STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G077	A. BUILDING _____ B. WING _____	11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEGUIN RCA HARVEY HOUSE	3309 SOUTH HARVEY AVENUE BERWYN, IL 60402

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W 369	Continued From page 18 R2 does not have any verbal skills and is able to ambulate independently. During medication pass observation on 11/20/2006 at 4:40 p.m., R2 did not receive any medications. R2 was observed at the dinner meal from 4:55 p.m. to 5:25 p.m. R2 was observed to be given a glass of milk and R2 drank the milk. During reconciliation of the medication administration pass on 11/21/2006, it was noted that when R2 is receiving milk, R2 is to receive Lactase 3,000 Units Caplet. R2 did not receive Lactase 3,000 Units Caplet during the medication administration pass on 11/20/2006. E3, nurse, validated on 11/21/06 at 1:45 p.m. that R2 did not receive the Lactase 3,000 Units Caplets as ordered by the physician. E3 states the clients usually do not have milk at the dinner meal and that is why R2 did not receive her Lactase 3,000 Units Caplet. E3 failed to give R2 her medication as ordered by the physician.	W 369		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.700a)1)2) 350.700b) 350.700c) 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	W9999		

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W9999	Continued From page 19 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. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurses' notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. 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 were not met as evidenced by the following: Based on interview and record review, the facility failed to implement policies to prevent neglect for	W9999		

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W9999	Continued From page 20 one individual, R5. R5 has a physician's order for a bed alarm and side rails due to history of falls. R5 was admitted to the hospital on 9/12/06 with a basilar skull fracture; the probable cause was a fall. Findings include: The Client Profile review states R5 is a 49 year old male whose diagnoses include Profound Mental Retardation, Generalized Convulsive Epilepsy, Cerebral Degeneration, Unspecified Phenylketonuria, Urinary Incontinence, Hydrocele, Unspecified Dysphagia and Atypical Mood Disorder. R5's 7/12/06 Individual Program Plan (IPP) states "(R5's) gross motor skills are limited due to his hemiplegia. He has an unsteady gait and frequently loses his balance." The IPP further states R5 needs assistance, supervision and prompting in the areas of self care, language, learning, mobility, self direction and capacity for independent living. There is no evidence that R5 had a bed assessment to determine R5's safety needs while he is in bed. E2, QMRP, was interviewed on 11/28/06 at 10:00 a.m. and confirmed that R5 has not had a bed assessment performed. R5's 2/8/06 Behavior Management Program (BMP) identifies his target behaviors as: "1. Pica Behavior - Eating or attempting to eat various objects or substances which may be lying on a table, floor or other areas (this includes food spilled or dropped on the floor and may include various grooming supplies). 2. Hyperactive Motor Activity - Getting up from his chair and or bed in an attempt to fulfill Pica behavior." The BMP states "pica behaviors are likely to	W9999		

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W9999	Continued From page 21	W9999		

occur and be maintained due to the sensory stimulation or internal gratification produced by these behaviors. This behavior typically occurs during periods of reduced monitoring due to competing activities. (R5) has a history of hyperactive behavior, including the inability to remain seated for programs/activities. His hyperactivity results in frequent falls, injuries, and property destruction in past due to poor balance associated with hemiplegia. Risk of injury due to frequent falls results in the need for close monitoring and supervision and physical assistance." The behavior control procedures include, "Staff shall monitor (R5) closely during all waking hours to reduce his opportunity for hyperactive behavior and food stealing during meals as well as during non-meal times. During non-meal times, staff shall monitor (R5) very closely to reduce his opportunity to gain access to any kitchen area or any other locations of food storage."

The facility policy for Abuse and Neglect; Reporting and Investigating defines neglect as: "The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration or an individual's physical or mental condition."

The facility's investigation states on 7/9/2006, "(R5) was observed lying on the floor in the kitchen with coffee spilled on his person. Nursing noted approximately 2" x 3" and 3" x 3" reddened areas on the upper chest and right collar bone areas." R5 was transported to a local hospital emergency room. R5 returned home with a diagnosis of mild thermal burns. The investigation reports that staff did not hear the

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W9999	Continued From page 22 alarm sound, when R5 got out of bed. During interview with E2 on 11/21/06 at 12:40 p.m., he stated that after the incident with R5 burning himself, a staff meeting was held. A copy of the meeting minutes was given to surveyor. It states: "a meeting was held today to address the recent incident where (R5) fell and sustained injuries. Preventive measures were discussed to avoid potential problems in the future. We have created a documentation procedure that staff will make sure (R5's) alarm is on and his bed rails up when he goes to bed. The staff will also document this on a daily basis. This procedure signals to staff that (R5) has gotten out of his bed so that they are immediately able to go to his bedroom in order to provide monitoring, physical assistance, and support as necessary to help reduce falls associated with his impaired equilibrium...." Facility Injury/illness report of 9/4/06 states several bruises were noted on R5's back area and a bruise on the right side of his forehead. Probable cause is noted as: "(R5) might have tried to gotten out of his bed and the bedrails and/or foot board might have caused the bruises." The injury is noted as discovered, not observed. Facility's investigation states on 9/12/06: "(R5) was observed lying on his bed with blood spots on his shirt. The staff notified this to the nurse on duty. The nurse examined him and found no external scratches or cut injuries on his body. But there was a discharge from his right ear and a bruise measuring 2-3 cm on his right cheek. The right side of his face was also swollen." The investigation notes that the alarm did not sound	W9999		

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W9999	Continued From page 23 during the night to alert staff. Record review notes that R5 was taken to the emergency room of a local hospital. 9/12/06 nurse's notes state, "the provisional diagnosis was Basilar Skull fracture may be due to a fall and head injury." Nurse's notes document a surgical procedure - Lumbar Drain Placement performed on 9/21/06 while R5 was still hospitalized. The procedure was done to help drain the cerebrospinal fluid from that area thus stopping the drainage from the ear. R5 was discharged from the hospital on 9/28/06. Nursing notes state "Client has q (every) 30 min (minute) bed checks from 7 p to 7a staff notified log posted and placed in sleep log (staff sig (signature) required)." Surveyor asked for a copy of the facility's log documenting R5's bed checks and the use of the siderails and bed alarm. Surveyor was given a copy of the logs for July 2006, August 2006, October 2006 and November 2006. Documentation is not completed as required. E2 confirmed that the staff documentation is missing. There are several dates where there is no documentation. R5's roommate, R4, was interviewed on 11/20/06 at 4:00 p.m. R4 said that R5 is always trying to get out of bed. E1, Administrator, and E2, QMRP, were interviewed on 11/20/06 at 3:45 p.m. E1 stated there was a problem with the alarm connection and it caused a malfunction. It did not sound on 9/12/06. The alarm also did not sound on 7/9/06 when R5 was burned. E2 stated on 11/21/06 at 12:40 p.m. that the facility is exploring whether a	W9999		

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W9999	Continued From page 24 Hospital bed is needed. A new bed alarm was purchased that is bigger and works all of the time. It was purchased after R5's skull fracture occurred on 9/12/06. R5 has a known history of hyperactivity and problems with falls. The facility neglected R5 when they failed to ensure his alarms functioned properly and failed to ensure staff perform hourly checks in accordance with his needs. R5 sustained a basilar skull fracture, which required surgery to facilitate drainage of accumulated cerebral spinal fluid. (A)	W9999		