STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G311	A. BUILDING _____ B. WING _____	C 11/21/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER COURT	760 EAST RIVER STREET KANKAKEE, IL 60901

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W 149	Continued From page 6 on 11/9/06 at 11:00 AM. She stated that IDPH was not notified of the R3's fall and injury of 10/29/06, because it was not an unknown injury. She confirmed that R3 had received medical care related to the fall. 5. E3 was interviewed on 11/9/06, at 9:30 AM. She states that injury trends and falls are monitored in the quarterly Quality Assurance (QA) meetings. The QA notes were reviewed from April 2005 to present. The facility staff could not find the QA notes for July, August and September 2005. The available notes did identify R3's falls, however recommendations were not made. The comment / consideration sections were blank and the section containing the following, "Patterns and or / Trends noted: If yes, plan implemented to prevent future accidents or incidents" was either blank or stated, "None." R3's level of supervision, pattern of falls and injuries, and functional assessments were not addressed in the QA notes. The facility failed to monitor trends of R3's falls and injuries, conduct reassessments as needed and implement interventions to protect her from further injury.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.700a)1) 350.700a)2) 350.1060a) 350.3240a) 350.3240c) 350.3240d)	W9999		

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W9999	Continued From page 7 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 350.700 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. 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	W9999		

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W9999	Continued From page 8 or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These Requirements were not met as evidenced by the following: Based on record review and interview it was determined that for 1 of 3 residents (R3), the facility failed to: 1. Implement policies and procedures which are set up to protect residents from mistreatment, neglect or abuse. 2. Review and update R3's individual service plan, including functional assessments, as needed. 3. Notify R3's guardian promptly of condition changes and incidents. 4. Report incidents which require medical care to Illinois Department of Public Health (IDPH). 5. Monitor incident trends for possible neglect or mistreatment, and implement interventions as needed. Findings include: 1. R3's case file was reviewed on 11/8 and	W9999		

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W9999	Continued From page 9 11/9/06. The file contained documentation that R3 is a 57 year old with diagnoses of Profound Mental Retardation, Chronic Schizophrenia, Hydrocephalus and Seizure Disorder. The Individual Service Plan (ISP), dated 7/6/06, indicated R3 was admitted to the facility on 9/20/1993 and that she primarily communicates her basic needs through gesture and sound effects, and that her primary language is Spanish. It further stated that she uses a wheeled walker to ambulate and wears a helmet and gait belt. The Qualified Mental Retardation Person (QMRP) (Z1), at day training (DT) was interviewed on 11/8/06 at 1:30 PM. She stated that at times R3 also uses her wheelchair at day training. A facility Direct Service Person (DSP) (E5) stated, during an interview on 11/8/06 at 3:00 PM, that R3 also uses her wheelchair at home. Facility policy titled, "Investigative Committee, #5.24" required, "The facility shall establish an Investigative Committee to assist in the protection of individual resident rights... Purpose: The Investigative Committee shall be responsible for the following: A. To identify, review and determine if alleged violations of any individuals' rights, including abuse and neglect, have occurred. C. To protect individuals from further harm." The RN's (E6) progress notes, dated 10/30/06 at 10:15 (AM), stated that R3 had sustained bruising and swelling to the face and right hand. E6 was interviewed on 11/8/06 at 10:00 AM. She stated that she asked R3 in Spanish, the morning of 10/30/06, if the injuries were caused by a fall out of bed and that R3 had nodded yes and said, "Si." X-rays, taken at the hospital the next day,	W9999		

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W9999	Continued From page 10 10/30/06, were negative for fractures. A head CT, taken on 11/13/06, concluded that, "...some superficial scalp soft tissue swelling [along the]...posterior, superior parietal region. There is otherwise no definite acute traumatic intracranial hemorrhage." The ISP, dated 7/6/06, contained documentation that R3 has a history of 4 nasal fractures '92, '95, '02, and '05. The quarterly nurse's note, dated 4/5/02, stated the '02 fractured nose was from a fall. The Emergency Department documentation, dated 7/4/05, stated the nasal fracture which occurred that day, was also from a fall. The home and DT files indicated that since 3/25/05, R3 fell 5 times at the home and 6 times at the DT site. Six of the falls resulted in injuries. Three of the falls were out of chairs, including the wheelchair. The file lacked a wheelchair assessment. The home and DT files contained a physical therapy (PT) evaluation dated 6/14/04, and an occupational therapy (OT) evaluation dated 2/9/05. The PT recommendation, from 6/04, was as follows, "...Contact guard assistance during ambulation for safety." The OT evaluation, from 2/05, included the following, " Balance: Impaired, at risk for falls - needs supervision for safety." The ISPs dated 7/15/05 and 7/6/06 stated, "R3 requires contact guard assistance at all times, with a stronger hold with turning or changes in surfaces" and that she "continues to require the 24 hr. staff supervision provided by the facility." R3's file lacked documentation that her supervision level had been reassessed after the falls. The Facility Trainer (E3) was interviewed on 11/9/06 at 9:30 AM. She confirmed the latter and stated the level of supervision is incorporated in	W9999		

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W9999	Continued From page 11 the ISP and that there is no specific, additional, assessment form. The dates of the PT and OT assessments and the lack of a wheelchair assessment was confirmed by the facility QMRP (E2) on 11/9/06. Additional incident and progress notes from the DT site contained documentation that since the fall of 10/29/06, R3 had slipped out of her wheelchair twice on 10/31/06, twice on 11/6/06 and once on 11/8/06 and that E2 had been notified. E2 stated during a phone interview on 11/8/06 at 9:30 AM, that there had not been a special team meeting conducted regarding R3's frequent falls, but that a PT reassessment was ordered after the fall of 10/29/06, and the appointment should take place within the next 2-3 weeks. 2. Facility policy titled, "Physical Injury and Illness/Individual Medical Emergencies, #5.57", required, "Procedure: In event that an individual sustains an injury or illness...F. The QMRP shall notify the guardian as soon as possible." The ISP, dated 7/6/06, indicated that R3's father was her guardian. However, additional QMRP progress notes not in R3's file, regarding guardian contact and the 10/29/06 injury, were obtained the second afternoon of this investigation, on 11/9/06. A note, written by E2, and dated 7/25/06, contained the following, "I was informed by the previous RSD [QMRP] that R3's father had passed away and that R3's brother was now the guardian...I called the number I have and when I asked for Carlos (brother) there was no response...the person answering the phone didn't speak English." The progress notes indicated that E2 unsuccessfully	W9999		

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W9999	Continued From page 12 called the same number on 9/18, 10/30, 10/31 and 11/2/06. The notes lacked documentation that an attempt was made to contact R3's family regarding an injurious fall, which occurred on 10/4/06. A note, dated 11/9/06, indicated a facility staff member provided additional information which enabled E2 to contact R3's sister, who then agreed take over guardianship. E2 confirmed the above findings on 11/9/06 at 2:30 PM. 3. The facility Administrator, E1, was interviewed on 11/9/06 at 11:00 AM. She stated that IDPH was not notified of the R3's fall and injury of 10/29/06, because it was not an unknown injury. She confirmed that R3 had received medical care related to the fall. 4. E3 was interviewed on 11/9/06, at 9:30 AM. She states that injury trends and falls are monitored in the quarterly Quality Assurance (QA) meetings. The QA notes were reviewed from April 2005 to present. The facility staff could not find the QA notes for July, August and September 2005. The available notes did identify R3's falls, however recommendations were not made. The comment/consideration sections were blank and the section containing the following, "Patterns and/or Trends noted: If yes, plan implemented to prevent future accidents or incidents" was either blank or stated, "None." R3's level of supervision, pattern of falls and injuries, and functional assessments were not addressed in the QA notes. The facility failed to monitor trends of R3's falls and injuries, conduct reassessments as needed and implement interventions to protect her from	W9999		