STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G378	A. BUILDING _____ B. WING _____	C 12/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLUND MILL CREEK HOME 4	1 S 410 WYATT DRIVE GENEVA, IL 60134

(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
W 192	Continued From page 14 R2's CNA Flow Sheet notes that R2 is to be repositioned "Every 1 - 2 hours." E1 (Acting Administrator) was interviewed 11/17/06 regarding R2's abrasions sustained 11/3/06. E1 stated R2 is supposed to be repositioned every 2 hours. E5 failed to demonstrate the competencies directed towards R2's repositioning needs.	W 192		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.670e) 350.670f)2) 350.670f)3) 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 350.670 Personnel Policies e) All personnel shall have either training or experience, or both, in the job assigned to them. f) Orientation and In-Service Training 2) All employees, except student interns, shall attend in-service training programs pertaining to their assigned duties at least annually. These	W9999		

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W9999	Continued From page 15 in-service training programs shall include the facility's policies, skill training and ongoing education to enable all personnel to perform their duties effectively. The in-service training sessions regarding personal care, nursing and restorative services shall include information on the prevention and treatment of decubitus ulcers. In-service training concerning dietary services shall include information on the effects of diet in treatment of various diseases or medical conditions and the importance of laboratory test results in determining therapeutic diets. Written records of program content for each session and of personnel attending each session shall be kept. 3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. 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 REQUIREMENTS were not met as evidenced by: Based on interview and record review the facility failed to implement their policy to prohibit neglect when they failed to: 1. Ensure R1 was properly transferred, causing a fall resulting in a laceration and fractured jaw, and 2. Ensure R2 was repositioned as necessary resulting in abrasions to cheek and chin and	W9999		

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W9999	Continued From page 16 Findings include: 1) R1, per review of her 9/26/06 IPP (Individual Program Plan), is a 24 year old female whose diagnoses include Profound Mental Retardation, Cerebral Palsy, Spastic Quadriparesis, Scoliosis, Microcephaly and Encephalopathy. R1 is non-ambulatory/non-mobile and non-verbal. R1 was observed 11/17/06 at 12:25pm. Review of Incident Report, dated 11/10/06 and subsequent facility investigation noted the following: On 11/10/06 at approximately 8:00pm E8 (LPN) was notified that R1 "... slipped from sling during transfer post bath." R1 sustained a laceration to her chin. The laceration was 2 inches in length and 1/2 inch in width (as documented by E8). R1 was transported to the local hospital for evaluation. R1 received 8 sutures to her chin. R1 was also diagnosed with a fractured jaw. The facility's investigation concluded: "After a thorough investigation it's the opinion of the investigating team that (Z2), despite knowing how to find the proper lift status in multiple places, chose not to follow (R1's) lift status resulting in her fall. Thus failure to follow the client's designated lift status resulted in injury and is therefore thought to be negligent." Z2's written statement, per the investigation, notes: On 11/10/06 at approximately 8:10pm Z2 began to transfer R1, via a mechanical lift, from the changing table to her wheelchair. R1 was crying and moving and one of the loops on the mechanical lift became disengaged. R1 fell out of the sling and onto the floor. Z2 was doing a 1	W9999		

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W9999	Continued From page 17 person transfer with R1 at this time. Z2 was interviewed 11/20/06 at 1:20pm via telephone call. Z2 stated at approximately 8:00pm on 11/10/06 he gave R1 a bath. After dressing R1, he (Z2) was using a mechanical lift to transfer R1 from the changing table to her wheelchair. R1 was in the mechanical lift when one side of the sling became unhooked. R1 fell out of the sling and landed on the floor on her left side. R1 landed on her face. Z2 stated he did a 1 person transfer of R1. Z2 stated he forgot to look at R1's information on her wheelchair which notes that R2 is a 2 person transfer/lift. E1 (Acting Administrator) was interviewed 11/17/06 at 2:20pm. E1 verified R1 was a 2 person transfer/lift on 11/10/06 when she sustained a laceration and fractured jaw. On 11/20/06 E1 measured the distance from the changing table to the floor and approximated the distance R1 fell at 42 inches (3 feet 6 inches). The facility's policy on Suspected Abuse, Neglect or Mistreatment of a Client (Unusual Events) last updated 7/1/05, identified 3 definitions of Neglect. The facility policy defined Neglect according to the Federal regulations - The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The policy also defined Neglect according to Illinois Department of Public Health and Office of Inspector General. Both definitions, in part, identifying Neglect as a failure to provide adequate medical or personal care or maintenance which failure results in physical or mental injury. Z2 failed to use a 2 person lift/ transfer of R1 on 11/10/06 - resulting in R2 sustaining a laceration to her chin and a fractured	W9999		

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W9999	Continued From page 18 jaw. Z2 neglected to use an appropriate lift/transfer technique with R1 resulting in her fall and injuries. 2) R2, per review of her 6/20/06 IPP (Individual Program Plan), is a 35 year old female whose diagnoses include Profound Mental Retardation, Microcephaly, Seizure Disorder, Spastic Quadriparesis, Cortical Blindness and Osteoporosis. R2 is non-ambulatory / non-mobile and non-verbal. Review of facility Incident Report, dated 11/4/06, noted that on 11/3/06 R2 sustained abrasions to her left cheek and left chin area. The abrasions were measured as, 4 1/2 cm (centimeter) X 2 cm to left cheek and 4 cm X 1 cm to chin area. The facility investigated R2's abrasions and noted the following: R2's face became red from laying prone and on side of face on a sheet. Redness to face continued for 24 hours. Skin care and lotion applied to area. E5 (CNA) provided a written statement regarding the abrasions R2 sustained. E5 documented - "Last night (11/3/06) we laid (R2) down prone on bean bags. We had inservice and then I cooked dinner and did several other things and got her up after 3 - 4 hours...." E8 (LPN) documented, "I failed to tell the CNA to move her (reposition) from the prone position..." R2's CNA Flow Sheet notes that R2 is to be repositioned "Every 1 - 2 hours." E1 (Acting Administrator) was interviewed 11/17/06 at 2:20pm regarding R2's abrasions	W9999		

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W9999	Continued From page 19 sustained 11/3/06. E1 stated R2 is supposed to be repositioned every 2 hours. E1 stated the facility's investigation does not address E5's statement that R2 was not repositioned for 3 to 4 hours. E5 failed to reposition R2 resulting in R2 sustaining abrasions to her left cheek and chin area. (A)	W9999		