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	14G169	A. BUILDING _____ B. WING _____	R 05/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE PLACE	**1705 SOUTH PARK AVENUE HERRIN, IL 62948**

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W9999	Continued From page 37 LICENSURE VIOLATIONS 350.620a) 350.680b) 350.680c)3) 350.1060h) 350.1230d) 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 350.680 Developmental Disabilities Aides b) Each of the facility's developmental disabilities aides shall comply with one of the following conditions no later than 45 days after the date of initial employment. 1) Provide documentation of registration on the Department's Nurse Aide Registry. 2) Enroll in a Department approved developmental disabilities aide training program (see 77 Ill. Adm. Code 395). The program shall be successfully completed no later than 120 days after the date of initial employment. Programs approved in accordance with 77 Ill. Adm. Code 395.150(a)(2) may last longer than 120 days. However, a developmental disabilities aide may be employed no more than 120 days prior to the successful completion of the program. 3) Submit documentation in accordance with Section 350.683 of this Part in order to be	W9999		

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W9999	Continued From page 38 registered on the Nurse Aide Registry. c) Each person employed by the facility as a developmental disabilities aide shall meet each of the following requirements: 3) Provide evidence of prior employment or occupation, if any, and residence for two years prior to present employment as a nursing assistant. (Section 3-206(a)(3) of the Act) Section 350.1060 Training and Habilitation Services 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 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 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 were not met as evidenced by the following: Based on observation, interview and file review, the facility failed to implement their own policy and procedures to protect individuals from mistreatment, neglect and abuse, as evidenced by:	W9999		

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W9999	Continued From page 39 A) The facility failed to thoroughly investigate an allegation and take necessary action to protect individuals of the facility regarding a staff person who was noted on 04/20/06 to smell of alcohol while on duty. After the facility became aware of the allegation, and after E4 admitted to drinking alcohol prior to coming to work, the facility allowed E4 (non certified direct care staff) to work by himself on 04/25 and 04/26/06 on the midnight shift, thereby jeopardizing the health and safety of the eleven individuals of the facility (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10 and R11). Findings include: 1) Review of the facility's "Abuse or Neglect Procedures" identifies, "The Agency Representative and president will conduct an investigation into alleged or suspected abuse..." Further review of the facility's Abuse or Neglect Procedures" did not identify safeguards that would be implemented by the facility during the investigation to prevent further possible abuse, neglect and/or mistreatment of the individuals of the facility. The facility has failed to thoroughly investigate an allegation and take necessary action to protect individuals of the facility regarding a staff person that was noted on 04/20/06 to smell of alcohol while on duty. E4 (non certified direct care staff) was observed at the facility on 04/20/06 from 6:00 A.M. to 7:10 A.M. during the medication pass. E4 was observed to make four medication errors during this observation.	W9999		

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W9999	Continued From page 40 While in the medication room on 04/20/06 at 10:15 A.M., R4's nebulizer treatment was observed, and the surveyor observed that medication remained within the chamber. E4 was present with the surveyor at the time of this observation in the medication room. During this observation, the surveyor smelled an odor on E4's breath. The surveyor later noted the smell to be that of alcohol possibly masked with some type of minty mouth wash or breath mint. The facility's owner (E3) was made aware of the surveyor's observations per telephone conversation on 04/21/06 at 10:50 A.M. Subsequent telephone interview with E3 at 12:50 P.M. confirmed that E4 (non certified direct care staff) was hired on 03/07/06. During confidential interviews with facility staff on 04/20 and 04/21/06, a staff member stated during interview that she had smelled alcohol on E4's breath while attending a staff meeting at the facility. No specific dates were provided to the surveyor at this time. Review of E4's personnel file on 04/25/06 did not identify that E4 was a certified direct care staff person. No documentation was noted in E4's personnel file that would identify that references and or E4's prior employers had been contacted prior to hire. Interview with E2 (Qualified Mental Retardation Professional - QMRP) on 04/25/06 at 1:00 P.M. confirmed that E4 had not completed his certification training to become a habilitation aide. E2 also confirmed that she had not contacted E4's references prior to hire. After the facility was informed of the surveyor's	W9999		

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W9999	Continued From page 41 observation, E4 worked the midnight shift on 04/25/06 and 04/26/06 by himself. During the Daily Status Meeting on 04/26/06 at 4:45 P.M., E2 confirmed that E4 had worked the midnight shift of 04/25/06 and 04/26/06 by himself unsupervised. E2 also confirmed that she had talked with E4 on 04/21/06 regarding the alcohol smell on his breath on 04/20/06. E2 stated, "I talked with E4 on 04/21/06 by phone. E4 admitted to drinking prior to coming to work on 04/20/06." During this meeting, E2 confirmed that she did not document her interview with E4. At this time, E2 provided the surveyor with a copy of the facility's Personnel Handbook. E2 confirmed that all staff members receive this handbook at the time of hire. Review of the handbook identified that reporting to work while under the influence of alcohol is classified as "Misconduct." Review of section 7.4 of the Personnel Handbook entitle "Misconduct" identified: "In administering discipline or imposing penalties, every effort will be made to utilize corrective action. Due consideration will be given to the individual's employment record, which shall be weighed against the necessity of maintaining equality with other employees. All allegations of mistreatment, abuse and neglect of individuals will be thoroughly investigated by the QMRP, Operations Manage and Agency Rep (CILA - Center for Independent Living Arrangement) within 24 hours of the incident. During the course of the investigation the employee will be suspended from work without pay. Appropriate sanctions including	W9999		

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W9999	Continued From page 42 dismissal will be invoked if the allegation is substantiated... While it is difficult to set forth all rules for misconduct the following list of improper actions is sufficiently comprehensive to serve as a guide, however, it is non inclusive: (1) abuse, neglect, or inconsiderate treatment of residents (2) willful destruction of property (3) stealing property from residents or the facility (4) reporting for work or working while under the influence of alcohol, narcotics, or hallucinogenic drugs... ... Nothing in this Personnel Handbook shall be construed as a contract..." After 04/21/06, E4 continued to work and was not suspended as per guidelines presented to the surveyor on 04/26/06 regarding misconduct. Per review of the Employee Time cards, E4 worked 04/21 (midnight shift), 04/22 (second shift and midnight shift), 04/24/06 (second shift), 04/25/06 (midnight shift) and 04/26/06 (midnight shift) and 04/27/06 (midnight shift). Per interview with E2 (QMRP) on 04/28/06 at 4:35 P.M., E4 worked the midnight shifts of 04/25/06 and 04/26/06 by himself, unsupervised. On 04/28/06 at 12:30 P.M., E3 (Owner) informed the surveyor that E4 had been suspended. When the surveyor asked the date of suspension, E2 (QMRP) informed E3 and the surveyor that	W9999		

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W9999	Continued From page 43 E4 had not been contacted yet regarding his suspension. 2) The facility failed to thoroughly investigate an allegation regarding staff's failure (E4) to administer R3's 6:00 A.M. medication prior to leaving for a home visit on 04/14/06. Per review of the Physician's Order sheet dated 04/2006, R3 is a 42 year old male who functions at a severe level of mental retardation. Per telephone interview with Z1 on 04/21/06 at 9:50 A.M., Z1 informed the surveyor that he had talked with E2 (QMRP) on 04/17/06 about R3 alleging that he had not received his morning medications on 04/14/06. Z1 stated, "I took R3 home on Good Friday. I picked him up about 10:30 A.M. that morning for the weekend. When I looked at the medication, I saw that the 6:00 A.M. pills were gone from the pack. No staff initials were on the back for 04/14/06 for 6:00 A.M. R3 told me that he didn't get his 6:00 A.M. medications. He (R3) said, "E4 told me that my name wasn't in the book." I called E2 and she said that she would look into it. R3 knows his medication..." R3 was interviewed on 04/21/06 at 3:30 P.M. with E5 (Food Service Supervisor) present during the interview. R3 confirmed that he had not received his medication on 04/14/06 during the 6:00 A.M. medication pass. R3 stated, "I went home on Good Friday. April 14th. I went home at 10:15 A.M. No I didn't get my morning meds (medications). E4 is tall, skinny and has brown hair. Told me my name not in the book..." When the surveyor asked R3 what medications he takes at 6:00 A.M., R3 stated, "Vitamin E,	W9999		

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W9999	Continued From page 44 Depakote, Risperdal and a white pill for blood pressure." R3 confirmed that 04/14/06 was the only day that he had missed his medications. Review of the Physician's Order sheet dated 04/2006 identified that daily at 6:00 A.M., R3 receives, Vitamin E capsule 400 units, Depakote ER tablet 500 mg. (milligram), Risperdal tablet 1 mg., and Propranolol tablet 20 mg. Interview with E2 (QMRP) on 04/25/06 at 10:45 A.M., confirmed that she had interviewed E4 in regards to the allegation that R3 did not receive his 6:00 A.M. medication on 04/14/06. E2 stated, "I talked with E4. He (E4) said he gave R3 his 6:00 A.M. medication. I typed up the report and it's laying on my desk..." E2 confirmed that E4 had not been removed from passing medication during her investigation. E2 also confirmed that she did not interview R3, nor any other individuals and or staff of the facility during her investigation. E4 was suspended by the facility on 04/28/06. E4 was terminated by the facility on 05/03/06. (A)	W9999		