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W 331	Continued From page 23 implementation of necessary staff supervision and existing and new policies and procedures, and make necessary revisions to the individual's plans, as well as policy and procedures on an on-going, as needed basis.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060h) 350.1210b) 350.1230b)3) 350.1230b)6) 350.1230b)7) 350.1230d)1) 350.1230d)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. h) There shall be available sufficient,	W9999		

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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.
6) Development of a written plan for each resident to provide for nursing services as part of the
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

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.

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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 file review, the facility has neglected to ensure that individuals receive adequate health care monitoring and services based on the individuals need for service, as evidenced by:

1) The facility has failed to develop and implement a plan of care to address health conditions for 1 of 1 individual outside the sample (R5) who had diagnosis of Diabetes Type II and has had five episodes of non responsiveness in the past two months (06/11, 06/23, 07/10, 07/17 and 07/18/06);

2) The facility has failed to develop and implement a plan of care that identifies the level of staff supervision and environmental modifications needed to prevent injury from falls for 1 of 1 individual in the sample (R4) who requires a wheelchair and a safety helmet due to his unsteady gait. R4 has had four documented incidents of sliding and or falling from his wheelchair in the past three months (04/29, 05/20, 05/31, and 07/26);

3) The facility has failed to have adequate

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W9999	Continued From page 26 numbers of direct care staff to supervise individuals in accordance with their individual program plans during periods of time when other direct care staff are unavailable as observed on 07/26/06 for 3 of 3 individuals of the facility (R1, R8 and R9) who are to be on continuous staff observation, and for 2 of 2 individuals of the facility who have have history of elopement and require electronic monitoring devices (R6 and R7); and 4) The facility has failed to have sufficient morning staff during the dates of 06/20 thru 06/24/06 to manage and supervise individuals in accordance with their needs having the potential to impact all individuals of the facility (R1 - R14). Findings include: 1) Per review of the Medication Administration Record (MAR) dated 07/16/06 thru 08/15/06, R5 is a 72 year old male who functions at a severe level of mental retardation and has diagnosis of Diabetes Type II and Hyperglycemia. Further review of the (MAR) identified that R5 is insulin dependent and that his dosage is administered on a regular and on a sliding scale basis. a) No plan of care developed and or implemented to address episodes of unresponsiveness. Nurse's Notes dated 06/11/06 identified that R5 was not responding to staff at 10:45 A.M. The nurse was contacted and R5 was given orange juice with sugar substitute. R5 was checked by the nurse and his blood sugar reading was 213. R5 also had a temperature of 100.9 axillary. Further documentation noted that R5 "responding after (symbol for "after" used) fifteen minutes..."	W9999		

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W9999	Continued From page 27 R5 was sent to the Emergency Room at 12:30 P.M. and was admitted to the hospital with a diagnosis of Urosepsis. R5 remained in the hospital until 06/14/06. Review of the Incident Report dated 06/23/06 identified that R5 was unresponsive while at day training. Further documentation identified that at 11:25 A.M., R5 was unresponsive. His blood pressure was noted at 78/58 and his blood sugar was 176. R5 was unresponsive for "...approximately 8 minutes, then lethargic, speech slurred, unable to ambulate." At 11:30 A.M., R5's blood pressure dropped to 62/40. At 11:40 A.M., R5's blood pressure was noted at 64/40. R5 remained lethargic and was slow to respond. R5 was sent to the Emergency Room at 12:00 P.M. Per telephone interview with E11 (Medical Director) on 08/03/06 at 11:50 A.M., E11 stated, "With R5 remaining unresponsive for 8 minutes and with his blood pressure so low, nursing should not have waited thirty five minutes before taking him to the hospital. If they called me and I didn't return their call, they can always talk to the physician on call. They also can page me or call my cell phone. If it is an emergency, they add "911" to the end of their number." Nurse's Notes dated 07/10/06 identified that R5 was unresponsive while at day training at 11:00 A.M. (no length of time specified). R5's blood sugar was 47. Orders were received at this time for the Glucagon Injectable. Review of the Telephone Orders for R5 dated 07/10/06 identified, "... Glucagon Injectable for symptomatic hypoglycemia when can't eat give	W9999		

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W9999	Continued From page 28 injection and call ambulance. Have one at home with one at offsite workshop." Further review of the Nurse's Notes identified that on 07/17/06, R5 was again unresponsive at workshop. R5's episode of unresponsiveness lasted 5 minutes. On 07/18/06, R5 had another unresponsive episode at day training, lasting approximately 3 minutes. No documentation was noted to identify that R5's blood sugar was checked, that the Glucagon Injectable was administered and/or that the ambulance was called on either on 07/17 or 07/18/06. Per review of the Medication Administration Record (MAR) dated 07/16/06 thru 08/15/06 no documentation was noted that would identify orders for the Glucagon injectable and/or that this medication had been administered while at day training. Per telephone interview with E5 (Licensed Practical Nurse - LPN) on 08/03/06 at 8:05 A.M., E5 confirmed that there was no documentation on the MAR and/or in the Nurse's Notes to identify that R5's blood sugar was checked on 07/17/06. E5 also confirmed that the Glucagon Injectable order was not written on the MAR and was not administered on 07/17 and or 07/18/06. During this interview, E5 stated that R5's blood sugar was checked at 11:30 A.M. by E3 (DON) with a reading of 195. R5's Nursing Care Plan was not updated and revised until 07/27/06 to address his current unresponsive episodes after brought to the attention of nursing staff by the surveyor. b) After the 07/18/06 episode, orders were	W9999		

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received for R5 to be scheduled for a heart (halter) monitor. R5 was scheduled for 07/24/06 to have a halter monitor placed on at a local hospital. No nursing entries were made in R5's record after 07/22/06, until brought to the attention of nursing staff by the surveyor.

Review of the Nursing Notes dated 07/18/06 identified that at 5:35 P.M. orders were received for R5 to be scheduled for a heart monitor. Further documentation identified that R5 was scheduled for 07/24/06 to have the heart (halter) monitor placed on at a local hospital. Nursing entries were made on 07/20, 07/21 and 07/22/06 in regards to R5's blood sugar readings. On 07/27/06 when the surveyor reviewed R5's chart, no further nursing entries had been made in R5's record since 07/22/06. No documentation was noted that would identify if R5 had the heart (halter) monitor placed on as ordered. Additionally, no entries were made that would identify that R5's vitals were monitored by nursing staff.

Per interview with E7 (Licensed Practical Nurse - LPN) on 07/27/06 at 10:00 A.M., E7 confirmed that no nursing entries had been made regarding R5's heart (halter) monitor. E7 stated, "I was just on the phone with the doctor's office. He has been on vacation. R5 had the heart monitor but it got wet, so we will need to do it again. I haven't had time to document..." During this interview, E7 confirmed that no plan had been developed to address the heart halter monitor.

2) Per review of the Physician's Orders Medications and Treatments sheet dated 06/16/06 thru 07/15/06, R4 is a 63 year old male who functions at a profound level of mental

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retardation and has diagnosis of Choreoathetosis of Upper and Lower Extremities.

During the Entrance Communication on 07/26/06, the surveyor was informed that R4 had fallen prior to the surveyor's entrance to the facility and had been sent to the emergency room.

a) No neurological checks done after head injury and the facility does not have policy and procedures for neurological checks and/or nursing protocol for monitoring after head injuries.

Review of the Incident Report dated 07/26/06, R4 was, "... sitting in w/c (wheelchair) in living Rm (room) with (symbol for "with" used) helmet off and (symbol for "and" used) staff next to him and fell asleep and fell to floor hitting right (symbol for "right" used) eyebrow causing V shaped laceration to site." Further review of the Incident Report did not identify that neurological checks were done after R4 fell from his wheelchair.

Per interview with E5 (Licensed Practical Nurse - LPN) on 07/26/06 at 2:51 P.M., E5 confirmed that no neurological checks had been completed after R4 fell at 10:50 A.M. and/or upon his return to the facility. E5 stated, "No, I did not do a neurological check when R4 fell. I checked his eyes, but I did not document. I didn't do a neurological check after R4 returned from the Emergency Room because he did not have return orders for a neurological check. " During this interview, E5 confirmed that the facility does not have policy and procedures for nursing protocol for monitoring after head injuries.

Per telephone interview with E11 (Medical

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W9999	Continued From page 31 Director) on 08/03/06 at 11:50 A.M., E11 stated, "I would expect neurological checks to be done by nursing staff after serious head injuries. If R4 required stitches for his injury, then nursing should have done neurological checks." b) No plan of care developed to address R4's to level of supervision needed to prevent falls from his wheelchair. After sustaining a head injury requiring emergency room treatment on 07/26/06, R4 was observed to be left unattended without his helmet worn. R4 was observed at 2:00 P.M. (on 07/26/06) sitting in his wheelchair, unsupervised in the living room. R4 was observed to have four stitches along the right eye brow area above his eye. No staff was present in the area. After brought to staff's immediate attention, E2 (QMRP - Qualified Mental Retardation Professional) stated that R4 was under general supervision and did not require staff to monitor him when his helmet is off. Per interview with E6 (Direct Care Staff) on 07/26/06 at 2:45 P.M., E6 confirmed that she was present in the living room when R4 fell from his wheelchair. E6 stated, "I was in the living room this morning when R4 fell out of his wheelchair. I was sitting on the couch and R4 was sitting in the middle of the floor in his wheelchair. I assume he fell asleep. He went head first and fell over forwards in his wheelchair. R4 did not have his helmet on at the time. R4 can be left by himself even with his helmet off. No one ever told me any different." During this interview, E6 showed the surveyor where she was sitting in the living room and where R4 was sitting at the time of the Incident. At this time, E6 confirmed that she was	W9999		

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W9999	Continued From page 32 approximately 5-6 feet away from R4 when he fell from his wheelchair. During the Daily Status Meeting on 07/21/06 at 2:01 P.M., E3 (Director of Nursing) confirmed that R4 should be monitored by staff when his safety helmet is removed. Per telephone interview with E11 (Medical Director) on 08/03/06 at 11:50 A.M., E11 stated, " I don't know if the facility can, but staff should be one on one with R4 when his helmet is removed." Review of the Incident Reports and per file review, R4 has had four incidents of falling from his wheelchair in the past three months on 04/29, 05/20 (slid from his wheelchair), 05/26 and 05/31/06. On 05/31, R4 sustained a superficial laceration to his right eye brow area. After these falls, no documentation was noted to identify that modifications had been made in R4's plan of care to address his level of supervision to prevent falls from his wheelchair. R4's plan of care related to his potential for injury from falls was not modified by the facility until 07/28/06 to identify the level of supervision needed to prevent further potential falls from his wheelchair. c) No plan of care developed to address modifications needed to R4's bed and or bedroom to prevent potential injury from falls when getting out of the bed at night, unsupervised. Review of the Physician's Orders Medications and Treatments sheet dated 06/16/06 thru 07/15/06, identified that R4 is to have a gait belt	W9999		

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used for all transfers and is to have staff assist when ambulating.

Review of the Incident Reports and per file review, R4 had also been found scooting on the floor of his bedroom on 05/04 and 05/24/06 after getting out of his bed unsupervised.

Review of R4's Nurse's Notes identified:

On 05/04/06 at 8:10 P.M., staff heard sounds coming from R4's bedroom. Staff went to check and found R4 was found sitting on the floor, near the bedroom door.

On 05/25/06 identified at 10:00 P.M. on 05/24/06, staff found R4 on the floor in his bedroom scooting towards the door. R4 was assisted back to bed R4 was again found 15 minutes later on the floor scooting across the floor. A few minutes later, R4 was discovered again found on the floor scooting towards the door.

After these incidents, no documentation was noted to identify that environmental modifications had been made to R4's bed and or bedroom area to prevent him from getting out of his bed unsupervised.

R4's bedroom was observed on 07/27/06 at 12:30 P.M. with E4 (Quality Assurance). Observations at this time identified that R4's bed remained at a normal height. E4 also confirmed that no bed rails and or side rails were present on R4's bed. E4 also confirmed that R4's bed had not been lowered after R4's incidents of getting out of bed.

During the Daily Status Meeting on 07/21/06 at

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W9999	Continued From page 34 2:01 P.M., E3 (Director of Nursing) confirmed that R4's bed and or bedroom had not been modified after these incidents. R4's plan of care related to his potential for injury from falls was not modified by the facility until 07/28/06 until brought to the attention of nursing staff by the surveyor. As of this date, R4's bed has been lowered to floor with a mattress placed besides the bed to assist in the prevention of potential injuries from falls. An additional observation is available for R4 in regards to the staff's failure to ambulate R4 with a gait belt on 07/26/06 at 4:30 P.M. and who has orders for a gait belt to be used while ambulating with staff. 3) The facility has failed to have adequate numbers of direct care staff to supervise individuals during periods of time when other direct care staff are unavailable as observed on 07/26/06. On 07/26/06 at 11:00 A.M. the surveyor entered the facility. R3, R5, R6, R7, R8, R12 and R13 were all sitting or pacing in the living room area of the facility. No staff were present in the living room area. R8 immediately walked up to the surveyor and showed the surveyor a superficial wound on his right elbow. Two staff were then observed to come from the south end of the facility. E8 (Direct Care Staff) informed the surveyor at this time that E1 (QMRP) was at the doctor's office with E11 and that two staff were at the hospital with R4 who had fallen out of his wheelchair early in the day. (Ratio at this time	W9999		

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was 2:12 with a food service staff who was in the kitchen of the facility.)

E9 was observed in the kitchen and R1 was observed assisting her with kitchen duties. E9 was not visible from the living room area of the facility. R1 was then observed to leave the dining room area and go to his bedroom.

After the surveyor's entrance to the facility, the two direct care staff were observed to remain in the living room and dining room areas of the facility.

Per interview with E1 (QMRP) on 07/26/06 at 3:00 P.M., E1 identified that R1, R8 and R9 are to be on continuous observation. During this interview, E1 confirmed that if there were only two direct care staff, those two staff could not provide continuous supervision if they were not in the main areas of the facility or where those individuals were.

Per review of the facility's policy and procedures for Resident Supervision and Special Observation, documentation identified that Continuous Supervision is defined as:

"Visual observation is maintained or whereabouts are known and visual contact is maintained with nearest exit door to the individual being monitored..."

a) Per review of the Physician's Orders Medications and Treatments record dated 06/16/06 thru 07/15/06, R1 is a 34 year old male who functions at a moderate level of mental retardation and has diagnosis of Autism.

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(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
W9999	Continued From page 36 Review of R1's behavior program identified that R1 has targeted behaviors of physical aggression, attempting to groom peers, exposing self and attempting to watch peers shower. Further documentation identified that R1 had been on 1:1 supervision on 07/02/06 due to two incidents of inappropriate behaviors. Review of the Incident Reports during Task II had identified that on 07/01/06 R1 had been found in R4's bedroom attempting to push his knees apart. On 07/02/06 R1 was observed by staff trying to put his hands on R9's pant's zipper. Further review of R1's behavior program identified that on 07/05/06, R1 was discontinued from 1:1 and placed on constant visual observation. b) Additional examples are available for R8 and R9 who are to be on constant staff supervision and for R6 and R7 who have history of elopement and whose whereabouts were not consistently monitored by staff as observed on 07/26/06. R8 who functions at a profound level of mental retardation and who is on a behavior program for physical aggression, property destruction and inappropriate sexual behavior. R9 who functions at a profound level of mental retardation and who is on a behavior program for attention seeking behavior leading to physical aggression, self injurious behaviors and elopement. R9 also wears an electronic monitoring device. R6 and R7 who both functions at a profound level	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G355	A. BUILDING ______ B. WING ______	C 08/04/2006

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W9999	Continued From page 37 of mental retardation and who are on a behavior program for elopement and wear electronic monitoring devices. R6 and R7 were observed on 07/26/06 at 11:00 in the living room of the facility without staff supervision. Per interview with E8 (Direct Care Staff)on 07/26/06) at 11:40 A.M., E8 confirmed that the facility had four staff earlier in the day. E8 stated, "We had four staff this morning, but two staff had to take R4 and that left only two staff plus E9 (Food Service Supervisor). Two staff can get them up and ready for work, but no, we can't always monitor them continually." During this interview, E2 confirmed that in the mornings, two direct care staff can not provide each individual with the level of supervision needed as identified per their individual program plans. Interview with E9 (Food Service Supervisor) on 07/27/06 at 8:50 A.M. confirmed that when she is in the kitchen cooking, she is not available to assist staff in supervising individuals of the facility. 4) The facility has failed to have sufficient morning staff during the dates of 06/20 thru 06/24/06 to manage and supervise individuals in accordance with their needs. Per review of the facility's schedule dated 06/11/06 thru 06/24/06 documentation identified that the facility had staffed for three direct care staff and a food service person during the hours of 6:30 to 9:15 A.M. when the individuals get up and get ready for work. Further documentation identified that on 06/19/06, the 6:30 to 2:30 P.M. person quit. No documentation was noted to identify that an additional staff member covered	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W9999	Continued From page 38 this shift from 06/20/06 thru 06/24/06 whereby leaving only two direct care staff and a food service person to supervise the fourteen individuals of the facility. Interview with E10 (Resident Services Director) on 07/27/06 at 10:00 A.M. confirmed that the facility did not have a staff member cover the 6:30 to 2:30 P.M. shift until 06/25/06. During the interview with E1 (QMRP) on 07/26/06 at 3:00 P.M., E1 identified that R1, R8 and R9 are to be on continuous observation. E1 also confirmed that if there were only two direct care staff, those two staff could not provide continuous supervision to these individuals if they were not in the main areas of the facility. Per interview with E8 (Direct Care Staff)on 07/26/06) at 11:40 A.M., E8 stated, "Two staff can get them up and ready for work, but no, we can't always monitor them continually." During this interview, E2 confirmed that in the mornings, two direct care staff can not provide each individual with the level of supervision needed as identified per their individual program plans. (A)	W9999		