STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	10/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	2150 EAST MCCORD, PO BOX 568 CENTRALIA, IL 62801

(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 Certification Survey Annual Licensure Survey Inspection of Care Survey	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure a thorough investigation was completed for 1 of 1 (R22) individual outside of the sample who is to have nothing by mouth. Findings Include: Review of the resident roster dated 09/06/16 documents R22 is a 66 year old male who functions at a Moderate Level of Intellectual Disability. Review of the facility General Event Report dated 08/06/16 documents at "1230 DSP (Direct Support Person) reported smelling menthol smell in room while sitting 1:1, spit cough drop out of mouth. Told the nurse that he got it out of transport van. Lungs are clear. No cough or congestion. Will monitor for s/s (signs/symptoms) of aspiration...cough drop in mouth of NPO (nothing by mouth) client...Upon return from a community outing, staff discovered client to have a cough drop in his mouth. Client stated he got it out of the console in the van while on the outing. No injury or adverse effects noted; will continue to	W 154		

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

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W 154	Continued From page 1 monitor." The General Event Report dated 08/06/16 continues to document under investigation details, "Team discussed resident will continue 1:1 status. Resident recently admitted. When asked to spit cough drop out resident complied with request. Vitals completed, resident monitored for any signs or symptoms of aspiration." Review of R22's Speech Language Pathology Services dated 7/23/16 documents, "These are the recommendations taken from the Modified Barium Swallow study on 7/22/16. Recommended Consistency: Mechanical Soft foods with thin liquids by teaspoon." During interview on 10/12/16 at 11:10 AM E1 (Administrator) stated there was no investigation completed by the facility related to the incident of R22 obtaining cough drops while on the van. The facility failed to investigate the incident dated 8/6/16 where R22, who is documented on the General Event Report to be 1:1 level of supervision and not to have anything by mouth, was able to obtain a cough drop while on the van and had the cough drop in his mouth.	W 154		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by:	W 189		

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W 189	Continued From page 2 Based on interview and record review the facility failed to train staff after a pattern of injuries related to hoyer lift transfers occurred. This affected 5 of 5 (R16-R18, R20, and R21) individuals outside of the sample. Findings Include: 1) Review of the facility resident roster dated 09/06/16 documents R16 is a 67 year old male who functions at a Mild Level of Intellectual Disability. Review of the facility General Event Report dated 07/09/16 documents. "(name of staff) reported an area posterior LT (left) knee. Has a intact blister with a red mark also noted posterior RT (right) knee small scab. No s/s (signs/symptoms) of infection or drainage noted. Actions taken or Planned: Red are to RT knee/blister most likely caused from direct pressure from sitting on Hoyer sling or from being re-positioned in wheel chair using the Hoyer sling." 2) Review of the facility resident roster dated 09/06/16 documents R17 is a 63 year old male who functions at a Profound Level of Intellectual Disability. Review of the facility General Event Report dated 07/13/16 documents, "staff reported scratch to right arm, nurse assess and noted 13 cm (centimeter) scratch to right forearm...Action Taken or Planned: Discovered long scratch, nearly the entire length of client's forearm. Possibly from hoyer sling strap rubbing against skin during sling removal." 3) Review of the facility resident roster dated	W 189		

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W 189	Continued From page 3 09/06/16 documents R18 is a 70 year old male who functions at a Profound Level of Intellectual Disability. Review of the facility General Event Report dated 09/25/16 documents, "Supervisor notified this nurse of a red line to right side of neck that hasn't faded at all. Possibly from sling when transferring client...Actions taken or planned: The are (sic) was discovered by staff providing care. Area appears to be from a hoyer sling not being positioned correctly supporting the clients head." 4) Review of the facility resident roster dated 09/06/16 documents R20 is a 44 year old female who functions at a Profound Level of Intellectual Disability. Review of the facility General Event Report dated 07/25/16 documents for R20 "The area was discovered by staff providing care. Area appears to be from hoyer sling being drug across her skin." Review of the facility General Event Report dated 09/13/16 documents, "DSP (Direct Support Person) reported a mark on the clients knee. Upon assessment this nurse noted a scrape on the left knee. It was in a waffle pattern. No treatment needed...Actions Taken or Planned: At 2:00 AM (name of nurse) reported to me that R20 had a mark on left knee. When I went to look at it, It was a waffle like shape and felt like it too. Looks like it was from hoyer sling." 5) Review of the facility resident roster dated 09/06/16 documents R21 is a 63 year old female who functions at a Profound Level of Intellectual Disability.	W 189		

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W 189	Continued From page 4 Review of the facility General Event Report dated 8/20/16 documents, "DSP reported that while providing hs (hour of sleep) care she noticed a 4.0 cm (centimeter) x 1.5 cm x 0.1 cm red area to underside of left forearm...Actions Taken or Planned: (name of staff) reported red area to underside of left forearm. Area is dry with no scabbing or edema noted. Appears to have been rubbed on something perhaps the strap of the hoyer sling. There is a small amount of skin tear and blood drawn to the surface but not through the skin...reminding all staff to ensure hoyer straps are down in chairs and not up where clients could rub their extremities on." Review of the July, August, and September Quality Assurance Committee Meeting notes did not document information related to the incidents related to a hoyer lift. Review of facility hoyer lift transfer in-services documents an in-service dated 6/13/16 related to lower extremity precautions during bed positioning and transferring. During interview on 10/11/16 at 12:10 PM E3 (Social Worker) stated the facility had not completed staff training for transfers with a lift since 06/13/16.	W 189		
W 298	483.450(d)(2)(i) PHYSICAL RESTRAINTS Authorizations to use or extend restraints as an emergency measure must be in effect no longer than 12 consecutive hours. This STANDARD is not met as evidenced by:	W 298		

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W 298	Continued From page 5 Based on interview and record review, the facility failed to ensure that their policy and procedures governing the use of physical restraints identifies the persons allowed to authorize the emergency use of restraints, extend the use of the restraint and the training that is required for those persons who may authorize the use of restraints for 7 of 7 individuals (R1, R10, R11, R12, R13, R14 and R15) who presently have restraint usage incorporated within their behavior plan(s). Findings include: Per review of the undated list submitted by the facility for the seven individuals presently having restraint usage as part of their behavior plans the following was noted: R12 - physical hold R13 - includes being placed on a mat R11 - includes physical hold R14 - includes being taken out of w/c (wheelchair) and placed on a mat R1 - includes a physical hold R15 - wrist restraints and bilateral mitts The facility's policy and procedures entitled Non-emergency use of Physical Restraints dated 08/26/2014 states. "Policy... Physical restraints will be used only as an integral part of the individual's program plan in an effort to manage and eliminate the behavior for which they are utilized... The devices must be an approved device or procedure listed on the facility's hierarchy of approved interventions... Procedures... 2. No restraint shall be used longer than a two	W 298		

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W 298	Continued From page 6 hour period without a minimum 10 minute release... nursing personnel shall be responsible to determine if the individual is de-escalating as a result of the intervention, or if the individual should be sent to the ER (emergency Room) for evaluation as a result of severe aggression or self injury in excess of one hour... 3. *Before initiating a restraint procedure, staff must insepct the environment and the individual and remove any objects that might present a hazard to the individual's safety. *The room must have enough space so that the person can lie down comfortably... 4. An opportunity for motion and exercise ... will be provided for a period of not less than 10 minutes during each two hour period in which restraints are used... Further review of the facility's policy and procedures for restraint usage states that individual in restraints,"... must be monitored every 30 minutes by staff trained in the use of mechanical restraints and that, "Physical restraints will not be applied if the individual does not display the targeted inappropriate behavior". The facility's current policy and procedures for physical restraints does not identify the persons who are allowed to authorize the use of restraints, extend the use of the restraints and/or the training that is required for persons who may authorized the use of the restraints as required. E1 (Administrator) was interviewed on 09/12/16 at 11:00 A.M. and stated that she has a list of persons who are allowed to authorize the use of physical restraints. E1 confirmed that the current	W 298		

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W 298	Continued From page 7 restraint policy does not identify the persons allowed to authorize the use of restraints, to extend the use of the restraint(s) and/or the training that is required for persons who authorize the use of the restraint(s) as applicable for R1, R10, R11, R12, R13, R14 and R15.	W 298		
W 299	483.450(d)(2)(ii) PHYSICAL RESTRAINTS Authorizations to use or extend restraints as an emergency measure must be obtained as soon as the client is restrained or stable. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's policy and procedures governing the use of physical restraints does not identify who staff are to contact to obtain authorization for the use of a physical restraint for 7 of 7 individuals (R1, R10, R11, R12, R13, R14 and R15) who presently have restraint usage incorporated within their behavior plan(s). Findings include: Per review of the undated list submitted by the facility for the seven individuals presently having restraint usage as part of their behavior plans, the following was noted: R12 - physical hold R13 - includes being placed on a mat R11 - includes physical hold R14 - includes being taken out of w/c (wheelchair) and placed on a mat R1 - includes a physical hold R15 - includes being placed on a mat R10 - wrist restraints and bilateral mitts	W 299		

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W 299	Continued From page 8 Record reviews for R12, R13, R11, R14, R1, R15 and R10 from 07/01/2014 to present does not identify that the physician or any other person was contacted by staff of the facility to obtain authorization for a specific physical restraint as identified in the individual's behavior plan. No authorizations were noted for physical restraints for behavior episodes for any of the seven individuals as required. The facility's policy and procedures entitled Non-emergency use of Physical Restraints dated 08/26/2014 states. "Procedures... 3. *Before initiating a restraint procedure, staff must insepct the environment and the individual and remove any objects that might present a hazard to the individual's safety. *The room must have enough space so that the person can lie down comfortably...". There are no procedures within this policy identifying who staff are to contact to obtain authorization for the use of a physical restraint for R1, R10, R11, R12, R13, R14 and/or R15 during behavioral episodes for these individuals with restraint usage identified within their behavior programs. Confirmed during interview with E1 (Administrator) on 09/12/16 at 11:00 A.M. that there are no procedures within the facility's restraint policy identifying who staff are to contact to obtain authorization for the use of physical restraints during behavioral episodes for these seven individuals.	W 299		
W 300	483.450(d)(3) PHYSICAL RESTRAINTS	W 300		

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W 300	Continued From page 9 The facility must not issue orders for restraint on a standing or as needed basis. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that their policy and procedures for physical restraints ensures that restraints are not applied on a standing or as needed basis without authorization affecting 7 of 7 individuals (R1, R10, R11, R12, R13, R14 and R15) who presently have restraint usage incorporated within their behavior plan(s) and the facility has failed to include procedures within their Non-emergency use of Physical Restraints policy identifying that each physical restraint must be ordered and/or authorized: a) on a case by case basis with individual assessment of the situation and be based on the behavior of the individual; and b) that documenation include the rationale for the use of the physical restraint Findings include: Per review of the undated list submitted by the facility of the seven individuals who presently have restraint usage as part of their behavior plans, the following was noted: R12 - physical hold R13 - includes being placed on a mat R11 - includes physical hold R14 - includes being taken out of w/c (wheelchair) and placed on a mat R1 - includes a physical hold R15 - includes being placed on a mat R10 - wrist restraints and bilateral mitts Record reviews for R12, R13, R11, R14, R1, R15	W 300		

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W 300	Continued From page 10	W 300		

and R10 from 07/01/2014 to present (for the documented behavioral incidents requiring physical restraints) does not identify that the physician or another authorized person was contacted by the facility to obtain authorization for the physical restraint as based on the behavior. There was no documention noted identifying that once authorizations were obtained, the rationale for the use of the physical restraint was documented as appropriate.

The facility's policy and procedures entitled Non-emergency use of Physical Restraints dated 08/26/2014 states. "Procedures... 3. *Before initiating a restraint procedure, staff must insepct the environment and the individual and remove any objects that might present a hazard to the individual's safety.
*The room must have enough space so that the person can lie down comfortably...".

There are no procedures contained within this policy identifying who staff are to contact to obtain authorization for the use of a physical restraint if needed for R1, R10, R11, R12, R13, R14 and/or R15 duringspecific behavioral episodes. There are no procedures contained within this policy identifying that each physical restraint should be ordered on a case by case basis with authorization for the restraint based upon the individual's behavior as per their behavior program. Additionally, the facility's policy does notinclude procedures identifying that once authorization is obtained, this authorization should include the rationale for the use of the physical restraint versus other less restrictive measures as required.

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W 300	Continued From page 11 Confirmed during interview with E1 (Administrator) on 09/12/16 at 11:00 A.M. that the facility's policy and procedures for Non-emergency use of Physical Restraints does not ensure that restraints are issued and applied on a standing or as needed basis without authorization affecting 7 of 7 individuals (R1, R10, R11, R12, R13, R14 and R15) who presently have restraint usage incorporated within their behavior plan(s) re are no procedures within the facility's restraint policy identifying who staff are to contact to obtain authorization for the use of physical restraints during behavioral episodes for these seven individuals.	W 300		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to ensure that their policy and procedures addresses the number of times medications can be used on an emergency basis for 2 of 2 individuals of the facility presently receiving as needed medications for behaviors (R11 and R12). Findings include: 1) Per review of R12's behavior program for aggression/self injurious behaviors with an initiation date of 02/29/16, R12 is presently	W 312		

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W 312	Continued From page 12	W 312		

receiving Geodon, Ativan, Depakote and Paxil for these behaviors in addition to the as needed medications. This program states that if R12's behavior continues beyond 15 minutes, staff will contact the nurse to consult with the physician for possible medical intervention.

In reviewing R12's nursing note (T-log) dated 07/08/16, documentation states, " Late entry - 725 pm client cont. (continues) with SIB (self injurious behaviors). Hitting self in head, slamming head against padded rails by bedside... new orders received for Haldol 5 mg/1 ml (milligrams/milliliter) IM (intramuscular) now..." Per review of the facility's T-logs and per information submitted by E3 (Social Worker) since 07/07/16, R12 has received nine as needed injections on 07/12, 07/27, 08/14, 09/11, 09/20, 09/25, 09/30, 10/04 and 10/08/16.

2) E3 was interviewed on on 10/11/16 at 2:32 P.M. and stated that R11 has received as needed emergency medications due to his behavior. E3 submitted documentation stating that R11 has received five injections of as needed medications (medication name not specified) from 07/02 - 09/11/16.

Review of R11's behavior plan for abusive aggressive behaviors with an initiation date of 08/18/16 does not identify methods for as needed emergency medications for behaviors even though he has received as needed medication for behaviors five times in a two month period.

During continued interview with E3 on 10/11/16, E3 was asked about the facility's policy for emergency medication usage on an as needed basis. E3 stated that she would have to check

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W 312	Continued From page 13 but upon return, she stated that she could not find a policy which identifies the number of times an as needed medication could be used as an emergency measure. E3 then presented the surveyors with a policy entitled, Medication Usage and Client behavior. The facility's undated policy and procedures for Medication Usage and Client behavior does not identify the maximum number of times a medication can be used as an emergency prior to being incorporated into the individual's program plan as required. E1 (Administrator) was interviewed on 09/12/16 at 11:00 A.M. and confirmed that the facility does not have a current policy which identifies the number of times a medication can be used as an emergency measure prior to incorporating the medication into his individual plan.	W 312		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to develop and implement policy and procedures regarding colorectal cancer screenings for men and women of the facility 50 years of age or older as per CDC (Center for Disease Control and Prevention) recommendations set forth by the U.S. Preventative Services Task Force recommendations for colorectal cancer screenings for 2 of 4 individuals in the sample 50	W 322		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	2150 EAST MCCORD, PO BOX 568 CENTRALIA, IL 62801

(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 322	Continued From page 14 years of age or older (R3 and R6). Findings include: The CDC.gov. web site regarding Colorectal (Colon) Cancer states, "... Colorectal cancer affects men and women of all racial and ethnic groups, and is most often found in people aged 50 years or older... Colorectal cancer screening saves lives. Screening can find precancerous polyps-abnormal growths in the colon or rectum-so that they can be removed before turning into cancer. Screening also helps find colorectal cancer at an early stage, when treatment often leads to a cure...". "The U.S. Preventative Services Task Force recommends colorectal cancer screening for men and women ages 50 -75 using high sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or a colonoscopy". Review of the facility's Roster dated 09/06/16, R3 is 57 years of age and R6 is 62 years of age and per the U.S. Preventative Services Task Force recommendations colorectal cancer screenings would be recommended as based on their age. Review of the Physician's Orders dated October 2016 for R3 and R6, no orders were noted for a colonoscopy, sigmoidoscopy or for fecal occult blood testing. E2 (DON - Director of Nursing) was interviewed on 10/12/16 at 2:00 P.M. and confirmed that the facility did not have any colorectal cancer screenings on file for R3 nor R6. E2 stated, "We usually wait for the doctor to order the	W 322		

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W 322	Continued From page 15 procedure". When E2 was asked if the facility had policy and procedures regarding colorectal cancer screenings she stated, "No".	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure nursing services were provided for 1 of 1 (R23) individual outside the sample who had an incident of possible ingestion of non-food items. Findings Include: Review of the facility resident roster dated 09/06/16 documents R23 is a 59 year old female who functions at a Severe Level of Intellectual Disability. Review of the facility General Event Report dated 07/28/16 documents, "client (R23) in main area on 300 hall. When client grabbed peers light bright pieces and placed in mouth. Two pieces of light bright removed from tongue and lips. One piece removed from lap...Actions taken or planned: Client in area on 300 hall. When client grabbed peers light bright pieces and placed in mouth. Two pieces of light bright removed from tongue and lips. One piece removed from lap. Did not see any signs of client swallowing any of the pieces however staff are unaware of how many pieces where (sic) in the container to begin with so we can not be certain. Protocol followed."	W 331		

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W 331	Continued From page 16 The General Event Report continues to document under Investigation Details: could be perceived as food items. The team discussed the pieces of light bright were kept in a blue medication cup and the incident occurred during snack time. The team agreed R23 likely thought the medication cup was her drink and/or snack. The team discussed R23 will not be placed on PICA (ingestion of non-food items) precautions. The team discussed the precautions will only be arms length from any items that could look or be perceived as food items and a lidded trash can." Review of R23's T-log (Nurses Notes) dated 7/29/16; "05:48 AM No ill effects noted from previous events. PICA protocol continues. 2030-While in common area client reached out and grabbed peers lite bright pieces placing them in mouth. Two pieces removed from tongue and mouth area and another piece from lap. Supervisor notified of event. PICA protocol initiated. 2150- Call placed to (name of physician) update given stated to follow facility protocol. 2200- Message left with OSG (office of state guardian)...for...state guardian. Monitoring continues with no changes noted." Review of the facility PICA incident and/or suspected PICA incident (not dated) documents; "1. Ensure all items are removed from the resident that they have ingested or possible ingested. 2. Notify the physician immediately, ADON (assistant director of nurses), or DON (director of	W 331		

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W 331	Continued From page 17	W 331		

nurses) with any actual or suspected PICA incidents. Describe the item to the physician to determine if we need to monitor feces. If physician asks that output be monitored; notify the Floor Supervisor to begin the process of checking feces for the ingested item; until further instructions from the nursing staff.

3. Assess resident for signs and symptoms of respiratory or GI (Gastrointestinal) distress which would include but are not limited to:

A) obvious change in resident behavior
B) changes in residents color
C) abnormal vital signs
D) abnormal lung sounds
E) abnormal SpO2
F) nausea and/or vomiting
G) change or absence of bowel sounds

4. GER (General Event Report)

5. Assessments must be done on the following schedule after an actual or suspected pica incident.

A) Blood pressure, pulse, respiration, temperature, SpO2 and lung sounds every 15 minutes for the first hour.
B) Blood pressure, pulse, respiration, temperature, SpO2 and lung sounds every 30 minutes for the next 2 hours.
C) Blood pressure, pulse, respiration, temperature, SpO2 and lung sounds every 4 hours for the next 24 hours.
D) bowel sounds initially after incident, after one hour, and then every 4 hours for 24 hours.

6. Resident must remain home from workshop to

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W 331	Continued From page 18 be monitored for 24 hours following suspected or actual pica incident as indicated. 7. Notify physician with any abnormal findings during assessment period that is outside the residents normal baseline. 8. Document all assessments in the pica monitoring program in (name of computer program)." Review of the PICA monitoring program for R23 did not document lung/bowel assessments. Review of R23's T-logs (nurses notes) did not document lung/bowel assessments. During interview on 10/11/16 at 2:20 PM E2 (Director of Nurses) stated, "It does not appear that the nurses followed the PICA policy. I can only find lung/bowel assessments four times in the 24 hour period after the incident."	W 331		