STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G055	A. BUILDING _____ B. WING _____	C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE - ELMWOOD HEIGHTS	**2662 ELMWOOD ROAD ROCKFORD, IL 61103**

(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 INCIDENT INVESTIGATION Incident of 6/24/15	W 000		
W 245	483.440(c)(6)(iv) INDIVIDUAL PROGRAM PLAN The individual program plan must identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify a schedule for the use of each support. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the IPP (Individual Program Plan) specified a schedule for the use of a gait belt for 1 of 1 client in the sample (R1) who fell and sustained a laceration and Intracranial bleed. Findings include: On 6/24/15 the facility completed an Investigative Report that includes the following information: On 6/24/15 at approximately 12:30am R1 was found sitting on the floor outside of another peers suite (bedroom). R1 was observed with blood on the right side of his forehead with a laceration received from an apparent tripping over a protective floor mat. R1 was found in the hallway with a bleeding laceration of the forehead on the right side of his head. 911 was called and R1 was transported to a local hospital. R1 was evaluated and admitted to the hospital's ICU (Intensive Care Unit) with a primary diagnosis of "Anticoagulant Induced Blood Clotting Disorder - bleed into the brain." R1 received 7 sutures to the laceration of his	W 245		8/1/15

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

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W 245	Continued From page 1	W 245		

forehead.
The facility's investigation identified that R1 may have tripped over a floor mat that was in his peer's bedroom.

R1's hospital discharge paperwork was reviewed.
R1's discharge diagnoses included: Intracranial bleed and Warfarin induced coagulopathy.
R1's current POS (Physician's Order Sheet) noted that R1 was receiving Warfarin 4mg 1 tablet every evening per G-tube.

R1's 9/9/14 IPP (Individual Program Plan) which included R1's medical history was reviewed.
R1 was admitted to the facility on 1/18/11.
In a previous placement in 2010, R1 sustained a Subdural Hematoma and required surgery (Craniotomy and Evacuation of Hematoma).
On 2/10/11 R1 tripped and fell and received 12 sutures to a laceration to his forehead.
On 12/22/11 R1 fell in the shower and hit his head. R1 sustained a walnut sized knot to the back of his head.
On 9/22/12 R1 fell and hit the left side of his head sustaining a quarter sized red area to the left side of his forehead.

On 6/30/15 at approximately 12:40pm R1 was observed in his home with E3 (RSD - Residential Services Director). E3 stated it is presumed that R1 walked from his bedroom to one of his peer's bedrooms (approximately 50 to 60 feet), tripped on a mat in this bedroom hitting his head on the headboard of his peer's bed.

R1's most current PT (Physical Therapy) evaluation, dated 2/15/11, was reviewed. The summary of the PT evaluation notes the following:

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W 245	Continued From page 2 "(R1) is a functional individual; however his balance is unsteady which has resulted in him falling. It is recommended that he wear a gait belt and be provided with supervision when he is walking due to unsteadiness when upright. ..." R1's 9/9/14 IPP was reviewed. R1's IPP does not identify a schedule for the use of the gait belt. The IPP does not specify the type of supervision R1 needs to prevent falls and a schedule for the use of the gait belt. E3 (RSD - Residential Services Director) was interviewed on 6/30/15 at 12:52pm. E3 reviewed R1's 9/9/14 IPP and stated that R1's IPP identifies that R1 has a gait belt, however, the IPP does not identify a schedule for the use of the gait belt. E3 verified the level of supervision to be provided to R1, as recommended by PT, is not specified in the IPP.	W 245		
W 433	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure floor surfaces promote mobility affecting 1 of 1 client in the sample (R1) who sustained a laceration to the forehead and a Subarachnoid bleed after an apparent tripping over a floor mat. Findings include: On 6/24/15 the facility completed an Investigative Report that includes the following information: On 6/24/15 at approximately 12:30am R1 was	W 433		7/1/15

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W 433	Continued From page 3 found sitting on the floor outside of another peers suite (bedroom). R1 was observed with blood on the right side of his forehead with a laceration received from an apparent tripping over a protective floor mat. R1 was found in the hallway with a bleeding laceration of the forehead on the right side of his head. 911 was called and R1 was transported to a local hospital. R1 was evaluated and admitted to the hospital's ICU (Intensive Care Unit) with a primary diagnosis of "Anticoagulant Induced Blood Clotting Disorder - bleed into the brain." R1 received 7 sutures to the laceration of his forehead. The facility's investigation identified that R1 may have tripped over a floor mat that was in his peer's bedroom. R1's hospital discharge paperwork was reviewed. R1's discharge diagnoses included: Intracranial bleed and Warfarin induced coagulopathy. R1's current POS (Physician's Order Sheet) noted that R1 was receiving Warfarin 4mg 1 tablet every evening per G-tube. R1's 9/14/15 IPP (Individual Program Plan) which included R1's medical history was reviewed. R1 was admitted to the facility on 1/18/11. In a previous placement in 2010, R1 sustained a Subdural Hematoma and required surgery (Craniotomy and Evacuation of Hematoma). On 2/10/11 R1 tripped and fell and received 12 sutures to a laceration to his forehead. On 12/22/11 R1 fell in the shower and hit his head. R1 sustained a walnut sized knot to the back of his head. On 9/22/12 R1 fell and hit the left side of his head sustaining a quarter sized red area to the left side of his forehead.	W 433		

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W 433	Continued From page 4 On 6/30/15 at approximately 12:40pm R1 was observed in his home with E3 (RSD - Residential Services Director). E3 stated it is presumed that R1 walked from his bedroom to one of his peer's bedrooms (approximately 50 to 60 feet), tripped on a mat in this bedroom hitting his head on the headboard of his peer's bed. E3 stated the mat has been removed from the bedroom and thrown away. E3 stated the mat was approximately 1/2 to 3/4 of an inch thick and it was not appropriate. E3 explained that due to the thickness of the mat it would have been easy to trip on the mat.	W 433		