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	14G217	A. BUILDING _____ B. WING _____	R 03/14/2007

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W 371	Continued From page 19 receiving Dilantin 100 mg 2 tablets, Oyster Shell 1 tablet, Akwa Tears 1 drop both eyes. R2 obtain her own water from the water cooler, E4 gave R2 hand sanitizer to clean her hands, R2 punch her pills and R2 drank her cup of water. R2 remained at the medication door and E4 put in her eye drops and gave R2 a tissue to wipe her face. R7 is a 51 year old male with a diagnosis of Moderate Mental Retardation, R7 was observed receiving Glucophage 500 mg 1 tablet and Amoxicillin 500 mg 1 tablet. E4 gave R2 hand sanitizer to clean his hands, he punch his pills and R7 drank his water. While he was standing at the medication room doorway, he was complaining to E4 and E1 that he had tooth pain, i.e. "my tooth start hurting again." The facility failed to ensure staff implement self-medication programs on formal or informal basis when the opportunity presented itself. This failure resulted in skill training not being implemented or re-enforced at the medication administration.	W 371		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.1060a) 350.1060d) 350.1060e 350.1230c) 350.1230d)1)2)3) 350.1230e) 350.3240a)	W9999		

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W9999	Continued From page 20 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. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) An appropriate, effective and individualized 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. 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 total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.	W9999		

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W9999	Continued From page 21 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. 3) First aid in the presence of accident or illness. 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. These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility neglected to develop and implement policies and procedures to safeguard one individual's (R6) health and safety during a medical emergency. R6 requires the use of an Epi-Pen injection when she develops facial, lingual swelling, and a protruding swollen tongue to prevent her from going into anaphylactic shock. 1. The facility failed to administered R6's Epi-Pen when she developed an allergic reaction which could result in a life threating medical emergency. 2. The facility failed to have a nurse present to	W9999		

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W9999	Continued From page 22 administer R6's Epi-Pen, since unlicensed staff are not adequately trained to administer the Epi-Pen injection. 3. The facility failed to implement the procedures in place which staff must follow when R6 starts developing symptoms of an allergic reaction which could result in a life threating medical emergency. 4. The facility nurse failed to follow up and update the nursing care plan for R6 when R6 had refused to accept administration of the Epi-Pen. Findings include: R6's Individual Service Plan dated 4/6/2006 states she is a 57 year old female with a diagnosis of Moderate Mental Retardation, Neurogenic Bladder Disorder, Bipolar Manic and General Anxiety Disorder. R6's Speech and Hearing Habilitation Plan Review Report dated 3/25/2006 documented "she is able to communicate via speech and her verbalizations range from single words to sentences. (R6) is able to ask/answer questions and engage in conversational situations...(R6) speech intelligibility is good. (R6) hearing is functionally adequate for activities of daily living." Incident reports from 4/8/2006 to 3/6/2007 were reviewed on 3/6/2007. It was documented in a letter to Illinois Department of Public Health (IDPH) dated 2/19/2007 that R6 "on 1/19/2007 that (typographical error in date of incident in letter) it was noted that (R6's) tongue was swollen and is a reoccurring condition for her. She refused to take her medication to address the swelling. Due to swelling and her difficulty in	W9999		

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W9999	Continued From page 23	W9999		

breathing she was transported to the hospital via ambulance. She was admitted for observation." On 4/8/2006, a letter to IDPH stated "On 4/7/2006 (R6)... was taken to the ER (emergency room) due to an allergic reaction that caused her tongue to become swollen. (R6) was admitted to determine the cause of the reaction."

Review of progress notes (GP15) dated 2/20/2007 written by E8, nurse, stated "received call from staff on 2/19/07 (no time documented) that resident was taken to E.R. for an allergic reaction. Her tongue swollen and protruding (from mouth)." E8 documented on 2/21/2007 (no time documented), (R6) "released from (hospital) on 2/20/07 (with) a diagnosis of chest pain, possible allergic reaction."

Review of progress notes (GP15) dated 2/20/2007 (no time documented) written by EI, Residential Service Director, stated "client was admitted to (hospital) due to chest pains coupled with lingual swelling. Client initially went to the ER due to her tongue being swollen but then admitted for her complaints of chest pains."

Upon review of R6's Nursing Care Plan dated 3/1/2006, it stated under Problem or Need: Monitor for signs of systemic allergic reactions and anaphylaxis; Approaches: Identify signs of throat tightness, wheezing, hoarseness, difficulty breathing, irregular pulse and hypotension; Short Term Goal: Administer Epi-Pen injection and call 911 for transport to hospital by ambulance. There is no evidence that the care plan has been updated as of 3/7/2007.

E4, direct care, was observed during medication administration on 3/6/2007 at 4:00 p.m. It was

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W9999	Continued From page 24 noted on the medication administration record that R6 receives Epi-Pen 0.3 mg Auto-Injection, inject 1 pen intramuscularly as directed (as needed). Epi-Pen 0.3 mg order was originally prescribed on 7/20/2005 and renewed monthly as document on the physician's order sheet from 7/20/2005 to 3/6/ 2007. Per interview with E4, direct care, on 3/6/2007 at 4:30 p.m., E4 stated one Epi-Pen is kept in the medication room. E4 obtained a plastic box and showed the surveyor the Epi-Pen (date on Epi-Pen noted to be 2/2006 with an expiration date of 7/2007). E4 stated R6 gives the Epi-Pen injection to (her) self but sometimes she refused because it hurts. E4 stated the pen (Epi-Pen) is given when R6's tongue and throat swell. After the Epi-Pen injection is used, the pen is returned to pharmacy for a new one (no back-up Epi-Pen injection was observed available when there would be a need to send to the pharmacy). E4 validated the facility only had one Epi-Pen available in the medication room for R6. Surveyor asked E4 if she was trained to use the Epi-Pen injection in an emergency. At first E4 said no, she was not trained; then she stated E9, nurse, trained her during the summer when (we) were getting medication certified. When asked how the Epi-Pen injection is given, E4 stated "all you do is jab her in the leg with the needle." E6, cook/direct care, was interviewed on 3/6/2007 at 4:40 p.m. and 3/7/2007 at 4:10 p.m. E6 stated R6 has "pre-signs to allergic reaction, first she gets a rash on her neck, then after a day or two, the swelling of the face on one side or maybe both sides, and swelling under the eye. (The) last time (R6) was hospitalized her tongue did swell. During the interview on 3/6/2007 with E6, she stated she "had not been trained in the	W9999		

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W9999	Continued From page 25 (use of) the Epi-Pen but we use hand over hand with all clients since they are on self medication programs, but she does not like to take it". E6 was re-interviewed on 3/7/2007 and stated, "I believe we were trained in using the (Epi) pen during medication certification class." E3, direct care, was interviewed on 3/7/2007 at 8:30 a.m. and stated she "don't know what a Epipen looks like and don't know where it is stored...I know nothing about the Epipen, I think the nurse would give since we do not give shots." E3 stated she has received medication certification. E7, direct care, was interviewed on 3/7/2007 at 8:50 a.m. and stated she "observed R6 the day before (2/18/2007) with a redden nose. The next day (2/19/2007), (E7) observed a rash on right side of face, and R6's face, lips, and tongue were swollen; mouth looking like 3 lips, and she was sent to the hospital." E7 stated R6 "is to receive the Epi-Pen (injection) when her tongue swells." There is no documentation that E7 gave the Epi-Pen upon the development of R6's allergic reaction. E5, direct care, was interviewed on 3/7/2007 at 3:50 p.m. and stated "he had not been trained in the use of the Epi-Pen for (R6). E5 stated R6 "is on a medication program but not for the use of the Epi-Pen (injection)." E2, direct care, was interviewed on 3/7/2007 at 2:40 p.m. and stated she would give the medication "Epi-Pen" in (R6's) thigh if needed for symptoms." When surveyor questioned E2 if she had ever given the medication, she stated "no." E2 stated she "would call the nurse and asked	W9999		

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W9999	Continued From page 26 what to do." R6, client, was interviewed on 3/6/2007 at 4:25 p.m. and stated she went to the hospital. When surveyor asked why, R6 asked E4 to tell surveyor why she went to the hospital. E4 stated R6's face, lips, and tongue was swollen and R6 was sent to the hospital. E1, Residential Service Director, was interviewed on 3/7/2007 at 9:00 a.m. and stated R6's "symptoms came on overnight and her tongue was swollen. I was notified after they (staff) called 911." E1 stated every staff has been trained to use the Epi-Pen and (R6) gets the Epi-Pen when her tongue swells. (R6) did not get the Epi-Pen on this day (2/19/2007) because she refused. E1 states R6's guardian states she should get the Epi-Pen." E1 was asked by surveyor if R6 was on any desensitization program to address her need for the Epi-Pen in a life threatening emergency and E1 stated "no." E1 stated the facility has made several attempts to meet with the guardian regarding R6. The facility faxed progress notes from 3/1/2007 to 3/5/2007 to IDPH on 3/12/2007, which were not available while surveyors were onsite regarding guardian phone contact. There is no evidence that an IDT meeting was held related to R6's refusal of the Epi-Pen as of 3/7/2007. In addition, there is no evidence that the nurse has followed up, following R6's refusal of the Epi-Pen when the Nursing Care Plan states to "Administer Epi-Pen...." The facility neglected to meet R6's medical need by failing to administer her Epi-Pen injection on 2/19/2007 and 4/8/06; failing to have a nurse administer the Epipen since all staff are not	W9999		