his medications as this time. E13(Registered Nurse) was the staff member observed performing this medication pass. E13 gave R12 his medications in applesauce, and then gave him honey thickened water, fed via a spoon. R12 was observed with water running down his face and onto his shirt. E13 did not wipe R12's face, nor change his shirt. Instead, E13 stated that he would find the aid to clean R12 up. E13 proceeded to tell E14(Direct Care Staff), who then came into R12's room, and wiped his face. E14 did not change his wet shirt however. When E13 was made aware of this fact, E13 told E14 that R12's shirt needed to be changed as well, and E13 proceeded to do so. During an interview with E13 at this same date and time, E13 was asked why the aid did not change his shirt, and or why he did not change R12's shirt, or wipe his face. E13 stated that E14 probably did not hear him correctly the first time, and she probably just thought she needed to wipe his face,(even though R12's shirt was observed to be wet from spilled water all over the front	W 268		

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W 268	Continued From page 5 neck line of his shirt.	W 268		
W 341	483.460(c)(5)(ii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to teach and promote infection control techniques for 1 individual (R11) who is outside of the sample when handwashing prompts were not observed before and after the dinner meal and breakfast for R11 who exhibited maladaptive behavior of "mouthing" and excessive secretions during dinner and breakfast for 1 individual (R11) who is outside of the sample. Findings include: 1) Dinner observations were conducted on 10/06/15 in the "Tree House" dining room area of the facility beginning at 4:00pm. (R11) was observed seated at a table with E5; Case Manager and exhibiting self stimulating behavior of putting his right hand and fingers in his mouth. R11 was also expelling a large amount of thick "mucus" that was "Free - flowing" from his mouth. The secretions from R11's fingers and mouth were "flowing" onto the table in front of R11, onto his shirt, left black custom - made shoe, chair and floor in the area where R11 was seated. At 4:40pm, E6; Certified Nursing Assistant (CNA)	W 341		

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W 341	Continued From page 6 began to wipe down the table where R11 was sitting and as she came near his place setting area, R11 "Waved her away ". At 4:43pm, E5; Case Manager began to wipe down the remaining tables in the dining room. At 4:55pm, E6 (CNA) tried to place the food for R11 in front of him when he "Waived her away". At 5:01pm, E7 (CNA) placed the food tray for R11 in front of him and R11 consumed his meal. E7 sat directly across from R11 at the same table while assisting another individual with feeding. R11 finished his meal at 5:30pm and E5; Case Manager assisted R11 with standing up from the table and disposing of his meal tray. Illinois Department of Public Health (IDPH) Surveyor did not observe from 4:00pm continuously until 5:30pm prompts from staff for handwashing prior to and after the dinner meal for R11 considering the "Mouthing" and excessive secretions that were "Free-flowing" from R11's mouth onto the table in front of R11, onto his shirt, left black custom - made shoe, chair and floor in the area where R11 was seated in the dining room. An interview was held with E3; Director of Nursing on 10/06/15 at 5:40pm in the nursing station, E6; CNA on 10/06/15 at 5:45pm in the dining room and E10; Residential Service Director (RSD) on 10/07/15 in the dining room at 11:40am and it was confirmed that "Handwashing should be done before and after meals and wipes are provided. Handwashing for (R11) should obviously be done when there is hand contact of mouthing and secretions on the tables, chairs, floor and areas where other individuals are exposed." 2) Observations were conducted at the residential site on 10/7/2015 from 7:30am thru	W 341		

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W 341	Continued From page 7 8:45am. At 8:30am in the Tree House dining/activity area surveyor observed R11 eating his breakfast. R11 was eating independently alone at a table. 1 staff person was present in the room, E8, Unit Director. E8 was engaged with another resident in the room. R11 was eating his pureed breakfast and was observed with copious amounts of saliva and pureed food flowing onto the table. R11's plate was off to the side. At 8:33am E8 was asked about R11's plate being off to the side and the extensive amount of saliva and pureed food on the table. E8 stated R11 pushes his plate off to the side and that is the way he likes to eat. E8 did not address the food/saliva on R11's table.	W 341		