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	14G355	A. BUILDING _____ B. WING _____	C 03/31/2006

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W 370	Continued From page 35 that direct care staff are not certified and or authorized to pass medication at the facility.	W 370		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060e) 350.1060h) 350.1210b) 350.1230b)3)5)6)7) 350.1230c) 350.1230d)1)2) 350.1230e) 350.3240a) 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 350.1060 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. e) An appropriate, effective and individualized	W9999		

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W9999	Continued From page 36 program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. 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. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 5) Training in habits in personal hygiene and activities of daily living. 6) Development of a written plan for each resident to provide for nursing services as part of	W9999		

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the total habilitation program.
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.

d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
2) Basic skills required to meet the health needs and problems of the residents.

e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities.

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 the following:

Based on observation, interview and record review, the facility neglected to implement their own policy and procedures prohibiting abuse and neglect by their failure to provide necessary services to prevent harm for one ndividual in the sample (R1). Since October of 2005, R1 has had eleven documented incidents of injuring and or cutting his hands and or wrist area with a razor

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W9999	Continued From page 38 and or other object(s) and the facility has failed to take necessary action to prevent reoccurrence. Findings include: Per review of the facility's Policy and Procedure for Abuse and Neglect, the policy identifies that, "... Any form of abuse or neglect is strictly prohibited... Neglect means a failure in a facility to provide adequate medical or personal care of maintenance, which failure results in physical or mental injury to a resident..." R1 was observed in the living room of the facility at 8:55 A.M. on 03/24/06. R1 was observed with a large guaze bandage to his left index finger. Per interview with E1 (Qualified Mental Retardation Professional - QMRP) at this time, E 1 confirmed that she had no knowledge of how R 1 injured his finger. Per review of the Incident Report dated 03/23/06, documentation identified that at 17:50 P.M., "... R 1 came up to her (staff) with blood on Rt. hand. 3 sm. (small) cuts noted on Rt hand by thumb and index finger. Unknown how cut it..." R1's hands were observed by the surveyor at 12: 20 P.M. on 03/24/06. R1's left hand was observed to have five abrased areas on the top portion of his hand that appeared healed. No top layer of skin was noted on any of the five abraised areas on R1's left hand. R1's right hand was observed to have one bandage to the middle of his index finger, one bandage to the lower area of his index finger between his thumb and index finger and one bandage to the side area of his thumb, near his wrist. R1 also had a red area to	W9999		

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the end of his middle finger and a large scabbed area to his upper right wrist area.

On 03/24/06 at 12:35 P.M., R1 was observed in the nurse's station of the facility. E13 (Licensed Practical Nurse - LPN) was observed to remove R1's bandages from his right hand/fingers. R1 was observed to have an open area to the inside of his right hand between his thumb and index finger, and superficial scrapes to the two other bandaged areas. E14 (LPN) was present in the nurse's station and informed the surveyor that she had put the guaze bandage on R1. E14 stated that she had placed on so much guaze because, "He bleeds so much." E13 also stated that R1 picks at his injuries.

Per review of the Physician's Orders sheet dated 02/16/06 through 03/15/06, R1 is a 23 year old male who functions at a profound level of mental retardation.

Per review of the Incident Reports and corresponding Nurse's Notes, R1 had eleven documented incidents of self injurious behaviors requiring first aid and/or physician notification. Examples included:

10/06/05 Nurse's Notes 5 P.M. "R1 picked up a safety razor in BR (bathroom) et (and) cut his L (left) hand causing skin tears et bleeding..."

11/20/05 Incident Report 7:40 P.M. "Staff reports noticing cut to upper (symbol for upper used) right hand and finding a disposable razor lying in floor of resident's bedroom... superficial cut/ scratch to upper right hand measuring approx. (approximately 1.5" L (long)... "

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W9999	Continued From page 40 An additional Incident Report was noted for 11/20 /05 that identified that staff had found a bottle of disinfectant besides R1's bed. Further documentation by the facility on 11/21/05 noted that a memo was issued that stated, "A bottle of ---- (name of disinfectant specified) and a razor were found in R1's room. This is the 3rd incident in recent weeks. Therefore nightly room checks of R1's room are now in process..." 11/27/05 Incident Report "3:55 P.M. R1 found razor that was left in the bathroom cutting himself in two places on top of rt. (right) hand, razor disposed of.... two superficial cuts to upper Rt. hand measuring 1/2" L (long) and 1/4" w (wide) with active bleeding..." 12/29/05 Incident Report "5:10 P.M. R1 came to staff with skin tear to top R wrist laughing. Staff checked bathrooms et (and) R1's bedroom et (and) found a personal care kit and razor head in bathroom. It appeared he had cut self with razor head..." 12/23/05 Incident Report "8:00 P.M. While staff was showering et shaving residents, R1 grabbed a razor et cut the top L (left) hand with a razor..." 01/03/06 Incident Report "6:00 P.M. R1 came up to staff in N (North) Hall. Blood on top Rt. wrist. Noted piece (of) broken plastic stem in Lt. hand. R1 had caused old injury to bleed..." 01/04/06 Nurse's Notes "R1 at 16:15 had pencil in hallway. Staff -- followed him to his Rm. (room). R1 trying to scrape @ (at) areas injured on hands with it. Staff removed pencil from him..."	W9999		

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W9999	Continued From page 41 01/06/06 Incident Report 7:30 A.M. R1 approached staff in hallway with bleeding et (and) open areas noted R palm hand/inner wrist area et (and) 1 scratch R inner forearm..." 02/18/06 Incident Report 10:42 A.M. Staff use key to get another staff cleaning supplies.... in the amount of time it took them to clean up R4, R1 got into razors and cut self on top of L hand. Door to chemical room doesn't always shut completely..." 03/12/06 Incident Report 3:30 P.M. While staff was in BR (bathroom) shaving peer, R1 walked in et grabbed the razor et cut top R hand..." 03/23/06 Incident Report 17:50 P.M. ...R1 came up to her (staff) with blood on Rt. hand. 3 sm. (small) cuts noted on Rt hand by thumb and index finger. Unknown how cut it..." An additional entry was noted in the Nurse's Notes for 03/23/06 that identified that nursing staff had been notified at 20:48 that R1 had been found with a "razor in his hand standing over his roommate (R5)." Per review of the Interdisciplinary Team Meeting report dated 07/21/05, R1 was assessed on 07/ 13/05 for environmental risks to determine his level of access. Review of this report identified that R1 has been assessed as needing " Supervised Access Only" when accessing " Razors" and or "Toxic Chemicals." Review of the Behavior Management Human Rights Committee Review of Restrictive	W9999		

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Procedures for R1 signed 12/21/05 identified that R1's pockets will be searched, "to remediate bringing unsafe/inapp. (inappropriate) items from W/S (Workshop) and stealing from W/S and home.... R1 has been found with money, gum, pens, pencils, candy and pennies in his pocket upon returning from workshop. He has also been found with ---- (name of disinfectant) bottles, razors and candy in his bedroom at night."

Per record review, R1 was reviewed on 01/19/06 by the Interdisciplinary Team due to his behaviors of refusing to get on the bus. Documentation for this date also noted, "... SIB (Self Injurious Behavior) BIP (Behavior Intervention Plan). Has 2 - Dec (December) 2 - Jan (January) Do not wrap large bandage - sm. (small) cover wound only..."

Per interview with E1 on 03/24/06 at 2:00 P.M., E 1 stated that after the 01/19/06 recommendation for a Self Injurious Behavior Program, the psychologist was to have developed a program. E1 then provided the surveyor with inservices that had been completed by the facility on the appropriate use of razors and safety issues on 01 /30/06 and 02/27/06. After the facility's inservices, R1 had two more documented incidents of cutting his hands (03/12/06 and 03/ 23/06) and one incident of being found with a razor (03/23/06) after staff were inserviced.

Record review on 03/24/06 identified that R1 has Behavior Treatment Plan(s) dated 02/01/06 for Attention Seeking Behavior leading to Physical Aggression and Theft and a Behavior Treatment Plan for Elopement. No behavior program was located on file for self injurious behaviors as

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W9999	Continued From page 43 recommended on 01/19/06. Further review of R1 's behavior plans and R1's individual program plan did not identify that any methods had been implemented to prevent R1 from gaining access to razors. Review of the facility's Safety Committee reports from 09/08/05 to 02/07/06 did not identify that this committee have reviewed safety issues related to R1 accessing razors and injuring himself and or staffing issues regarding necessary precautions needed to prevent R1 from accessing razors and or chemicals. (A)	W9999		