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	14G072	A. BUILDING _____ B. WING _____	01/16/2015

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BETHSHAN ASSOCIATION	**12927 SOUTH MONITOR PALOS HEIGHTS, IL 60463**

(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
W 000	INITIAL COMMENTS ANNUAL LICENSURE CERTIFICATION SURVEY FUNDAMENTAL SURVEY INSPECTION OF CARE SURVEY	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review, observation and interview it was determined, for one of one resident (R1) attending this day training (DT) site, the facility failed to ensure: 1) The facility and DT staff communicate with each other regarding a significant, functional change for R1, specifically her non functioning electric wheelchair. 2) That R1' priority DT goals are adjusted as needed. 3) That R1's activity with the DT programs and goals are communicated to the facility. Findings include: A) According to the record, R1 is a verbal 55 year old who is dependent on her electric wheelchair (wc) for mobility and positioning. R1 operates her wc independently, and also has a manual w/c if the electric one is out of operation. R1's right hand is functional, however her left hand is contracted. R1 goes to DT five days a week.	W 120		1/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/16/2015

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W 120	Continued From page 1 R1 was observed at the day training site at 11 AM on 1/14/15. R1 was sitting in her manual wheelchair, leaning towards the right, to such a degree that neither her head nor her right arm was support by the rests. The other residents were participating in an art project, however R1 said she couldn't because her right hand movement is restricted when in her manual wc. R1 said she sits in the manual chair doing nothing all day at DT. At this time, R1 said her neck, head, right side and arm were hurting from her position in the wheelchair. Z2 (DT direct care staff) stated she was assigned to R1 and had noticed she was in a manual wc the past few days. Z2 said that R1 can not participate in many of the activities because the manual wc limits her movement. Z2 confirmed that R1 appeared uncomfortable in the wc, but had not informed anyone, such as the DT Case Manager (Z1), or the home facility. Z1 then arrived in the room, and confirmed that R1 appeared uncomfortable in the wc. Z1 said she wasn't notified by the facility, or DT staff, that R1 was in a manual wc this week, so that adjustments could be made as needed. B) R1's DT Individual Program Plan (IPP), dated 7/24/14, includes 2 priority goals. A communication goal at 80 % and a work production goal with weekly opportunities. However the IPP for the prior year also included the same goals. The data sheets, dated from 8/2013 to 12/2014 identified that R1 had completed the communication goal multiple times at 100%. Z2 said on 1/14/15 at 11 am, she has been working with R1 for a while and there has been no production work for R1, since 10/2014. Z1 agreed with Z2 on 1/14/15, at 12:15 PM, that there has been no production work for R1 since	W 120		

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W 120	Continued From page 2	W 120		

around this past fall. However the data sheets show that R1 has had 3-7 opportunities a month at production. R1 said on 1/14/15 at 11:30 AM, that she has not been working production.

C) On 1/14/15, at 2 PM, E6 (QIDP) was asked about R1's DT goal revisions and work production. The facility record lacked updated DT documentation regarding R1's DT goals and activity. E6 said all she has is the DT IPP, not any information regarding R1's progress at DT. E6 said she has not received data for R1's priority goals since the annual IPP dated 7/2014.
Based on observations, record review and interview, the facility failed to ensure that outside daytraining site implement program objectives. This occurred in one of one (R6) who required specific oral hygiene needs.

Observations were made of R6 on 1/14/15 from 10:20am to 11:15am. R6 was seated in a custom wheelchair in classroom 119 listening to the instructor read a story

Record review of the program objective dated 3/2014 includes an objective for R6, as follows, "R6 will allow staff to brush her teeth after each meal, with supervision, 40% of trails, until she receives 2 consecutive dental reports by 3/31/15. "staff will brush R6's teeth using child/youth size toothbrush. Staff may also use a mouth swab to get extra food out of her mouth." The same record also included a dental report dated 2/10/14 states states, "severe gingivitis, slight calculus, heavy plague, care of teeth is poor, severe recession, general condition of the teeth is poor, brush after each meal."

An interview was conducted with Z5 (daytraining

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W 120	Continued From page 3 classroom instructor) on 1/14/15 at 11:15am, Z5 was asked if the program objective was implemented and if so where was R6's toothbrush kept since her teeth have to be brushed after each meal. Z5 retrieved a toothbrush from the classroom desk drawer which was new and still sealed in the packaged (unused). Z5 then stated that they don't use the toothbrush but rather the mouth swabs to remove extra food from R6's mouth. Z5 (R6's case manager at daytraining confirmed the program objective is not being followed."	W 120		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: 4.) An Injury/Illness/Health Incident Report Investigation dated 11/25/14 was reviewed. The report states, "R7 was maneuvering himself through the dining room area once breakfast was over when he approached R17 and started hitting and grabbing him." An interview was conducted with E1 on 1/13/15 at 12pm, E1 states the facility do not have guardian notification for R17 who was involved in a peer to peer physical strike. Based on interview and record review, the facility	W 148		2/15/15

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W 148	Continued From page 4 failed to ensure guardians were notified of peer to peer incidents impacting 1 resident in the sample (R2) and 10 residents outside of the sample (R5, R11, R12, R13, R14, R15, R16, R17, R18, R20) and one injury sustained by 1 resident outside of the sample R22. Findings include: 1) Review of incidents include: 1. R7 grabbed R13's arm on 11/15/14 at 10:10 AM. 2. R7 grabbed R13 and R2 on 11/4/14 at 3:30 PM. 3. R7 grabbed R14 and hit R13 on 11/5/14 at 7:15 AM. 4. R7 grabbed R14 on 10/28/14 at 3:00 PM. 5. R7 grabbed eyeglasses from R15 at 3:05 PM. 6. R11 hit R13 on 10/23/14 at 4:00 PM. 7. R9 kicked and punched R16 on 10/20/14 at 5:30 PM. 8. R13 grabbed and hit R17 on 10/21/14 at 7:15 AM. 9. R7 grabbed and pinched R13 on 10/18/14 at 1:30 PM. 10. R7 grabbed R18 on 10/13/14 at 8:15 PM. 11. R19 pushed R20 on 12/15/14 at 3:00 PM. 12. R22 sustained a cut to the left thumb while propelling wheelchair on 11/20/14 at 3:40 PM. Facility Incident/Injury reports do not have information regarding notification of the guardians of R2, R13, R14, R15, R16, R17, R18, R20 and R22 involving their residents who were recipients of peer to peer aggression or injury. Administrator E1 validated on 01/13/15 at 1:41 PM that the guardians were not notified of the	W 148		

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W 148	Continued From page 5 above incidents. 2) Review of facility " Unusual Incident Report" dated 11/22/14 states a peer to peer incident occurred in the home at 4:00pm. R11 was observed teasing and taunting R13 and then hit R13. R13 then hit R11 and both R11 and R13 were hitting each other at the same time. Facility Unusual Incident Report do not have information regarding notification to the guardian for R11 and R13. An interview was held with E5; Qualified Intellectual Disability Professional (QIDP) on 01/13/15 at 1:50pm in the QIDP office. E5 confirmed that the guardians for R11 and R13 were not notified. Surveyor: Ruebe, Ann 3) R18 was found to have an abrasion on the right shoulder on 11/25/14. R18's guardian was not notified. Administrator E1 confirmed on 01/13/15 at 12:00 PM that R18's guardian was not notified. a) R7 was pulling the arm of R5 on 11/28/14 and staff had to manually assist R7 with removing his hand from R5's arm. R5's guardian was not notified of the incident. Administrator E1 confirmed on 01/13/15 at 12:00PM that R7's guardian was not notified.	W 148		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153		2/15/15

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W 153	Continued From page 6	W 153		

This STANDARD is not met as evidenced by:
2) R18 was found to have an abrasion on the right shoulder on 11/25/14. IDPH was not notified and Administrator E1 confirmed on 01/13/15 at 12:00 PM that there was no notification to IDPH for R18.

a. R7 was sent to the hospital on 01/02/15 for right knee infection. IDPH was notified late on 01/05/13. Administrator E1 confirmed on 01/13/15 at 12:00 PM that IDPH was notified late for R7.

b. R21 was found to have bruises on his right thigh and upper hips. IDPH was not notified of this incident. Administrator E1 confirmed on 01/13/15 at 12:00 PM that IDPH was not notified for R21.

c. R7 was pulling the arm of R5 on 11/28/14 and staff had to manually assist R7 with removing his hand from R5's arm. IDPH was notified on 12/01/14 of the incident. Administrator E1 confirmed on 01/13/15 at 12:00 PM that there was late notification to IDPH for R5.

d. R7 grabbed R13's face on 11/22/14. IDPH was notified late on 11/24/14. Administrator E1 confirmed on 01/13/15 at 12:00 PM that IDPH was notified late for R7.

Based on interview and record review, the facility

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W 153	Continued From page 7	W 153		

failed to notify and report in a timely manner to the IDPH (Illinois Department of Public Health) the following reportable incidents involving peer to peer incidents of aggression involving 4 residents outside of the sample as recipients of the aggression (R13, R16, R17, R20).

Findings include:

Illinois Administrative Code 350.700 includes:
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

1) R7 grabbed R13's arm on 11/15/14 at 10:10 AM. IDPH was notified late on 11/17/14.

a. R9 kicked and punched R16 on 10/20/14 at 5:30 PM. There is no documented IDPH notification for this incident.

b. R13 grabbed and hit R17 on 10/21/14 at 7:15 AM. There is no documented IDPH notification for this incident.

c. R19 pushed R20 on 12/15/14 at 3:00 PM. There is no documented IDPH notification for this incident.

Administrator E1 confirmed on 01/13/15 at 12:30 PM that notification to IDPH was late for R7's 11/15/14 incident with R13. E1 also confirmed that IDPH was not notified of the incidents

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W 153	Continued From page 8 involving R9 and R16 on 10/20/14, R13 and R17 on 10/21/14, and R19 and R20 on 12/15/14.	W 153		
W 253	483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure there is significant information regarding the injury discovered on 1 resident outside of the sample, R21. Findings include: Injury Report dated 12/8/14 for R21 include the narrative "R21's body is covered with bruises. The left top of the foot for R21 was very blue." Injury Report Form includes a front and back diagram of the human body. On this diagram were x marks on the front body including: three x marks on the right arm, two x marks on the right chest, four x marks on the right leg, two x marks on the left leg, one x mark on the left foot, two x marks on the left chest, and two x marks on the left arm. A description includes "black and blue bruises all different sizes." Administrator E1 was interviewed on 01/15/15 at 9:22 AM. E1 confirmed that per Director Of Nursing E2, there was no other documentation of the bruises/marks indicated on the injury report's diagram. There is no description of the size, shape, location and other pertinent information regarding R21's bruises found on 12/8/14.	W 253		1/26/15

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W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure there was ongoing monitoring and documentation for the use of a weighted blanket and padding to the furniture and wall of 1 resident outside of the sample, R12. Findings include: Observation of Pod 3 with Direct Support Person E10 on 01/13/15 include blue padding with gray duck tape to the edges of R12's dresser and bed frame, blue pad (the approximate size is as long and wide as R12's twin bed) hanging on the wall where R12's bed is placed, and a dark blue weighted blanket on top of R12's bed cover. E10 validated approximately at 4:00 PM that R12 uses the weighted blanket nightly and the blue padding to the furniture and walls were used for R12's behavior that lead to serious injury to his head. E10 validated that R12 has not displayed behaviors that requires the need for the padding. Qualified Intellectual Disability Professional E5 validated on 01/13/15 at approximately 4:45 PM that R12's serious behavior that previously required the use of the pads is no longer a current issue.	W 285		2/15/15

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W 285	Continued From page 10 R12's 10/17/14 Individual Service Plan and 9/24/14 Behavior Interventions Program do not mention the use of blue pads to address any behavior. The Program Plans do not indicate when, how long, why and when to stop the use of the pads. In R12's Behavior Interventions Program validate the following: - "January 2012 purchase of a weighted blanket that is 18 pounds to provide deep pressure. - Methods: 4. R12 has a specially designed weighted blanket (18 lbs.) At times throughout the day, staff may bring R12 his weighted blanket. If he appears interested, staff may either lay it over him or wrap it over his shoulders. 5. The weighted blanket will be used as the coverlet on R12's bed during hours of nighttime sleep to the extent that he will tolerate. - Behavior Control Procedures: 3. If R12 begins to tantrum or display physical aggression at Facility...If R12 will tolerate it...staff may lay his weighted blanket over him..." Administrator E1 on 01/15/15 at 9:22 AM was asked regarding documentation of when, how long and whether the use of the weighted blanket. E1 was also asked about the purpose of the padded furniture and blue pad on the wall in R12's room. E1 validated that R12 uses the weighted blanket nightly. There is no documentation of the nightly use and other times that the weighted blanket is used, for how long and how R12 responded to the use of the weighted blanket. E1 confirmed that the padding in R12's furniture and wall were used for his past self-injurious behavior which is no longer a current issue.	W 285		

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W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: surveyor #32141 2) Review of Emergency Interdisciplinary Team Meeting for R11 dated 9/03/14 states "Physical Aggression/Severe tantrum: We added procedures to this program to address severe physical aggression- we hadn't seen this from (R11) in over 2 years, and so the program no longer addressed the more severe aggression. Most important: staff need to stay out of arm's reach when (R11) is in a rage, and talk to him as little as possible. His chair should be held by staff from behind when they need to prevent him from moving for safety reasons." Review of facility "Monthly Review of Progress" Qualified Intellectual Disability Professional (QIDP) note for November 2014 and facility data sheets for R11 state "Restraint - x2 at home for the month of 8/14, x2 at day training and x10 at home for the month of 9/14." Review of R11's Behavior Intervention Program dated 10/23/14 references the use of manual restraints for R11, however their is no mention of duration of the application of the manual restraint. Facility "Behavior Notes" dated 8/31/14 at "2:20-10:30" stated that a staff had to physically restrain R11 to the floor, however no duration was indicated for this restraint. Behavior note dated 9/02/14 for R11 states : (R11's) behavior "Required several staff to hold (R11's) chair so he could not break doors or windows" but does not indicate duration of the hold. On 9/08/14 at 10:30am-5:30pm, the behavior note states that a manual hold was used	W 303		2/28/15

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W 303	Continued From page 12 to restrain R11 but does not state the duration. An interview held with E5; Qualified Intellectual Disability Professional (QIDP), E9; Social Worker (SW) and E1; Administrator on 01/13/15 at 1:55p confirmed that "Restraints, Manual/Physical holds are to be documented in the behavior notes for all individuals' and are to document the specific duration of the hold from start to finish and the frequency and that the facility failed to document this." Based on interview and record review, the facility failed to ensure there is a record of the restraint use for 1 resident in the sample (R3) and 1 resident outside of the sample (R11). Findings include: 1) Facility Policy on Restraint (Approved 06/02/11) includes: "IV: Documentation. Behavior Incident Reports and Progress Notes shall be developed for the individual's clinical record following the use of manual restraint for documenting. C. The outcome or result of the intervention(s) utilized. D. The date, approximate time, location and duration of the restraint." R3's 8/27/14 Behavior Interventions Program identifies Behavior Control Procedure 7. When R3 displays physical aggression towards others or if she has three instances of taunting/provoking others within a 30 minute period, Staff shall immediately verbally reprimand her in a calm but firm voice. Staff may use minimal manual prompting, or may briefly hold R3's wheelchair in place to prevent further aggression towards others."	W 303		

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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
W 303	Continued From page 13 R3's December 2014 Monthly Progress Report include summary of use of manual restraint as follows: 12/14 - 6 times 11/14 - 0 times 10/14 - 2 times 9/14 - 1 time 8/14 - 14 times 7/14 - 4 times 6/14 - 1 time 5/14 - 1 time. Review of the Behavior Notes of R3 for the month of October 2014 and interview with Social Worker E9 on 01/14/15 approximately at 3:00 PM validates that the Behavior Notes do not contain the information regarding length of time the manual restraint was applied to R3 but that information should be in the notes. Administrator E1 confirmed on 01/15/15 at 9:22 AM that E9 spoke with E1 and both agree that there should be information regarding the use of the manual restraint for R3 in the Behavior Notes. E1 validated they will need to re-train staff.	W 303		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were administered according to the physician's orders for 3 residents outside of the sample (R11,	W 368		1/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G072	A. BUILDING _____ B. WING _____	01/16/2015

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W 368	Continued From page 14 R23 and R24). Findings include: Nurses E7 and E9 administered the PolyEthylene Glycol 9 (PEG) with the Benefiber to R11, R23 and R24 on 01/13/15 from 5:25 PM through 6:15 PM. January 2015 Physician's Order Sheets for R11, R23 and R24 validated the orders for one scoop of PEG with 8 ounces of liquid and one scoop of Benefiber with 8 ounces of liquid. Both E7 and E9 placed one scoop of the PEG and the Benefiber into an 8 ounce disposable cup and poured juice into the cup. The juices poured filled the cup a little above half of the cup. Director Of Nursing E2 validated on 01/14/15 approximately at 1:00 PM that the disposable cups were 8 ounce cups. R11, R23 and R24 did not get 16 ounces of fluid with their combined PEG and Benefiber in one cup at the evening med pass on 01/13/15.	W 368		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	W 436		1/30/15

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W 436	Continued From page 15 Based on observation, record review and interview, it was determined the manual wheelchair, used for one of one resident (R1) whose electric wheelchair was being repaired, provided proper and comfortable body alignment. Findings include: According to the record, R1 is a verbal 55 year old who is dependent on her electric wheelchair (wc) for mobility and positioning. R1 operates her wc independently, and also has a manual w/c if the electric one is out of operation. R1's right hand is functional, however her left hand is not due to contractures. The Individual Service Plan specifies R1's head should be in a neutral position for adequate swallowing during meals. R1 was observed eating breakfast in her manual wc, on 1/14/15 at 7:15 AM. R1's electric wc was being repaired. R1 was leaning toward the right, with her arm extending beyond the armrest and her head leaning to the right of the head rest. That day, R1 was observed at the day training site at 11 AM. R1 was sitting in the wheelchair, still leaning towards the right, so much so neither her head nor her right arm was support by the rests. The rest of the residents were doing art projects, however R1 stated she could not participate because the movement of her right hand was restricted. At this time, R1 said her neck, head, right side and arm hurt from her position in the wheelchair. The DT staff reclined the chair backwards and R1 shifted toward a more central position. However, because the head rest was too high, it did not touch her head and neck. R1 was holding her head upright. R1 said reclining her did little to help the discomfort. R1 was observed at home, approximately 2:30 PM, with her QIDP (E6). R1 was crying, saying	W 436		

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W 436	Continued From page 16 she could not do much for herself because her position in the manual wheelchair was restricting her right hand movement. She said she was uncomfortable. E6 confirmed during this observation that R1's head is not properly supported by the head rest, she was leaning far toward the right, and her movement was restricted.	W 436		