| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14G158 | A. BUILDING _____ B. WING _____ | 03/03/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMNESS SQUARE | 340 HERITAGE DRIVE BOURBONNAIS, IL 60914 |

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| W 000 | INITIAL COMMENTS<br><br>ANNUAL CERTIFICATION SURVEY - FUNDAMENTAL<br>ANNUAL LICENSURE<br>INPSECTION OF CARE | W 000 | | |
| W 120 | 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES<br><br>The facility must assure that outside services meet the needs of each client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review, and interview the facility failed to assure the outside day program met the needs of 2 of 2 in the sample (R1 and R2) and 3 of 3 outside the sample (R5, R6, and R7) who attended an outside day program (site A) by not providing the safeguards to prevent chemical inhalation exposure, adequate staff, and current cardiopulmonary resuscitation training for staff that work directly with the clients. This failure potentially affected all clients who attended the day program. Furthermore the facility failed to assure the outside day program at (site B) implement program objectives to teach money skills to 2 of 2 residents in the sample (R3 and R4)<br><br>Findings include:<br><br>1) Observations were made of the production area in the back of the facility located by senior classroom 5 on 3/1/16 at 11:30am. Upon entering the area there was a strong odor in the room similar to glue. The room had all doors and windows that could provide possible ventilation | W 120 | | |

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 120 | Continued From page 1<br>closed. There were several residents sitting at tables in the room. A count was 32 community residents, R7 was included in that count. The odor was coming from a room with a sign on the door that said Seniors classroom 5. The carpet had been removed and there was a yellow substance spread across the entire floor that appeared still wet. There was large objects holding the doors to the entrance of the room open.<br><br>An interview was conducted with the staff Z1, Lead Qualified Intellectual Disability Professional (QIDP), Z4 (QIDP), Z5 (QIDP), and Z6 (Direct Support Person) from 12:30pm to 1:25pm. Each staff member confirmed that they smelled the strong odor.<br>Z5 (QIDP) states, "The glue from the carpet change is strong, clients have to smell that." Z4 (QIDP) observed the classroom with the surveyor and confirmed the odor was strong and coming from the open room." Z6 states the contractor had started the work earlier in the day and put the carpet adhesive glue down, she states the doors were closed because the smell was so strong but then the contractors came back and said the glue will not dry and the doors must be left open.<br><br>The surveyor at 12:55pm requested someone from Administration to come over and assess the above finding for resolution. Z1 (Lead QIDP) came over and states, "since this is like this we are going to have to move everyone upstairs, this is a big problem."<br><br>2) Observations were made of the same production area the same day 3/1/16 at 12:50pm that a community resident was yelling, jumping up and down, pacing, clapping his hands fast, had | W 120 | | |

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| W 120 | Continued From page 2 | W 120 | | |

facial perspiration, approaching other residents, staff and surveyor at a rapid pace and in close personal range, this same resident did not accept several attempts at redirection from Z3 (DSP), Z4 (QIDP, or Z6 (DSP).
There were several community residents (32) including R7 who were seated at 7 large tables with 2 Direct Support staff in the room with them. There was a resident that was observed eating out of the garbage and was redirected by Z6. Observations were made that most of the clients were sitting unengaged.

An interview was conducted with Z4 (QIDP), Z5 (QIDP), and Z5(QIDP) on 3/1/16 at 12:45pm and all staff confirmed the detraining site did not have adequate staff for the number of residents receiving service.

An interview was conducted with Z1 (Lead QIDP) on 3/1/16 at 1:15pm, Z1 was informed of the above observations and confirmed that the production room was short staff and stated she "had a couple call offs today"

3) Observations were made of an expired cardiopulmonary resuscitation (CPR) certificate for Z5 (QIDP)'s in his office. The card expired 11/13/2013 (over 2 years ago)

Review of other staff that work directly with R1, R2 (in the sample) and R5, R6, and R7 (outside the sample) who have cardiopulmonary resuscitation completion were as follow:
Z2 (DSP) card expired 11/13/13
Z3 (DSP) card expired 11/10/15
Z4 (DSP) card expired 11/10/15
Z6 (DSP) card expired 09/08/15

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| W 120 | Continued From page 3<br>An interview was conducted with Z2 (DSP assigned to classroom 3 for seniors) on 3/1/16 at 12:50pm. Z2 states her CPR card expired in September 2015.<br><br>An interview was conducted with Z1 on 3/2/16 at 9:00am, Z1 states all staff that work directly with clients are required to have current CPR completion and that daytraining site A will be providing CPR training "today" to the staff.<br><br>4) According to the Individual Service Plan (ISP) dated 3/2015, R3 has a formal money program with both the Day Training site and the home. Data is to be collected on M-W-F.<br><br>According to R4's ISP, dated 1/13/16, she has a formal money goal with both the DT site and home. Data is to be collected on M-W-F.<br><br>DT site B was toured on 3/1/16 at 12 PM. R4's room supervisor (Z10) said that R4 does have a joint money goal, but currently it is not being run because of the amount of production work. Z9 (QIDP) stated on 3/1/16 at 12:45 PM, that R4's joint money goal is not being run because they are too busy with production work.<br><br>At 12:50 PM, R3's QIDP (Z8) was contacted by the DT Lead Program Manager (Z7). Z8 said R3's money program was not implemented in February and March because the facility did not send the "forms". | W 120 | | |

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| W 120 | Continued From page 4<br>Z7 said joint goals are not implemented as long as the residents are busy with production line work.<br><br>E3 (Facility QIDP) confirmed on 3/2/16, at 10:45 am, that both R3 and R4 have joint money goals and the DT should be implementing the programs and collecting data. | W 120 | | |
| W 255 | 483.440(f)(1)(i) PROGRAM MONITORING & CHANGE<br><br>The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, it was determined the facility failed to ensure that objectives are revised once the goal is met, for 1 of 4 residents in the sample (R3).<br><br>Findings include:<br><br>According to the Individual Service Plan(ISP), dated 3/5/15, R3's has formal goals for self medication, money, community awareness, and hygiene. R3 is ambulatory, verbal, and has an IQ of 47.<br><br>Starting in 10/2015, R3's short term goals were as follows: 1) Self medication goal was to state the time of day he takes a medication. According to the QIDP notes, he met this goal from 10/2015 through 1/2016, without revision. 2) Money goal was to add up to $4.22. According to the QIDP notes, R3 met this goal without revision from | W 255 | | |

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| W 255 | Continued From page 5<br>10/2015 through 1/2016. 3) Community goal was to name the street his guardians live on. According to the QIDP notes, this goal was met from 10/2015 through 1/2016 without revision. 4) Hygiene goal was to perform self grooming with personal products. According to the QIDP notes, this goal was met from 10/2015 through 1/2016, without revision.<br><br>E3 (QIDP) confirmed the above documentation for R3, on 3/2/16 at 11am. E3 stated the short term goals had been met and should have been revised. | W 255 | | |
| W 350 | 483.460(e)(3) DENTAL SERVICES<br><br>The facility must provide education and training in the maintenance of oral health.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, it was determined the facility failed to ensure oral hygiene training was implemented for 2 of 2 residents (R2, R3) in the sample with identified dental needs.<br><br>Findings include:<br><br>According to the record, R3 uses a walker and has a diagnosis of Cerebral Palsy. A dental note, dated 7/27/15, states "Very heavy plaque/tartar. Advanced Periodontal Disease. Maintain hygiene schedule." Another dental note, dated 2/15/16, states R3 is scheduled for tooth extractions.<br>R3's Individual Service Plan (ISP), dated 3/5/15, includes a body hygiene program, but lacks a program for oral hygiene. | W 350 | | |

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| W 350 | Continued From page 6<br>According to the record, R4 has a history of Periodontitis. A dental note, dated 7/27/15, states, "Very heavy tartar... Maintain hygiene schedule." A second dental note, dated 8/20/15, documents that R4 had two dental extractions. A third dental note, dated 2/5/16, states, "Soft tissues are inflamed because of heavy plaque, tartar and food particles adhering to teeth." R4's ISP, dated 1/13/16, lacks an oral hygiene program.<br><br>R3's and R4's documentation was confirmed by E3 (QIDP), on 3/2/16 at 10:45 am. E3 stated both R3 and R4 should be on a formal oral hygiene program. | W 350 | | |
| W 369 | 483.460(k)(2) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview it was determined, for 1 of 2 residents observed during the medication pass (R1), that the facility failed to ensure the blood pressure was checked according to physician orders, before giving an antihypertensive medication.<br><br>Findings include:<br><br>The 4 PM medication pass, conducted by E6 (DSP), on 3/1/16, was observed. R1 has diagnoses of Hypertension and Atrial Fibrillation. According to the physician order sheet dated 2/2016, and the Mediation Administration Record dated 3/2016, R1 is to receive her | W 369 | | |

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| W 369 | Continued From page 7<br>antihypertensive medication only if her blood pressure (b/p) is over 95/65. The medication and b/p check is scheduled at 5 PM.<br>E6 gave R1 her antihypertensive medication, and then conducted the b/p check.<br><br>E4 (RN Trainer) stated on 3/2/16, at 10:40 am, that the b/p should have been checked before administering the medication. | W 369 | | |