STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G368	A. BUILDING ____ B. WING ____	03/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN OF OLD TOWN WEST	118 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108

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W 445	Continued From page 48 E2 (Executive Director) was interviewed 3/21/06 at 3:15pm. E2 stated the facility only conducted 1 complete evacuation in the past year. E2 verified the evacuation drill was held on 4/19/05. E2 verified there were no evacuation drills for 2nd and 3rd shifts.	W 445		
W 447	483.470(i)(2)(iii) EVACUATION DRILLS The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that evacuation drills identified any and all clients that participated in the actual drill. Findings include: The facility's evacuation drills dated 2/22/05 thru 2/22/06 were reviewed. There were a total of 16 drills conducted. Of the 16 drills, 9 failed to identify what clients if any participated in the drill. E2 (Executive Director) was interviewed 3/21/06 at 3:15pm. E2 stated the previous maintenance man wrote the clients names on the evacuation drills. E2 also stated the current maintenance man , E5, does not write the names of the clients on the evacuation drills. E5 was interviewed 3/21/06 at 3:35pm. E5 was	W 447		4/30/06

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W 447	Continued From page 49 asked if he remembered what clients participated in specific evacuation drills. E5 stated he could not remember which clients participated in any specific drill.	W 447		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350..620a) 350.700a)1) 350.700a)2) 350.1060a)h)j) 350.3240a)b)c)d)e) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification	W9999		

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shall be made by a phone call to the Department's toll-free complaint registry number.
2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence.

Section 350.1060 Training and Habilitation Services
a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.
h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.
j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record.

Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to

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the resident's representative. (Section 3-610 of the Act)
d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)
e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These regulations were not ment as evidenced by the following:

Based on interview and record review the facility failed to ensure that 1 of 1 clients (R1) was not subjected to psychological abuse and punishment by staff on 2 occasions (2/22/06 and 12/29/05).

1) R1 is a 35 year old female whose diagnoses include Mild MR, Congenital Adrenal Hyperplasia, Spina Bifida, Cerebral Palsy, Depression and Dysthymic Disorder. R1, observed 3/21/06 and 3/23/06, is verbal and able to communicate her needs. R1 is non-ambulatory but mobile via electric wheelchair.

On 3/23/06 at 7:50am during an interview, R1 told the surveyor she wanted to talk about an incident that occurred a few weeks ago. R1 explained that (a few weeks ago) a staff (E4 -

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direct care) told her to crawl to the bathroom/ shower after she was incontinent of BM (bowel movement). R1 stated she scraped her breast and got bruises on her chest from crawling to the shower room. R1 stated that E3 (Facility Manager) was aware of the Incident the next day.

R1 was again interviewed 3/23/06 at 3:52pm regarding the allegation that E4 made her crawl to the shower room after being incontinent of bowel. R1 was asked if she remembered the day or date of the incident. R1 said she could not remember the date but it was after dinner (2nd shift). R1 explained that after dinner she went to the bathroom but had an accident before she could get to the toilet. R1 stated she called E4's name for assistance but E8 (direct care staff) started to assist her because E4 was busy. R1 said then E4 came and told E8, "I got it." E4 then told R1 to get down on the floor and crawl to the shower room. R1 said she told E4 she could not crawl because her leg was swelling. R1 stated E 4 insisted she crawl and R1 repeated to E4, "I can not crawl." R1 explained because she could not crawl she scooted on her chest/breast. R1 stated she did not have pants, a shirt or bra on when she scooted naked on her chest. R1 stated E4 did put a bath blanket over her. R1 stated after she was in the shower room E4 had her lay naked on the floor. E4 then showered her on the "dirty floor." R1 stated she was upset that E4 made her crawl from the bathroom to the shower room (approximately 15 feet a common use area - hallway between bedrooms) naked and then showered her on the "dirty floor."

R1's record was reviewed and the following was documented in R1's nurses notes:

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"2/22/06 1800 Hab staff reported multiple bruises to breast of resident. Resident stated no one has abused her and that the only way she possibly got the bruise was way she crawled on the floor. I've seen her crawl in her way of independent ambulation is similar to military combat control."

On 3/23/06 R1 was asked why she told the nurse she was not abused (when told to crawl naked approximately 15 feet after a BM accident). R1 stated because she was not hit - it was not abuse .

On 3/23/06 at 9:45am E3 (Facility Manager) was interviewed regarding R1's explanation of her bruises, per nursing documentation of 2/22/06. E 3 stated that on 2/23/06, in the morning, E11 (nurse) told her that R1 had multiple bruises on her breast and upper chest. E3 stated she observed R1 the afternoon of 2/23/06 and multiple bruises were observed on her breast. E 3 stated she questioned R1 regarding how she sustained bruises. R1 told E3 that the bruises were from crawling from the bathroom to the shower room. R1 told E3 that E4 made her crawl from the bathroom to the shower room (approximately 15 feet in a common use area) after she had an accident. E3 stated she questioned E4 as to why she had R1 crawl on the floor. E4 told E3 the reason she had R1 crawl was because she was fostering independence. E3 stated she again asked E4 why she did not assist R1 as opposed to having her crawl approximately 15 feet naked in a common use area. E3 stated E4 just kept saying that R1 had BM all over her. E3 was asked if it was appropriate for R1 to crawl naked, after being incontinent of BM, approximately 15 feet in a

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common use area. E3 was also asked if E4 was fostering R1's independence. E3 stated she thought it was neglect.

E4 was interviewed 3/23/06 at 3:30pm. E4 verified that in February (date unknown), after dinner R1 was in the bathroom when she called out for E4. E4 went to the bathroom and R1 was incontinent of BM. E4 stated the BM was all over R1, the floor and the toilet bowl. E4 stated she asked R1 to crawl to the shower room. E4 explained R1 was dressed (pants and shirt on), and she covered her with a bath blanket as she crawled to the shower room. E4 stated she did shower R1 on the floor, R1 was on a bath blanket on the floor.

E3 provided to surveyors a Disciplinary Memorandum regarding E4, the Memorandum notes the following:
"(E4) instructed (R1) to crawl from the bathroom to the shower room. Resident crawl to the shower room nude with a towel draped over her back. (E4) then showered her on the floor. (E4) will be inserviced on proper residents care."

On 3/21/06 at 11:30am, E2, Executive Director stated to the surveyors, "Couple of weeks ago, R 1 had bruises on both breast. R1 told the nurse she got it from crawling on the floor." E2 stated that E14 reported it to her on 2/22/06 during the pm shift. E2 was then asked when E1, Administrator was notified of the incident. E2 stated she notified E1 of the incident the following morning (3/23/06).

This incident was not reported to IDPH.

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2) On 3/23/06 at approximately 11:30am E3 (Facility Manager) notified surveyors of a 2nd incident of psychological abuse and punishment. E3 stated on 12/29/05 2 staff, E12 (former direct care) and E4 (direct care) refused to assist R1 with toileting. Disciplinary Memorandum's for E 12 and E4 were provided to surveyor. E12's Memorandum notes: "(E12) told (R1) to wait until she was finished with her break before she could help her with toileting. (R1) asked her after asking another staff that refused ... " E12 documented (on the Memorandum) she was eating and told R1 to ask the staff that is assigned to her (E4) to assist her with toileting. The other staff refused, so E12 "finished eating" then assisted R1.

E4's Memorandum notes that E4 was asked by R 1 to assist her with toileting. E4 told R1 to wait for her assigned staff (E12) who was on break at the time.

E12's and E4's Disciplinary Memorandum's are both dated 1/9/06 by E3 (11 days after the Incident occurred).

There is no documentation as to how long R1 had to sit on the toilet before E12 ultimately provided assistance to R1.

This incident was not reported to Illinois Department of Public Health.

E13, Former Administrator signed the Disciplinary Memorandum on 1/5/06. No other documentation can be found to show that E13 was notified prior to 1/5/06.