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W 331	Continued From page 94	W 331		

bed putting on clothes, asking for bag of ice." A medical report of 5/1 with the time of 7:00pm states, "While getting (R2) ready for shower noticed bruising to left thigh. Approximately 3 inches in length and yellowish in color. Appeared to be a few days old." Report form states that E11 (nurse) was notified. Again no indication of a referral to his physician.

A note from day training by E10 regarding R2 at work on 5/2 states "At lunch time, he would not walk into the break room, wanting to eat in the "shower room". (R2) was told he could not eat in the shower room, and the only area's eating was allowed at work was the break areas. (R2) put his lunch down and "crawled" on his hands and knees back to area C."

A Medical Report regarding R2, dated 5/2 and with the time listed as 7:45pm states, "Bruise on inside of (left) thigh. There's a bruise on the back of thigh also." The report states that R2 was taken to a Medical facility at 7:45pm. A Health Note dated 5/2 from E11 (nurse) states, "When undressed I noticed bruising on left leg. Bruising on inner left leg the whole thigh. There's also a bruise on the back of (left) thigh (whole back thigh). There's a bruise at the top of the (left) thigh also." E11 was interviewed on 5/30/07 at 10:07am. E11 described the injury as "the bruising was tremendous".

The investigative report states that on 5/02/07, R2 was taken to the emergency room. It states that R2 was admitted "with a fracture to the left hip". The "Operative Report" from 5/03/07 states under "Preoperative Diagnosis" "Comminuted low left femoral neck fracture with fracture of greater trochanter." Under "Surgical

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W 331	Continued From page 95 Indications" it states, "who had an unwitnessed fall approximately 3 days ago and sustained a displaced low left femoral neck fracture with a fracture of the greater trochanter as well. The patient is taken to surgery at this time for open reduction, internal fixation and placement of hemiarthroplasty." E3 (program supervisor) was interviewed on 5/31/07 at 10:03am. When asked if at any time from 4/26/07 to 5/3/07, was R2 referred to his physician due to his complaints, E3 stated, "Yes, they notified his doctor and he said to take him to the emergency room." When asked if he saw his own physician, E3 stated, no.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.700a)1)2) 350.700b) 350.1030b)3)7) 350.1230c) 350.1230d)1)2)3) 350.1230e)f)g) 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.	W9999		

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W9999	Continued From page 96 Section 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurses' notes for each resident involved. 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. 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.	W9999		

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W9999	Continued From page 97 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. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications. 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 the following: Based on interview and record review, the facility failed to implement their policy to prevent neglect as follows. The facility procedure "Handling, Investigating, and Reporting Unusual Incidents" section 1.212 states, "Neglect is defined as failure to provide adequate medical or personal care or maintenance resulting in physical or mental injury to a resident or in deterioration in resident's physical or medical condition." The facility failed to implement their policy prohibiting neglect as evidenced by: 1) Neglecting to ensure that day training staff implemented the facility procedure "Handling, Investigating, and Reporting Unusual Incidents"	W9999		

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W9999	Continued From page 98 section 8.8 which states, "The nurse or staff responsible for noting the injury is to document the injury and any follow-up to the injury on an Incident Report form," by failing to document a fall on 4/23/07 for R2. 2) Neglecting to implement facility procedure "Obtaining Medical Care For Individuals," section 3.3 which states, "An illness or injury that may be based on staff observation require medical intervention. This may include: Pain - moderate, unrelieved" and section 4.1 which states "Observe the individual, look for signs of illness or injury. Ask questions and look at the area of complaint or injury. Check color, skin temperature and vital signs (blood pressure, pulse, respiration, temperature) as appropriate. Check for swelling, signs for infection, or deformity." The facility neglected to implement these procedures regarding R1 and R2 who were reporting pain, and had a change in condition post fall. 3) Neglecting to implement facility procedure "Handling, Investigating, and Reporting Unusual Incidents" section 3.2 which states, "Upon conclusion of the investigation, the lead investigators will share with the program director their findings. For an ICFDD individual, findings are to be reported within five (5) days. The program director will take any necessary follow-up action to prevent similar incidents from occurring." The facility neglected to implement the recommendations included in their internal investigative report for R2. Findings include: 1) R2, per physicians order sheet (POS) of 5/07	W9999		

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is a 46 year old male with diagnoses of Profound MR, Hydrocephalus, Congenital Cerebral Defect, and Agitated Behavior. The results of an adaptive behavior scale dated 11/04/06 indicate a broad independence score of 4 years 7 months. R2's current Individualized Program Plan (IPP) of 11/17/06 under "Relating" states, "It is difficult for a lot of people to understand me verbally, especially if they do not know me, but I can make my wants and needs known."

According to the summary of an investigative report of 5/8/07, "On April 23rd (R2) fell while on an outing with E6 (direct care -day training) in day program. She turned around and found him sitting on the ground. (E6) assisted him to stand and asked if he was all right. (R2) walked to the vehicle and did not complain of any pain. No report was filled out and this was not reported to the Nurse on Duty or the Supervisor on site." On 4/26/07, according to a day training "Medical Report" and facility "Health Notes," R2 started complaining of pain in his left leg thigh area.

Facility documentation (Intervention Reports, Health Notes, and Social Service notes) states that he continued to make complaints of pain, have incidences of incontinence, and exhibited unwillingness to walk from 4/27 to 4/29 when he was taken to the emergency room. "Emergency Physician Record" from the emergency room visit of 4/29/07 states under chief complaint, "left knee." Under duration/occurred, it states, "yesterday." Under context it states, "unknown if any injury." Under associated symptoms it states, "painful/unable to bear weight."

An Interdisciplinary Team Meeting (IDT) was held 4/30/07 regarding R2. Notes from that meeting

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W9999	Continued From page 100 written by E4 (Qualified Mental Retardation Professional-QMRP) state, "According to (facility staff), (R2) had allegedly been holding his urine for 24 hours, and that this and his complaint about knee pain, was why he was taken to the hospital emergency room on Sunday, April 29, 2007. Several tests were run (UA, vascular Doppler, and knee X-Ray), but all had negative results." A Health Note dated 4/30 states, "When (R2) got undressed noticed 2 bruises one on inner thigh by groin area. It was dark purple on inside of bruise it look (sic) spotted around it. 2 bruise on back outer part of thigh. Color was dark purple and lighter towards outside of bruising." A Medical Report was filled out on 4/30 which stated type of injury, "Bruising/scratches." Area affected stated, "inner/outer left thigh scratch on right knee/left toe." Under "Why did it happen" it states, "Behaviors for the past 4 days." The bruise to the left thigh was documented again in a Medical Report on 5/1. The bruise was again documented on a Medical Report on 5/2. Under "Why did it happen" it states, "When talking with day program staff and staff at home they didn't see (R2) fall or hit anything. (R2) unable to tell us what happened." The investigative report states that on 5/02/07, R2 was taken to the emergency room again. It states that R2 was admitted "with a fracture to the left hip." The "Operative Report" from 5/03/07 states under "Preoperative Diagnosis," "Comminuted low left femoral neck fracture with fracture of greater trochanter." Under "Surgical Indications" it states, "who had an unwitnessed fall approximately 3 days ago and sustained a	W9999		

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W9999	Continued From page 101	W9999		

displaced low left femoral neck fracture with a fracture of the greater trochanter as well. The patient is taken to surgery at this time for open reduction, internal fixation and placement of hemiarthroplasty."

E7 (direct care) was interviewed on 5/30/07 at 9:17am. When asked when she became aware of R2's fall on 4/23, E7 stated, "We just found out about that about a week and a half ago." E8 (direct care) was interviewed on 5/30 at 8:55am. When asked when she became aware of R2's fall on 4/23 E8 stated, "I recently heard about it in the last couple weeks from other staff." E3 (program supervisor) was interviewed on 5/30/07 at 9:28am. When asked when she became aware of R2's fall, E3 stated, "I was never aware that he had fallen at work. I heard it when the investigation was going on."

E10 (program supervisor-day training) was interviewed on 5/30/07 at 10:06am. When asked when she became aware of R2's fall, E10 stated that it was during the investigation. E10 stated that prior to E13 (program supervisor-day training-lead investigator) coming to do staff interviews, one staff reported that she had been on an outing with R2 and that he had a fall. E10 stated that the staff stated that it was "not a real fall" and that she did not write it. When E10 was asked what the day training policy is, E10 stated, "Normally, fill out a medical incident report." When asked if one should have been filled out in this case, E10 said yes.

Additional staff interviewed who reported not being aware of R2's fall are E4 (QMRP), E2 (second shift specialist, E11 (nurse) and E12 (Director of Team Services - day training). E6

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W9999	Continued From page 102 was asked to provide a written statement on 5/30/07. E6 stated, R2 "walked out of the store. When I looked around I saw (R2) on the ground. I helped him up. I thought it was maybe off balance. When I returned I did not write up a medical because I thought it was an innocent fall. When (R2) got up there was no limping." E6 was interviewed on 5/30/07 at 10:35am. E6 stated the fall was in a retail store parking lot. When asked how he was positioned when she saw him, E6 indicated that he was sitting on his buttocks. When asked if she had worked at the day training site on 4/26/07, E6 stated yes. E6 stated that R2 was fine that day. E10 sent a note to the residential facility on 4/27/07 regarding how R2 had been on 4/26/07. The note states, R2 "arrived to work and had some difficulty getting off the bus. He stated his leg hurt and that he needed ice. Ice pack was applied. He would not walk without assistance for the rest of the day." E12 was interviewed on 5/30/07 at 11:12am. E12 was asked what policy contained documenting on medical incidents. E12 provided a copy of "Handling, Investigating, and Reporting Unusual Incidents". When asked where in the policy it was located, E12 stated "Section 8.8". E12 continued, "They are to document anything, if a person falls, anytime anybody falls. Any incident that could cause an injury." 2) a) According to the summary of an investigative report of 5/8/07, "On April 23rd (R2) fell while on an outing with E6 (direct care -day training) in day program. She turned around and found him sitting on the ground. (E6) assisted	W9999		

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W9999	Continued From page 103 him to stand and asked if he was all right. (R2) walked to the vehicle and did not complain of any pain. No report was filled out and this was not reported to the Nurse on Duty or the Supervisor on site." On 4/26/07, according to a day training "Medical Report" and facility "Health Notes," R2 started complaining of pain in his left leg thigh area. The investigative report states that on 5/02/07, R2 was taken to the emergency room. It states that R2 was admitted "with a fracture to the left hip." The "Operative Report" from 5/03/07 states under "Preoperative Diagnosis" "Comminuted low left femoral neck fracture with fracture of greater trochanter." Under "Surgical Indications" it states, "who had an unwitnessed fall approximately 3 days ago and sustained a displaced low left femoral neck fracture with a fracture of the greater trochanter as well. The patient is taken to surgery at this time for open reduction, internal fixation and placement of hemiarthroplasty." Facility procedure "Obtaining Medical Care For Individuals," section 3.3 states, "An illness or injury that may be based on staff observation require medical intervention. This may include: Pain - moderate, unrelieved", section 4.1 which states "Observe the individual, look for signs of illness or injury. Ask questions and look at the area of complaint or injury. Check color, skin temperature and vital signs (blood pressure, pulse, respiration, temperature) as appropriate. Check for swelling, signs for infection, or deformity." The facility neglected to implement these procedures regarding R2 who was reporting pain and had a change in condition post fall.	W9999		

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W9999	Continued From page 104 A "Health Notes" entry dated 4/26 states, "8AM This morning (R2) complaining his left leg thigh area hurts and acting as if he cannot walk. He has no red area on leg and it is possible he is doing this to imitate another individual who is having this problem." A Medical Report from the day training site dated 4/26/07 at 9:00am states, Area affected, "Upper left thigh area." It continues, "Observed that he seemed to have difficulty getting off of the bus. He said that his leg hurt and that he needed ice. He would not walk without assistance and his steps were very slow and laborous." E10 sent a note to the residential facility on 4/27/07 regarding how R2 had been on 4/26/07. The note states, R2 "arrived to work and had some difficulty getting off the bus. He stated his leg hurt and that he needed ice. Ice pack was applied. He would not walk without assistance for the rest of the day." An "Intervention Report" was filled out regarding R2 for the evening of the 4/26. It states, R2 "has been agitated all night complaining of pain and limping. No injury noted - refusing to walk into house, standing in yard screaming. Refusing to walk from one room to another. Grabbing staffs hand and squeezing/twisting fingers." A "Health Notes" entry states that R2 was assessed by a nurse (E11) on 4/26 to have, "no noted injury, bruise, swelling ROM (Range Of Motion) good to lower extremities." However, the note two entries above from 4/26 states his complaint was "his left leg thigh area." A "Health Notes" entry dated 4/27 states, "9:30am c/o (complain of) leg hurting not wanting to move L (left) leg or bear weight with staff watching stating I want ice. Warm pack given to	W9999		

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him he placed it on thigh. Informed ice would hurt more. Continue to monitor." The entry was by E11. A later entry stated he had been given acetaminophen for pain. The last entry for 4/27 states, R2 "was complaining about L leg all night. He was sitting in dining room chair where he became incontinent because he wouldn't get up + go to toilet. He was escorted back to his room where he yelled for awhile."

A "Health Notes entry dated 4/28 states, R2 "refuses to walk when (staff around) but will crawl on hands + knees complaining of pain in left leg. No bruising, discoloration or ... noted." A "Social Service Note" dated 4/28/07, not signed but a tag indicated it was from E1 (administrator) states, "I received a call from (E2) regarding (R2) and how we should react to the behaviors he was displaying. He had been refusing to walk, yelling at staff, refusing to get up to go to the bathroom instead urinating on himself and refusing to shower all day. (E2) stated that he was currently outside on the gazebo sitting and was refusing to come inside. She wanted to know if he should be two person escorted back into the house."

E13 (program supervisor-day training-lead investigator) was interviewed on 5/30/07 at 12:21pm. Regarding how R2 got out to the gazebo, E13 stated it was from a "2 person escort." E13 stated that E2 and E3 had done it. E13 stated that she believed that they had lifted him so that his feet were not touching the ground. E13 stated that if they were doing a two person escort that it was not done correctly. E13 stated that was the reason for the recommendation regarding NCI (behavioral techniques) in the recommendations section of the investigative report. Recommendation #2. in the investigative

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report states, "Review NCI protocol with staff in day program and residential to ensure that there is a proper protocol in place."

A later Health Notes entry dated 4/28 states, "was told by (E2) who talked to (E1) that we are to ignore him. I did put sunscreen and try to coax him to come inside throughout my shift - no luck there. He refused to get up and walk around or come in to bathroom or supper." It continues, "He would stand up, & half way stand up at supper time but would sit back down saying "ouch" (we could hear him through the window) he did this 10 - 12 times. (E2) called and said when 8:30pm gets here and he still won't come inside, to take a pillow and blanket to him." The note states that he did come in at 8:15pm but refused to go to the bathroom or move.

E13 stated that R2 was outside from 3:00pm to 8:15pm. E13 stated that, "He finally did come in with the assistance of a chair." When asked if he used the chair as a walker, E13 stated yes. E13 stated that "Staff were instructed not to take food out to him but to make him come in. A staff disregarded that and took food out to him." When asked who gave the instruction not to take food out to him, E13 stated E1. When asked if R2 had wanted to be outside, E13 stated that "He never indicated he wanted to go out, staff indicated it was because he was having a behavior."

The last paragraph of the social service note of 4/28/07 by E1 states, "I instructed (E2) not to two person escort him back into the house because this seemed to be happening frequently to get (R2) to go to one part of the house or another. I told her I was concerned that someone would get

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hurt if we had to continue to two person escort him. She asked what to do if her (sic) refused to come inside once night fell. I told her that we could take a pillow and blanket out to him if he refused to come inside and check on him frequently but I didn't think he would stay outside all night."

The first entry in the "Health Notes" from 4/29/07 states, R2 "slept in a chair in the living room all night. He wouldn't get up to go to bed. I asked him 3 times if he was ready but he just looked at me. He didn't use the restroom at all since I've been at work (3PM-9AM)" The second entry stated, R2 "stayed in chair all day wouldn't get up to go change clothes, BR or eat, kept saying 'want to go to hospital.'" An incident report dated 4/29/07 at 2:00pm., states, R2 "was refusing to walk X 3 days, had not urinated for 12+ hours despite frequent fluid intake. Was taken to ER for assessment."

The Emergency Nursing Record from the emergency room visit of 4/29, under "Chief Complaint" it states, "Caregiver states pt (patient) has c/o L leg/knee pain and "has not tried to urinate X 24 hrs." Also states that pt is very Dr. oriented and his peer came to hospital a few days ago. Now he wants to see the Dr. Pt encouraged to void and pt immediately voided 500 cc with no difficulty. Caregiver states will not walk." Results of an X-Ray of the Knee and a Doppler study of the left lower extremity were negative.

The first "Health Note" entry for 4/30 (now the fifth day since first exhibiting symptoms) states, R2 "needed assistance with dressing and undressing this morning. Refused to walk or

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W9999	Continued From page 108 brush teeth. He was incontinent." An IDT meeting was held on 4/30/07 regarding R2. In attendance were E2, E10, E1, E3, E14 (nurse) and E4. According to notes from the meeting prepared by E4 (QMRP) R2 "has been refusing to walk and complaining of pain in his knee and all over." Notes of the meeting from E14 state that "The issues with (R2's) behavior were discussed." It continues, "The recent ER visit was discussed and the lack of the physician finding any definitive diagnosis for (R2's) knee and lower leg pain. The comment was made by (E4) that doctors have been known to make mistakes and we should listen to our individuals more closely. It was felt by all who knew (R2) that he had been listened to and he had been taken to ER." It continues with, "it was decided to ignore his behaviors and encourage (R2) to come out of his room and to ambulate." The paragraph ends with, "Everyone was in agreement when the meeting ended that this is how issues with (R2) would be handled." Notes from the meeting from E3 and E2 state, "The group also discussed how (R2) has a history of crying wolf of being sick or mimicking when other are sick. Upon discussing this with the group it was added by (E4) that we needed to keep medical possibilities in mind, all the group agreed." The final paragraph states, "The consensus of group was to ignore maladaptive behavior but to make sure to vigorously praise positive behaviors and to see if by waiting him out this would help." Notes from the meeting from E1 state, "We discussed that (R2's) symptoms began the same time as (R1's) decline and hospitalization. We	W9999		

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W9999	Continued From page 109 talked about (R2's) history of mimicking other people's symptoms and theorized that (R2's) difficulties were behavioral in nature since he had been to the ER and cleared medically. (E4) stated throughout the meeting that we need to keep in mind that it may not be all behavioral. We all agreed with her that we need to keep that in mind." E4 was interviewed on 5/30/07 at 11:52am. When asked if the consensus of the IDT meeting on 4/30 was that it was behavioral, E4 stated, "The majority thought it was behavior, I wouldn't say it was consensus." R2 currently has a behavior program for "head banging, slamming things, hitting others, kicking and biting others, swearing, yelling, throwing things and head butting." R2's behavior data was reviewed from January of 2007. The data indicates the following frequency; 1/07=2 incidents, 2/07=0 incidents, 3/07=1 incident, and 4/07 up until 4/22=5 incidents. Review of all the notes available from the IDT meeting of 4/30, no recommendation is made regarding having R2 follow-up the emergency room visit with a visit to his personal physician. E11 was interviewed 5/31/07 at 10:30am. When asked if a referral had been made to his physician, E11 stated that he had seen the ER doctor on 4/29 and 5/2. When asked specifically did he see his regular physician, E11 stated no. E11 was interviewed on 5/30/07 at 10:07am. When asked if any recommendation had been made to check R2's temperature, pulse,or blood pressure, E11 stated, "No, just monitor for bruises, swelling, range of motion." Facility procedure "Obtaining Medical Care For	W9999		

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W9999	Continued From page 110 Individuals", section 3.3 states, "An illness or injury that may be based on staff observation require medical intervention. This may include: Pain - moderate, unrelieved." Section 4.1 states "Observe the individual, look for signs of illness or injury. Ask questions and look at the area of complaint or injury. Check color, skin temperature and vital signs (blood pressure, pulse, respiration, temperature) as appropriate. Check for swelling, signs for infection, or deformity." E14's notes from the IDT meeting of 4/30 state, R2 "did come out of his room by the end of the meeting. He initialed (sic) walked but then crawled down the hallway. Eventually he did get up and walk. Attempted to use a dining room chair as a walker but that was taken away from him. He eventually walked to a chair in the living room and sat down." A Health Note dated 4/30 states, "When (R2) got undressed noticed 2 bruises one on inner thigh by groin area. It was dark purple on inside of bruise it look (sic) spotted around it. 2 bruise on back outer part of thigh. Color was dark purple and lighter towards outside of bruising." A Medical Report was filled out on 4/30 which stated type of injury, "Bruising/scratches." Area affected stated, "inner/outer left thigh scratch on right knee/left toe." Under "Why did it happen" it states, "Behaviors for the past 4 days." An unsigned "Individual Consultation" note of 4/30 states, R2 "was sitting in living room, he then crawled into dining room and sat @ table + ate for 1 hour + 15 minutes. Staff asked (R2) to leave dining room so they could mop. (R2) began to scream + curse @ staff. Staff walked	W9999		

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away + after 5 minutes came back. (R2) was still standing holding onto table refusing to let go. After multiple attempts + re-directions by staff, 2nd shift staff grabbed the table + pulled table to doorway of dining room (with) (R2) walking behind it."

A Health Note of 5/1 at 9:00am. states, R2 "came up for breakfast this AM with a lot of prompts, crawled down the hallway. After breakfast with more prompts got him back to his bedroom. @ present X (time) 1:45pm., sitting on bed putting on clothes, asking for bag of ice." A medical report of 5/1 with the time of 7:00pm states, "While getting (R2) ready for shower noticed bruising to left thigh. Approximately 3 inches in length and yellowish in color. Appeared to be a few days old." Report form states that E11 (nurse) was notified. Again no indication of a referral to his physician.

A note from day training by E10 regarding R2 at work on 5/2 states "At lunch time, he would not walk into the break room, wanting to eat in the "shower room." (R2) was told he could not eat in the shower room, and the only area's eating was allowed at work was the break areas. (R2) put his lunch down and "crawled" on his hands and knees back to area C."

A Medical Report regarding R2, dated 5/2 and with the time listed as 7:45pm states, "Bruise on inside of (left) thigh. There's a bruise on the back of thigh also." The report states that R2 was taken to a Medical facility at 7:45pm. A Health Note dated 5/2 from E11 states, "When undressed I noticed bruising on left leg. Bruising on inner left leg the whole thigh. There's also a bruise on the back of (left) thigh (whole back

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W9999	Continued From page 112 thigh). There's a bruise at the top of the (left) thigh also." E11 was interviewed on 5/30/07 at 10:07am. E11 described the injury as "the bruising was tremendous." The investigative report states that on 5/02/07, R2 was taken to the emergency room. It states that R2 was admitted "with a fracture to the left hip." The "Operative Report" from 5/03/07 states under "Preoperative Diagnosis" "Comminuted low left femoral neck fracture with fracture of greater trochanter." Under "Surgical Indications" it states, "who had an unwitnessed fall approximately 3 days ago and sustained a displaced low left femoral neck fracture with a fracture of the greater trochanter as well. The patient is taken to surgery at this time for open reduction, internal fixation and placement of hemiarthroplasty." E3 (program supervisor) was interviewed on 5/31/07 at 10:03am. When asked if at any time from 4/26/07 to 5/3/07, was R2 referred to his physician due to his complaints, E3 stated, "Yes, they notified his doctor and he said to take him to the emergency room." When asked if he saw his own physician, E3 stated, no. b) Per record review of a Medical Report dated 04-02-07 completed by E8, Direct Care Staff working with R1 on that morning, R1 was found to be incontinent sometime between 5:00a.m. and 6:00a.m., so E8 took him to get a bath. E8 stated that R1 kept repeating, "I got problems," but did not explain what the problems were. During the bath, R1 made a sudden loud yell. R1 returned to his bedroom to get dressed in the clothes which were laid out for him. E8 left to help another resident. As E8 left the room, she	W9999		

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heard what sounded like someone fall, and returned to find R1 face down on the floor, bleeding from his mouth, eyes open but not responsive. E8 stated R1 "appeared unconscious." E8 verified these events in an interview at 8:38a.m. on 05-30-07.

The extent of the injury was verified per interview at 9:06a.m. on 05-30-07 with E2, Second Shift Specialist, who described the injury as "an egg standing out three inches on his forehead." "It was a really bad fall."

This information was confirmed by an Incident Report completed by E1, Administrator, and dated 04-02-07. The report states, R1 fell in his bedroom at 6:21a.m. on 04-02-07. R1 sustained a bump to his forehead and a bruise to his left eye. R1 was unresponsive. 911 was called and R1 was transported to the emergency room for treatment, and was returned to the facility. The Incident Report indicates R1's family was notified on 04-02-07. No time is indicated for the notification.

Per review of another Medical Report written by E15, dated 04-02-07 at 8:45p.m., R1 "fell on his bottom on the bathtub bottom" when E15 turned away to get a wash cloth while attempting to clean R1 following an incident of incontinence.

During a telephone interview at 1:18p.m. on 05-30-07, E15 verified the events reported in the Medical Report, and added that she had to wheel him into the bathroom in a wheelchair because he wasn not walking or bearing weight at that time. E15 stated that she called other staff for help and checked (R1) for bruising. E15 was asked if she was trained to assess for fractures,

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and replied, No." E15 was asked why there was no documentation in the Health Notes, and stated, "I forgot."

On 05-30-07 at 12:52p.m., E2, Second Shift Specialist, was asked why the second fall on 04-02-07 was not mentioned in the Health Notes. E2 responded, "I would guess (E15), who was working with him (R1), just forgot to do it."

A review of hospital records showed that R1 was seen in the emergency department at 7:05a.m. on 04-02-07 following a fall. Findings included periorbital ecchymosis, swelling to the left forehead, and laceration to the left side of the tongue. A CT scan was ordered, where the hematoma was identified, but no depressed skull fractures were seen. R1 was diagnosed with a concussion, and returned to the facility that evening. According to the hospital nurse's notes, at 1400 (2:00p.m.) R1 was "ataxic - attempt to walk - unable s (without) mech(anical) assist." "1500 (3:00p.m.) Unable to ambulate per norm(al). (Physician) notified - will hold and eval(uate) walk again in an hour." "1800 pt (patient) able to walk p (after) several attempts, not 100%."

According to additional hospital records, R1 was admitted on 04-27-07 for complaints of weakness of unknown origin, vomiting,, anemia, and epigastric pain and discomfort. A urinary tract infection was identified. An EGD (Esophagogastroduodenoscopy) was performed and showed a large duodenal ulcer and multiple gastric ulcers. R1 was treated and released on 05-01-07, with discharge instructions to "followup with (Z5) next week."

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W9999	Continued From page 115 Per review of more hospital records, R1 was again admitted to the hospital when a right hip fracture was identified on a post-hospital office visit with Z5 on 05-08-07. According to Z5, "the caretaker stated that he (R1) has been unable to weight bear particularly favoring his right leg right thigh with it flexed, and complaining of it a lot." Z5 continues that, "we were able to carry him onto the x-ray table were (sic) a lateral view of the hip shows a definite impacted femoral neck fracture. The X-Ray report, dated 05-08-07, from the hospital defines, "a comminuted severely fragmented transcervical fracture of the right hip identified. The fracture extends from the base of the femoral head to the trochanteric region." When the x-ray was observed by this surveyor, the trochanter was noted to be lying in the acetabulum, completely severed from the femur, which was fragmented on the proximal end and situated approximately 2-1/2 inches lateral to the trochanter. Z4 stated when he read the x-ray, "It's a very bad fracture." Z4 also stated that it was possible that the severe fragmentation could have been caused by bearing weight on the fracture. Following a consultation at the hospital, on 05-08-07, a hemiarthroplasty (right hip replacement) was recommended. The surgery was performed on 05-09-07. According to the Operative Report, upon viewing the fracture site, a definitive diagnosis was made of a widely displaced femoral neck fracture and greater trochanter fracture. It is noted to be an old injury of about three to four weeks ago.	W9999		

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W9999	Continued From page 116 In an interview at 3:32p.m. on 05-29-07, Z1 stated Z7 told him following the surgery that he (Z7) believed the fracture happened several weeks ago and it had to be a really hard fall to cause that. During this hospital stay beginning on 05-08-07, R1 was treated for pressure ulcers/decubitus, which were described as "Type D (Decubitus); Site Sacral; Size 2 - Quarter size; Color Red; Drainage (zero); Odor (zero); 2 - partial thickness skin loss c (with) surrounding area red." Post-Operative Orders include decub(itus) precautions (pt has sacral decubs). In an interview on 05-29-07 at 12:20p.m. Z6 verified that R1 had two stage II decubiti and that they were being treated with Xenoderm. On 05-12-07, R1 was transferred to the rehabilitation unit of the hospital where he stayed until 05-29-07, at which time he was discharged to a nursing home for further recuperation. During an interview on 05-30-07 at 1:37p.m., E11, Licensed Practical Nurse, acknowledged that she had been notified of the 6:21a.m. fall on 04-02-07. When asked if E11 had come to the facility to assess R1 upon his return home from the emergency department, E11 stated that she did not, and added that it was Doctor Day that day and she left at 5:30p.m., but the facility had notified her and E11 instructed staff to monitor him and use fall precautions. E11 was then asked if she had been notified of the fall into the tub on that same night. E11 replied that she had not, but that she did see that it was noted a day or two later. E11 was asked if	W9999		

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W9999	Continued From page 117 she had assessed R1 when she found out about the 8:45p.m. fall which occurred on 04-02-07. E11 stated that she did, but when asked when, replied, "I don't know." There was no notation of the assessment in any of R1's documentation (Health Notes, Communication Log, Medical Report, Incident Report, or Individual Consultation Sheets.) E11 was asked where the nurses document their visits to the facility, phone calls from the facility, and assessments performed. E11 stated, "I do all documenting in the Health Notes in their charts." E11 acknowledged that direct care staff is trained in basic assessments, but "probably not in assessing for fractures." When asked if it was facility policy to initiate neurological checks following head injuries, E11 responded, "If we're here, we do." E14, Registered Nurse, Health Services Specialist, was interviewed on 05-31-07 at 1:55p.m. E14 was asked if she was to be notified following an injury or possible injury. E14 replied, "Not necessarily immediately; it depends on the time it occurs," and explained that she is not on-call. E14 was asked if she comes to assess for injuries, and again responded, "Not necessarily, I might refer it to another nurse." E14 stated that if she did come to assess, the findings would be charted in the Health Notes in the individual's chart. E14 was asked if neurological checks would be ordered following a head injury. E14 responded, "I would want it done." E14 added that if staff were trained in performing neuro checks, she	W9999		

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was not aware of it, and added that she is planning to make some changes regarding the delivery of health care to the residents.

E14 was then asked if she had been notified of R1's ongoing complaints and refusals to walk or be touched, or dressed, etc. and what her response had been. E14 stated that she had not been notified, and that she got involved when staff reported that the sister had made a list of her concerns she wanted addressed at R1's next doctor appointment.

During a review of Intervention Reports for tracking behaviors, a report dated 04-16-07 at 8:30p.m. states, "refusing to stand up so staff can change him due to incontinence he droped (sic) to the floor, was screaming, was grabbing at staff, (we gave him 5 min to do on his own, didn't happen so staff grabed (sic) a gait belt and we two men lifted him to his walker, got him to the bathroom where he went down to floor forcefully, again two of us lifted him up again to the toilet where we changed him and again (the gait belt went back on and we) two man him to bed ."

There is a physician's telephone order slip dated the following day, 04-17-07 "Okay to use gait Belt."

On 04-17-07, there are several Intervention Reports. At 6:10p.m, R1 is described as anxious at dinner. "(R1) refused to stand up and walk (even with walker) to go sit in living room. He procedded (sic) to yell & stick his fingers in his mouth." At 6:30p.m., "anxious all evening. Putting himself on the ground, refusing to get up & sit in chair." "(R1) was repeating himself over & again. He threw himself onto ground (not hard)

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	14G296	A. BUILDING _____ B. WING _____	C 06/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NINTH STREET PLACE	2850 9TH STREET ROCK ISLAND, IL 61201

(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 119 & was scooting around on the floor." At 7:00p.m., "anxious all evening." "yelling very loudly." A review of the Residential Alternatives Health Notes of 04-02-07 at 2:20p.m. written by E7, direct care staff, verify, while in the emergency department, "gait very unsteady wouldn't stand up straight or walk." There is no nursing entry until 04-03-07 when E14 entered a "New medication order," no mention of an assessment or findings. There are several entries describing R1 as chewing on his hands in the ensuing days. This is identified later as something R1 does when he is in pain. R1 is described as "leaning towards the right and unsteady at times on 04-05-07. On 04-06-07 at 11:30p.m., R1 is "sitting on his bedroom floor." On 04-08-07, (R1) " refused to walk when stood would try to drop. Staff walked him w/gait belt and full assist." Entries on 04-09-07 report balance and walking unsteady, also having difficulty getting undressed and redressed. An entry on 04-10-07 states, (R1) "was being difficult when it was time for bed. He didn't want to get off the toilet and go to his bed." On 04-11-07, E7 took R1 to an eye doctor appointment and charted, "while trying to walk (R1) he is doing a lot of unsteady walking and leaning to R (right) side - doesn't bear weight to (sic) well." R1 is described as "getting too anxious. I struggle getting him in the shower," on 04-13-07. Then on 04-14-07 (R1) "wouldn't even try to walk away from table. 2 staff had to assist him back to the	W9999		

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W9999	Continued From page 120	W9999		

chair. All he would do is try to drop to floor and get upset. On 04-16-07, "still doesn't want to walk." On 04-17-07, "didn't want to stand or walk for staff; had to use W/C to transport. Similar entries continue throughout the charting describing him yelling, chewing on his fingers, saying "I got problems" over and over, leading up to his hospitalization on 04-27-07. In April Health Notes there were only four entries noted by nursing, three of which only refer to physician orders and do not even mention seeing R1, and one on 04-10-07, eight days after the falls, when E11 assesses R1's eye and describes walking with R1 from the bus "leaning forward about 30-40 (degrees.)"

On 04-25-07, E18, direct care staff, charted, "I am concerned about the bump that is still on his (R1's) forehead from his fall." Per interview on 05-30-07 at 9:06a.m., E2 was asked about the entry and the bump remaining for so long. E2 responded, "It's still there. It's fading a little, but you can still see it."

The Residential Alternatives Com Logs for this time period had similar entries regarding these abnormal behaviors and not sleeping. Individual Consultation notes start on 05-01-07, the day of his discharge from the hospital admission when the urinary tract infection and the multiple ulcers were identified. The entries are much the same, describing "refusing to bear weight, yelling, pushing, and grabbing at staff; chewing on fingers, yelled like he was getting hurt; yelling at us to stop, wait a minute, struggling; took 3 staff to accomplish getting him up and dressed; resisting assistance to transfer; yelled no, don't touch me, okay, okay."

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W9999	Continued From page 121 Written statements obtained by the facility during the course of their investigation also verify the documentation by staff. The consensus seems to be that R1 "had been acting normal prior to the fall" and "wasn't the same after the fall." 3) The Investigative Report into R2's fracture lists 5 recommendations which include: 1. All staff at (facility), Day Program and QMRP to be refreshed in documentation protocol. 2. Review NCI (behavior intervention) protocol with staff in day program and residential to ensure that there is a proper protocol in place. 3. When taking an individual to the hospital or doctor appointment report medical facts only. 4. Any time a fall occurs a medical report must be filled out. Refresh on protocol with (E6). 5. Ensure individual's privacy and dignity are maintained. E7 was interviewed on 5/30/07 at 9:17am. When asked if any inservice training had taken place regarding documentation protocol, E7 stated no inservice, but just be sure to date and time it. E8 was interviewed on 5/30/07 at 8:55am. E8 also stated there had been no inservices since the injury. E2 was interviewed on 5/30/07 at 9:12am. E2 stated that there had been 3 different inservices but none were fracture oriented. E3 when interviewed on 5/30/07 at 9:28am., stated that there was a memo and we talked about unusual incidents. E4 (QMRP) was interviewed on 5/30/07 at 11:35am. When asked if there had been any training since the incident, E4 stated, "Not that I'm aware of." E12 (Director of Team Services) was interviewed on 5/30/07 at 10:55am. When	W9999		

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W9999	Continued From page 122	W9999		

asked if there had been any disciplinary action regarding E6, E12 stated, "No not at this time." When asked about retraining, E12 stated, "Not that I'm aware of." When asked who would be responsible, E12 stated, "I would." While conducting interviews at the day training site, E10 informed surveyor that E6 had left on an outing but had been notified to return to site.

E3 and E2 were interviewed on 5/30/07 at 2:15pm. When asked if there had been any training on NCI protocol, both stated it had been in April on the 12th. When asked if any NCI training had been done since the incident with R2, both stated, no. E3 stated that NCI is only offered every 2 months. E13 (lead investigator) was interviewed on 5/30/07 at 11:05am. When asked who was responsible for implementing the recommendations from the investigation, E13 stated, "I believe it would be the director and the supervisor of (the facility)." When asked if there was evidence of the recommendations being implemented, E13 stated, "Not that I'm aware of ." E13 stated that there was a memo sent out regarding documenting incidents when they happen.

The facility provided copies of two memos regarding documentation dated 5/21/07 and medical information dated 5/22/07. The memos are addressed to all facility employees. Neither contained signatures indicating that staff had reviewed and understood.

The facility provided a document titled "Recommendations regarding resident care." E5 (Associate Director of Residential Services) was interviewed on 5/31/07 at 2:05pm. When asked when this document was done, E5 informed

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W9999	Continued From page 123 surveyor that it was written 5/25/07 and reviewed by management on 5/29/07. When asked who had written the document, E5 stated it was E16. The recommendations include: 1. The IDT must identify and seek a medical opinion for all indicators of pain, illness, or possible injury. Any employee who observes signs of pain or witness a fall must file a report. It lists the persons responsible as all AEDs who will prepare a memo for their employees and ensure that all program directors formally address with their staff in department meetings. A time frame is listed as 6/30/07. 2. Request that nursing personnel prepare a survey for assessing potential fractures. A time frame is listed as 6/30/07. 3. When an individual refuses to bear weight or demonstrates other indicators of possible fracture as indicated in the survey above, the IDT must seek medical assessment and request X-Rays of both sides from waist down. A time frame is listed as 6/30/07. 4. QMRP must expressly review and confirm all IDT decisions, including Who/What/When before adjourning meeting. The QMRP should also ensure that contrary opinions are recorded and debated until consensus is achieved. If consensus cannot be achieved, the IDT should defer a decision until the issue is resolved. A time frame is listed as 6/30/07. 5. Retrain (facility) staff on NCI and proper techniques for 2-person escorts. A time frame is listed as 7/15/07.	W9999		