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W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.680e) 350.3240a) Section 350.680 Developmental Disabilities Aides e) During inspections of the facility, the Department may require developmental disabilities aides to demonstrate competency in the principles, techniques, and procedures covered by the developmental disabilities aide training program curriculum described in the rules governing training programs for developmental disabilities aides (see 77 Ill. Adm. Code 395.310), when possible problems in the care provided by developmental disabilities aides or other evidences of inadequate training are observed. Failure to demonstrate competency of the principles, techniques and procedures shall result in the provision of in-service training to the individual by the facility. The in-service training shall address the developmental disabilities aide training principles and techniques relative to the procedures in which the developmental disabilities aides are found to be deficient during inspection (see 77 Ill. Adm. Code 395). 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) These REGULATIONS are not met as evidenced by:	W9999		

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W9999	Continued From page 46 Based on observation, interview and record review, the facility failed to implement their own policies and procedures to prevent neglect when: 1) the facility failed to implement their "FALL RISK POLICY/PROTOCOL", after R3 was identified as being at high risk for falls from her 10/04/2005 fall risk assessment. 2) - the facility failed to implement their "ABUSE AND NEGLECT POLICY FOR DETECTION AND PREVENTION" when they failed to (a) analyze trends and patterns relative to R3's falls/seizures/ injuries; b) further investigate R3's three falls/ injuries on 11/18/05, relative to staffing patterns and/or the need for staff training (R3). Findings include: 1. Per review of R3's current physician's orders, R3 (admitted to this facility on 08/28/89), has the following medical diagnoses: Epilepsy, Sleep Disturbance, History of Depression, Chronic Sinusitis, Attention Deficit Disorder without Hyperactivity, and is at a high risk for falls. A nursing note dated 2/4/04 states that R3 also has double vision on her (R) {right} peripheral field, which is uncorrectable. R3's current IPP (Individual Program Plan) of 06/21/2005, documents that R3's Seizure Disorder consists of grand mal and petite mal seizures and that the seizures are not controlled. (R3's intelligence quotient of 54 places her in the moderate range of mental retardation, but her ICAP {Inventory Client Agency Planning} gives her an adaptive score of 5 years/2 months which, given her uncontrolled seizures, places her in the severe range of mental retardation). R3's IPP also	W9999		

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W9999	Continued From page 47 documents that R3 has a guardian. Current physician's orders for R3 document that R3 receives the following medications to assist in seizure control: Topamax 100 mg (milligram) tablet, I tablet by mouth at hs (night) with 200 mg dose to equal 300 mg; Depakote ER 500 mg tablet, 3 tablets (1500 mg) by mouth twice daily; Lamictal 100 mg tablet, 1 tablet by mouth twice daily; Lyrica 200 mg capsule, I capsule by mouth twice daily; Topamax 200 mg tablet, I tablet by mouth twice daily; and, Gabitril 4 mg tablet, I tablet by mouth three times daily. R3 also has an order for Lorazepam 2 mg tablet, I tablet by mouth every 12 hours as needed for more than 10 seizures per day. R3's IPP also documents that R3 has a VNS (Vagus Nerve Stimulator) to assist with seizure control. In interviews with E1 (Residential Services Supervisor/Qualified Mental Retardation Professional - RSD/QMRP) and E2 (Supervisor) on 2/9/06 at the facility in the a.m., E1 and E2 were not sure when R3 received the VNS. There is, however, in R3's file, a fax dated 12/6/2000 from her neurology clinic that provides instruction in the use of the VNS, indicating that the VNS was placed around this date. This was confirmed per E1 and E2 in the same interview. R3's IPP also documents the use of a seizure helmet for R3. E1 and E2 stated, on 2/9/06, at the facility that R3's helmet was ordered sometime after an IDT (Interdisciplinary Team Meeting) held in 2/2004. In observations made at the facility from 2/7/06 through 2/10/06, R3 was observed to be ambulatory and verbal.	W9999		

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A review of "Nursing Consult Synopsis" notes, facility incident reports, day training incident reports and seizure charts for R3 summarize the following seizures, falls and injuries:

01/2005 - 7 separate dates recorded for seizures - some dates recording multiple times per day -

FALLS AT FACILITY - 3
INJURIES FROM FALLS - 1 - fell in kitchen and knocked arm and head

HIT HEAD AT FACILITY - 1

02/2005 - 12 separate dates recorded for seizures - some dates recording multiple times per day

FALLS AT FACILITY OR ON VAN - 12 - on outing, porch to ground, one fall between wheelchair and wall - hanging limp, one from dining chair, two drops to floor - one wall to floor and one from sitting position to couch. One fall from couch - caught by staff.

INJURIES FROM FALLS - 2 bumped leg on van,bleeding from scratch type wound on back of head

HIT HEAD AT FACILITY - 2

03/2005 - 3 separate dates recorded
FALLS AT FACILITY - 1

04/2005 - 9 separate dates - some dates recording multiple times per day

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W9999	Continued From page 49 FALLS AT FACILITY - 5 FALLS AT DAY TRAINING SITE - 3 HIT HEAD AT FACILITY - 1 - fell in hall 05/2005 - 4 separate dates recorded FALLS AT FACILITY - 1 INJURIES AT FACILITY - 1 - skinned face/ bruised/ice to face 06/2005 - 19 separate dates recorded - some dates recording multiple times per day FALLS AT FACILITY OR FACILITY OUTING - 16 INJURIES AT FACILITY OR FACILITY OUTING - 5 Fell while on front porch, hit back of head, quarter size scratch, cut lip, laceration to back of head, approximately 1 inch, 2 sutures at emergency room. Fell to knees on porch, bumped right side of head midway back, nose bleed. HIT HEAD AT FACILITY - 5 07/2005 - 19 separate dates, some dates recording multiple times per day. FALLS AT FACILITY - 15 08/2005 - 18 separate dates - some dates recording multiple times per day FALLS AT FACILITY - 13 FALLS AT DAY TRAINING SITE - 1 INJURIES AT FACILITY - 4 - fell outside scraping both arms and right hand, fell in hallway on face, fell in kitchen to floor - hit head, fell on sidewalk -	W9999		

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W9999	Continued From page 50 left swollen ankle, and bruised left hand, resulting in pain - elevate and ice ankle - x-ray to rule out fracture. HIT HEAD - 2 09/2005 - 10 separate dates - some dates recording multiple times per day. FALLS AT FACILITY - 6 FALLS ON HOME VISIT - 1(hit left eye on picnic table - left black eye INJURIES AT FACILITY - 2 Fell and hit upper and lower side of mouth on cabinet - tooth cut through lower lip - to emergency room - 10 sutures. Drop seizure hitting left eye - bruise already present from home visit fall. Fell in pantry hitting head on trash can. HIT HEAD - 2 10/2005 - 9 separate dates - some dates recording multiple times per day. FALLS AT FACILITY - 7 INJURIES AT FACILITY - 1 (fell to floor while dressing - hit head on night stand. HIT HEAD - 1 11/2005 - 4 separate dates FELL AT DAY TRAINING WITH INJURIES - 2 - fell out of chair to floor - complained of right knee - given a chair with arms. Fell - to emergency room after complaining of pain to arm and head. Fell with the chair she was sitting in - right thigh bruise.	W9999		

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FELL AT FACILITY - 3
INJURIES AT FACILITY - (3 FALLS IN ONE P.M .) Fell and hit left shoulder in bathroom. Fell and hit left eye. Fell an hit right wrist - resulting in 3rd metacarpal fracture - requiring surgery and therapy.

12/2005 - 4 separate dates
FALLS AT DAY TRAINING - 1
FALLS AT FACILITY - 1

01/2//6 - 5 separate dates
FALLS AT FACILITY - 1

02/06 (through February 7th)
FALLS AT FACILITY - 1
HIT HEAD - 1

Head drop seizures which occur in as many as 15-20 continuous lasting 1-3-5 seconds each are numerous and are not summarized in the above summarization.

SUMMARY -

TOTAL FALLS - 93
TOTAL INJURIES - 21
TOTAL HEAD HITS - 15 (direct care staff implement neurological checks as per nursing consult recommendations)

There is a "FALL ASSESSMENT TOOL" dated 10/04/05 for R3. R3's score is 35. Per the assessment tool instructions, fall precautions are to be implemented for a total score of 15 or greater.

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There is a "FALL RISK POLICY/PROTOCOL" with an 11/05 date stating that the purpose of this policy is to: provide multidisciplinary assessment of fall risk factors; coordinate management of acute and recurrent falls; and provide measures to help prevent falls. Under the process portion it states that the nurse consultant will complete the Fall Risk Factor assessment quarterly. The Fall Risk Factor will be rated at low (1-2 checks), moderate (3-4 checks) or high (5-6 checks). Per review of R3's assessment, 5 areas are checked: "(history of falls -15 score; impaired judgement - 5; decreased level of cooperation -; increased anxiety/emotional liability - 5; medications affecting blood pressure or level of consciousness - 5)", giving an overall score of 35 and placing R3 in the high risk category for falls.

In an interview with E1 on 2/8/05, at the facility at 12:30 p.m., E1 confirmed that the fall risk assessment was utilized with R3 on 10/04/05. E 1 was not sure of the date for the actual development of the fall risk policy/protocol, but confirmed that the policy/protocol was in conjunction with the implementation of the fall assessment tool. (Surveyor located the 11/05 date - {as noted above}, on the last page of the policy/protocol, after this interview).

Per the Fall Risk Policy/Protocol, when an individual has been identified as a high fall risk, the following will occur: 1) contact the primary physician for physical therapy evaluation; 2) contact for occupational therapy evaluation; 3) documentation of fall risk status on the medical record and physician orders; 4) communication with all disciplines involved in caring for the individual regarding fall risk status; 5) schedule

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an interdisciplinary team meeting to discuss fall risk; 6) review of fall environmental checklist with direct support staff; 7) consultant nurse will continue to complete the quarterly/annual fall risk assessment.

In review of R3's physical therapy documentation in her personal file, there is no therapy evaluation after the initiation of the fall risk assessment tool/ fall risk policy/protocol relating to R3's status as a high fall risk. Her file does contain physical therapy exercises beginning in 01/06 that are specifically related to the metacarpal fracture she received in 11/05 (described above in seizure record). In an interview with E2 at the facility on 2/8/06 at 12:30 p.m., E2 confirmed that the physical therapy information in R3's file is the most current and is related only to R3's metacarpal fracture only.

In review of R3's occupational therapy documentation in her personal file, there is no evaluation after the initiation of the fall risk assessment tool/fall risk policy/protocol relating to R3's status as a high fall risk. Her file does contain occupational therapy exercises beginning in 01/06 that are specifically related to the metacarpal fracture she received in 11/05 (described above in the seizure record). In an interview with E2 , at the facility on 2/8/06 at 12: 30 p.m., E2 confirmed that the occupational therapy information in R3's file is the most current and is related to R3's metacarpal fracture only.

In review of R3's personal file, her most recent IPP is dated 06/21/05, with no interdisciplinary team meetings found after this date, as per the fall risk policy/protocol. In an interview with E1 at

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the facility on 2/8/06 at 12:30 p.m., E1 confirmed that there have been no interdisciplinary team meetings for R3 since her 6/21/05 annual (as per the fall risk policy/protocol).

In review of R3's personal file, her only fall assessment was completed on 10/4/05. The fall risk policy/protocol states that the consultant nurse will complete the fall assessment on a quarterly basis. Given that R3's first and only fall assessment was completed on 10/4/05, the next quarterly assessment would have occured on 01/04/06, and none was found. In a phone interview on 2/16/06, at 12:50 p.m. with E1 and E2 , E1 confirmed that R3 has not had any further fall assessments (as per the fall risk policy/protocol) since the 10/04/05 initial assessment.

2.a. In review of the facility's, "ABUSE AND NEGLECT POLICY FOR DETECTION AND PREVENTION", it states that this agency recognizes its responsibility to detect and prevent the occurrence of abuse and neglect, and reviews specific incidents for "lessons learned", which form a feedback look to affect necessary policy changes.

Within this policy, neglect is defined as, "the failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness".

It further states that this policy defines a proactive approach, "to prevent incidence of abuse and neglect and promotes the quality of life of each resident".

Under, "SIGNS AND SYMPTOMS OF

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POTENTIAL ABUSE AND NEGLECT", it includes :
< Bruises, black eyes, lacerations
< Fractures
< Sprains

The policy further states that the agency monitors the care and services of the residents to prevent abuse and neglect through a number of methods, one of them being - incident reporting and analysis of all incidents to determine if possible abuse or neglect exists and to identify patterns and trends. It further states that when any of the above activities deviate from acceptable standards, a problem-solving approach will be initiated which includes: (1) plan for improvement by analyzing the extent of the problem, (2) engage staff to determine the cause and extent of the problem and develop plans for improvement, (3) implement the plan for improvement, (4) evaluate the response, and (4) revise the plan as needed, educate staff and residents when necessary and continue to study.

From 01/05 through 2/7/06 - R3 has had a total of 93 falls, 21 injuries and 15 head hits (for which neurological checks were implemented by direct care staff - per consulting nurse recommendations - per record review of R3's personal chart).

In review of quarterly nursing assessments for R3 , the 5/17/05 assessment documents that R3's seizures remain unpredictable. Nursing quarterlies of 11/4/04, 5/17/05, 8/8/05, 11/10/05 and 2/2/06 document multiple complaints from R 3 related to sinus headaches and sinus problems . Nursing quarterlies of 2/2/06 state, "multiple

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sinus headaches - after (increase - arrow pointing up) seizures; as does the nursing quarterly of 11/5/05. A 1/18/06 nurses note states that is it common for (R3) to have (arrow up - increased) seizure activity R/T (related to) infections.

A Health Services Consultants note dated 6/20/05 states for R3: "any signs of sinus/ear or urinary tract infection? Often the cause of many seizures."

In a phone interview with E3 (consulting Registered Nurse) on 2/9/06 at 1:10 p.m., E3 stated that she thinks R3's sinus infections, menses and other infections may play a role in triggering seizures for R3. There is no documentation in R3's personal file that document any trends and patterns analysis for the nurse's observations.

Per review of R3's personal chart, it does not reflect consistent information relative to staff implementing the use and effectiveness of the VNS. There is no documentation in R3's personal file that documents any trends and patterns analysis for use/effectiveness of the VNS. In surveyor review of direct care staff seizure documentation, of 163 separate seizure documentations from 01/05-2/7/06, there are only 17 separate documentations for staff use of the VNS; and not all of these reflect whether the VNS was effective or not.

Surveyor review of R3's seizure charts from 01/05-2/7/06 document that of 163 separate seizure documentations reviewed, 130 documented seizure times are in the p.m., 18 documented

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seizure times are in the a.m. and there are 15 seizure entries with no documented time. There is no documentation in R3's personal file that documents any trends and patterns analysis for tracking the time of day for R3's seizures occurence.

In an interview with E1 and E2 during the daily status meeting of 2/8/05 at 2:45 p.m., E1 and E2 confirmed that the facility had not analyzed trends and patterns relative to R3's seizures/falls/ injuries.

b. In review of a facility incident report dated 11/ 18/05 and a nursing consultant synopsis dated 11/18/05, at 2:00 p.m. R3 was observed having drop seizures. During one of the drop seizures R 3 hit her left shoulder on the door frame of the bathroom. R3 later had another drop seizure and fell hitting her left eye. R3 experienced several head drop seizures and again fell to the "ground," hitting her right wrist. Ice was applied to the shoulder, wrist and eye. On 11/20/05 R3 developed a bruise on her left eye and her right hand was observed to be swollen and bruised. R 3 went to the doctor for a x-ray of her hand, and a fracture of the right metacarpal 3rd finger was diagnosed. R3 had surgery on the hand on 11/ 28/05 and as of the current survey date is still receiving therapy exercises for the hand.

In an interview with E6 (direct care staff - DSP) on 2/10/06 at 1:05 p.m., at the facility, E6 stated that she could not remember how R3 hit her eye, that R3 was in her room when she fell on her hand. E6 could not remember the timing of the seizures or how far apart they were, and there is no documentation of this on the incident report or

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W9999	Continued From page 58 nurses synopsis. E6 further confirmed in this interview that she has not been trained on the use of the VNS, that she was on funeral leave at the time of the training. In review of the facility "ABUSE AND NEGLECT POLICY FOR DETECTION AND PREVENTION", it states, "It is the practice of this agency to implement strong policies and procedures to detect and prevent incidents of abuse and neglect through education of staff, residents, guardians, and family members". The policy further states that the agency monitors the care and services of the residents to prevent abuse and neglect. A number of methods are listed, including: incident reporting and analysis of all incidents to determine if possible abuse or neglect exists and to identify patterns and trends; review staffing levels. When any of the above activities deviate from acceptable standards, a problem-solving approach will be initiated which include; (1) plan for improvement by analyzing the extent of the problem, (2) engage staff to determine the cause and extent of the problem and develop plans for improvement, (3) implement the plan for improvement, (4) evaluate the response, and (4) revise the plan as needed, educate staff and residents when necessary, and continue to study. The policy further states that the agency recognizes that neglect is often the result of inadequate staff volume or of staff who are not trained adequately to meet the needs of the individuals receiving services; that a determination will be made in consideration of current staffing patterns and staff knowledge.	W9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G220	A. BUILDING ______ B. WING ______	**02/22/2006**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW HOME	**503 SOUTH BOURNE STREET** **TOLONO, IL 61880**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
W9999	Continued From page 59 (A)	W9999		