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W 331	Continued From page 32 assessment of extremities prior to helping R5 back to bed; asked if hurt; and no reproducible documentation of a follow-up check for bruises and/or injuries from the falls. (The next note for R5 is dated 2/25/07 and addresses his continuing temperature from the Pneumonia diagnosis). In an interview with E5, on 3/9/07 at the facility at 11:26 a.m., E5 stated that she had presented all of the GP-15's for R5 from 01/07 to date.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210b) 350.1230d)1)2)3) 350.3240a) 350.3240b) 350.3240e) 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident	W9999		

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by a registered professional nurse or a licensed practical nurse, or the equivalent.

Section 350.1230 Nursing Services
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.

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)
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)
e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These Regulations were not met as evidenced by the following:

Based on observation, interview and record review, the facility failed to implement their system to prevent neglect for R3, when:

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W9999	Continued From page 34 1) The facility neglected to ensure a thorough description of symptoms and thorough assessment for R3's 1/23/07 "sick" episode; neglected to ensure thorough assessment of R3's unresponsive episode of 2/21/07; and neglected to ensure thorough assessment and prompt medical attention after R3's 3/3/07 fall. 2) The facility neglected to implement their own policies related to medical care for R3. 3) The facility neglected to implement their own policies for abuse and neglect when direct care staff neglected to notify the facility Executive Director or Director of Operations of an allegation of abuse/neglect against the facility QMRP/RSD/Administrator (Qualified Mental Retardation Professional/Residential Services Director/Administrator), regarding R3's fall of 3/3/07, when R3 was left laying on the floor for at least 7 hours. Findings include: 1. In review of a facility resident roster validating level of functioning, R3 functions in the severe range of mental retardation. A facility document listing resident guardians validates R3 has a State guardian. During observations at the facility on 03/09/07, R3 was observed to be an ambulatory female. When ambulating however, R3 took small, shuffling steps slumping forward from her shoulders. R3 was also observed to be verbal, but limited in her expressive language, utilizing 2-3 word combinations in phrases or short sentences.	W9999		

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R3's current physician's orders document medical diagnoses of Osteoporosis, Partial Complex Seizures, Anemia, Anxiety, Urinary Incontinence and Arteriosclerosis Obliterans. A health assessment dated 6/26/06 from the nursing consultant validates R3's height as 5 foot/5 inches tall, with a weight of 203 pounds.

R3 has current physician's orders for daily blood pressure monitoring and weekly pulse monitoring.
R3's MAR (Medication Administration Record) documents R3 receives Oyst Cal D tab., and Actonel for Osteoporosis; Neurontin for seizure control; Lisinopril for Hypertension; Lopressor for Arteriosclerosis; Pravachol for Hyperlipidemia; Oxybutyn for Urinary Incontinence; Paxil and Risperdal for behavior control.

Per R3's current behavior management program (12/01/06), R3 is diagnosed with anxiety, which is expressed through behaviors of physical and verbal aggression. Physical aggression is defined as R3 shoving or hitting the person in the closest proximity to her. Verbal aggression is defined as R3 yelling in a very high-pitched tone, cursing and screaming. R3's maladaptive/adaptive behavior recording form documents incidents of yelling and hitting, with no other behaviors tracked.

GP-15's (facility progress notes) document on 1/23/07 at 1:00 a.m., R3 "got sick..gave her a bath and cleaned up everything...no temp (temperature)." There is no description of R3's specific symptoms and no vitals recorded. The note states "no temp," but the actual temperature is not documented. In an interview with E5 on 3/9/07, at the facility at 3:40 p.m., E5

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W9999	Continued From page 36 (QMRP/RSD/Administrator), confirmed that all facility GP-15's for R3 since 01/07 had been presented. On 2/1/07 R3's Risperdal was increased from 0.25 mg tablet, I tablet twice daily to a l mg tablet twice daily. GP-15's of 2/12/07 document at 6:00 a.m., R3 was, "unresponsive" when staff tried to wake her up this morning. Staff would help (R3) sit up but as soon as staff stopped supporting her she would fall back on the bed. Two separate blood pressure and pulses are recorded, but there is no documentation for temperature. R3 was subsequently taken to the emergency room and admitted. R3 was discharged on 2/19/07 after treatment for Pneumonia. In an interview with E5 on 3/9/07 at the facility at 3:40 p.m., E5 confirmed that all facility GP-15's for R3 since 01/07 had been presented. In an interview with E4 (DSP) on 3/9/07 at the facility at 4:00 p.m., E4 stated R3 seemed like she was really tired since her 2/12/07 hospitalization. E4 stated about a week before R3's fall, E4 had taken R3 to a physician appointment. R3 would not get out of the van and kept saying she was tired. In a phone interview with E1 (Nurse Consultant) on 3/15/07 at 11:55 a.m., (regarding the 1/23/07 and 2/12/07 health issues for R3), E1 stated she expects staff to describe symptoms when an individual is sick, i.e., coughing, diarrhea, vomiting; and she has instructed staff to always take a temperature. E1 further stated she has instructed staff to record the actual temperature, and not to report, "no temperature/no fever."	W9999		

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A physician consult report dated 2/22/07 states R3 was being seen on this date for decreased mental alertness and some memory decrease, probably due to the increase in the Risperdal dose. The physician ordered a decrease in Risperdal to 0.5 mg twice daily and to recheck R3 in 1-2 weeks. (In an interview with E5, at the facility, on 3/13/07 in the a.m., E5 stated that R3 had not been the same since her hospitalization of 2/12/07, so the facility had scheduled a physician appointment; thus the decrease in Risperdal).

In a phone interview on 3/13/07 with E2 (DSP) at 11:00 a.m., E2 stated after R3's Risperdal increase on 2/1/07, R3 kept her eyes closed a lot. If R3 was sitting, she would require help getting up from the couch or bed. In an interview on 3/14/07 with E2 at 9:00 a.m., R3 also began having trouble getting in and out of vehicles. E2 stated R3 would try, just couldn't seem to complete the action. R3 would lift her foot, then couldn't do anymore; it was like R3 forgot what to do. E2 stated now that R3's Risperdal has been decreased (i.e. the 2/27/07 decrease), R3 seems to be a lot more alert.

In a phone interview with E3 (DSP) on 3/14/07 at 8:30 a.m., E3 also stated she thought R3 was sluggish, extra slow and thought R3 had not been acting herself for a few days prior to R3's fall. E3 thought these symptoms could be from R3's increased Risperdal.

GP-15's of 3/3/07 document at 6:30 a.m., R3 fell when getting out of bed, falling onto her hands and knees, sustaining a small scrape on her left knee and a quarter size bruise under the scrape.

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This note states staff tried to help R3 up, but R3 wanted to be left alone. This note (written by E2), states the RSD (Residential Services Director) was notified at 7:00 a.m. In an interview with R6 (R3's roommate) on 3/14/07, at 3:50 p.m., R6 stated when she woke up she saw R3 sitting on the floor with her hands,"on my bed." R6 asked R3 if she fell and R3 said yes. R6 stated she tried to help R3 up, but could not get her up and left the room to tell E2.

Partial vitals are first recorded at 8:00 a.m., with blood pressure at 130/85 and a pulse of 73.

Partial vitals are again documented at 11:00 a.m. with a blood pressure of 127/47 and pulse of 55; and RSD came in.

Partial vitals are again documented at 11:30 a.m., after RSD spoke with the consulting nurse, documenting a blood pressure of 140/62, a pulse of 61 and the first temperature recorded at 98.1.

At 12:30 p.m., GP-15's document staff could not get a blood pressure or pulse and R3's temperature was 97.5. The consulting nurse was called and advised staff to call 911. In a phone interview with E3, on 3/14/07 at 8:30 a.m., E3 stated R3's pulse was irregular each time checked, and that staff tried to obtain the pulse from various areas on R3's body. In an interview with E5 on 3/9/07 at the facility at 3:40 p.m., E5 confirmed that all GP-15's for R3 since 01/07 had been presented.

In a phone interview with E1 (Nurse Consultant) on 3/15/07 at 11:55 a.m., E1 stated if an individual falls, she expects staff to first assess the individual and see if the individual is able to

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move extremities, ask if hurt, and check for injuries before assisting the individual up. E1 also stated she expects staff to notify her if an individual has a significant fall such as falling out of bed, a non-witnessed fall, a fall resulting in hitting one's head, and would expect complete vital signs (temperature, pulse, respirations and blood pressure). E1 stressed staff are to call if the fall is not witnessed and if they are unresponsive. E1 expressed concern for not being called right away, stating she was called between 11:00 -11:30 a.m. (R3 having been on the floor since as least 6:30 a.m.).

The ambulance report of 3/3/07 documents patient contact with R3 at 1:27 p.m., with hospital arrival time at 1:48 p.m. Per this report, it states upon arrival to the residential facility, R3 was sitting on the floor with both legs under the bed, and reports from facility caregivers stated R3 had "slipped" out of bed around 6:00 a.m. on this day. R3 had not eaten since around 5:30 p.m. the night before and that she had not been talking. The primary assessment by ambulance staff documents confused conversation/speech and motor response. In an interview with Z3 on 3/9/07 at the city hospital at 8:10 a.m., Z3 stated when he arrived on the scene, R3's hands and feet were, "very cold to the touch...legs had some redness to top/inner thighs." In the same interview, Z2 stated R3 told Z2, "fall," and Z2 stated R3 's legs were under her bed and her arms were resting on the bed. Z3 stated R3 was warmed up in the ambulance with blankets and at that time R3 began talking.

In the hospital emergency room at 1:48 p.m., R3's rectal temperature was 95.5., pulse 55, respirations 31, blood pressure 136/85 and

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W9999	Continued From page 40 oxygen saturation at 99% (per hospital emergency room report). This report further states, (R3)'s, "skin cold to touch - thighs/calves mottled....." At 3:10 p.m. pulse is recorded at 46; and 4:10 p.m. at 48. The "Emergency Department Record" dated 3/3/07 states, "According to caregivers....patient is not acting normal for two to three days...refused to eat...is also not able to walk as usual....Heart rhythm is regular, but very bradycardic...patient pulse rate is running between 45-50 here in the emergency room...admitted in hospital for 23 hour observation...." In a phone interview with Z1 on 3/8/07 at 2:16 p.m., Z1 stated she was on duty in the emergency room when R3 arrived on 3/3/07. In an interview with Z1 on 3/13/07 at 8:00 a.m., Z1 stated when R3 arrived R3 was, "very lethargic...cold to the touch....laid there with her eyes closed...on legs from hip line down.....very mottled....piled on warm blankets to warm her up...". Z1 stated R3 appeared dehydrated as her mouth was very dry and coated. R3 was able to respond 'yes' or 'no' but she was, "not that arousable". Z1 further stated she thought R3 was in "mild hypothermic range". Z1 explained that when a body is warm the skin is soft and "squishy", but R3's body was firm to the touch and mottled, indicating that her body was cold. R3's discharge diagnoses was Bradycardia and Altered Mental Status and R3 was subsequently discharged on 3/4/07 with instructions to the residential facility for close blood pressure and heart rate monitoring. In a phone interview with E8 (Consulting Physician) on 3/13/07 at 10:45 a.m., E8 stated he	W9999		

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would, "definitely" expect full vitals for an individual after a fall. E8 stated he was concerned for the length of time R3 was allowed to remain on the floor, the delay in seeking medical assistance for R3; and stated R3's extended length of time on the floor could cause R3's legs to become mottled from being cold.

2) Policy 5.57, entitled "Physical Injury and Illness/Individual Medical Emergencies," states, "Individuals served by the agency shall receive timely and effective medical service for physical injuries and illnesses and medical emergencies." Within this policy Abuse is defined as, "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish." Neglect is defined as, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Under the 'Procedure' section it states, "In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following: A. Observe the individual to determine basic information necessary for nurses or physicians to make further judgements."

Policy 7.02, entitled "Nursing Services," states, "The facility shall provide nursing services to meet individuals' needs and to comply with licensing standards. All individuals shall receive proper treatment for minor accidents and/or illness through the R.N. Consultant."

Policy 7.07, entitled "Medical Services," states the purpose of this policy is to ensure, "appropriate procurement, distribution, administration, and utilization of medical services

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for individuals of the facility." Under "Procedure," it states, "Each individual shall be seen by his/her physician as often as necessary to assure adequate health care...The facility shall maintain effective arrangements through which medical and remedial services outside the facility that are required by individuals can be obtained promptly when needed."

There is no evidence that the facility implemented the policies as described above.

3) In review of the 03/07 facility staff schedule, E2 was scheduled to report to work on 3/2/07 at 11:30 p.m. through 3/3/07 at 9:30 a.m. In a phone interview with E2 on 3/13/07 at 11:00 a.m., E2 stated that around 6:30 a.m., R6 notified her R3 was on the floor. E2 went into R3's room and R3 was on her hands and knees by her bed. E2 helped R3 into a sitting position and observed a scratch on R3's left knee. E2 notified E5 (QMRP/RSD/Adm.) concerning R3 around 7:00 a.m. E2 stated that E5 insisted this was a behavior on R3's part. (R3's current behavior program described above addresses physical and verbal aggression, but does not address non-compliance or refusing to get up from the floor). Instructions from E5 were to leave R3 on the floor, to give her a blanket if she wanted one, but not to give her a pillow; E5 did not want her to get too comfortable and there was no need to call the consulting nurse. E2 stated she provided R3 with a blanket and at this time R3 was not incontinent. E2 said at 7:30 a.m. E9 arrived for work (also confirmed per the March 2007 schedule). E2 said E9 had also talked to E5 on the phone; E5 had told E9 to put incontinence pads under R3 and E5 was trying to teach her a lesson, as she did not want R3 to pull that

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W9999	Continued From page 43 behavior again. E2 said that herself, E9 and E4 (who reported for work at 9:30 a.m. - per schedule and this interview with E2) tried to place an incontinence pad under R3, but due to R3's weight, they could not get the pad under R3. E2 stated at approximately 8:45-9:00 a.m., E5 called E2 and said R3 could have water with her pills, but not to give her fluids or food until R3 got up on her own. Per E2, E5 stated it was not going to hurt her (R3) to miss a few meals. In a follow-up interview with E2 on 3/14/07 at 9:00 a.m., E2 stated that during this same phone conversation, E5 discussed the incontinence pads and E5 stated she was worried about R3 getting urine on the carpet. R3 did say to leave her alone, but E2 thinks R3 was tired of staff trying to help her up. Per the 3/13/07 phone interview with E2, E2 stated when she left work around 9:35 a.m., R3 was still on the floor; both feet partially under the bed and part of R3's head was also under the bed. R3 had a pink blanket, but no pillow. In review of the facility staff schedule E4 (DSP) was scheduled to work on 3/3/07 from 9:30 a.m. -5:30 p.m. In an interview on 3/9/07 at the facility at 4:00 p.m., E4 stated when she arrived at the facility, E4 tried to help R3 up; but it was like she (R3) could not move. Every time E4 went in to check on R3, R3 would have her eyes closed and E4 thought R3 was, "weak." "I think she wanted to get up...don't think she could." E4 stated that R3 was incontinent a few times. E4 further stated we (staff) were instructed to put covers on her, but no pillow. In a follow-up phone interview with E4 on 3/14/07 at 11:25 a.m., E4 stated she was in R3's room with E5 that morning. Per E4, E5 tried to get R3 up. E5 told R3 that she was wet and needed something to eat. E4 stated that E5, "started to get angry" and	W9999		

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(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 44 told R3 she could miss a couple of meals as she was overweight or obese. (E4 could not remember the exact word, but stated that E5 used one of the above words to describe R3's weight). E4 said E5's voice was "raised" and "demanding" and E5 further told R3 she would wind up in a nursing home. E4 again stated in this interview that R3 was given a blanket but no pillow, and that at one time R3's feet were under her own bed and her head was partially under her roommates bed. In review of the facility staff schedule for 03/07 E3 was scheduled to work on 3/3/07 from 10:30 a.m. 7:00 p.m. and was scheduled to cook. In a phone interview with E3 on 3/14/07 at 8:30 a.m., E3 confirmed she arrived at the facility at 10:30 a.m. on 3/3/07. When E3 went into the room, R3 was attempting to get up. E3 had R3 hold on to the side of the bed. E3 stated she was not sure if this was a behavior or not, but R3, "didn't look right to me.". E3 stated R3's behaviors are yelling and hitting outbursts, and did not mention non-compliance issues with staff. E3 stated E9 talked to E5 on the phone and instructions were to leave R3 on the floor, that this was a behavior and to let her get up on her own; and E9 instructed E3 not to make her too comfortable so she (R3) would want to get up. E3 stated to surveyor, even if this was a behavior, R3 should have been gotten up off of the floor. E3 stated that R3 was beginning to "shiver;" her hands were cold to the touch; and that R3 received no food for the time that she was on duty (10:30 a.m. until ambulance arrived at 1:27 p.m.). E3 also confirmed in this interview that R3 had no incontinence pad under her while she lay on the floor. E3 stated she accompanied R3 to the emergency room after the ambulance arrived and	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G186	A. BUILDING ____ B. WING ____	C **03/30/2007**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN COURT	**1650 EAST MAIN STREET CLINTON, IL 61727**

(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 45	W9999		

that E5 was not at the facility when the ambulance arrived.

In an interview with E5 on 3/13/07 at the facility at 10:30 a.m., when discussing R3's fall episode of 3/3/07, E5 stated, R3 "goes limp" the minute you start to help her up and this is a behavior. E5 further stated R3 had been having behaviors of not wanting to get on and off the bus and out of bed in varying degrees since her hospitalization on 2/12/07. (As above, R3's formal behavior program addresses physical and verbal aggression only; non-compliance is not addressed).

However, in an interview with E5 at the facility on 3/14/07 at 1:10 p.m., E5 further stated after R3's 2/12/07-2/19/07 hospitalization, R3 was lethargic. E5 also stated when R3's Risperdal was increased she did notice a difference in R3's energy level about a week after the increased dosage.

In a phone interview on 3/14/07 with E3 at 8:30 a.m., E3 stated E5 called her while she was at the hospital with R3, yelling at E3, telling E3 she had better watch what she said and how she said it, regarding R3 in her discussions with hospital personnel. E3 stated E5 called her at her home on 3/9/07, telling E3 that IDPH had entered the facility and that the surveyors might be calling her. E3 was instructed by E5 to tell surveyors R3 was made comfortable. E3 further stated E5 called her again on 3/10/07 on two separate occasions to remind E3 to watch what she says to IDPH surveyors. At this phone call E5 instructed E3 to tell surveyors staff gave her a pillow and blanket.

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	14G186	A. BUILDING ______ B. WING ______	C 03/30/2007

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W9999	Continued From page 46 In a 3/14/07 interview with E2 at 9:00 a.m., E2 stated E11 (clerk) called her on 3/9/07 in the a.m., the day IDPH entered the facility, telling E2 that the State was in the facility and if surveyors called, to be careful what she said. In the same interview with E2, E2 stated on 3/12/07 E5 asked her if R3 was responsive on 3/3/07. E2 replied R3 was kind of responsive, was "in and out" and thought it was R3's Risperdal. E5 instructed E2 not to relate this information to surveyors. On 3/14/07, E9 instructed E2 to tell state surveyors R3 was given a blanket, pillow, an incontinence pad and incontinence briefs. E5, on the same day asked E2 if surveyors had called yet and reminded E2 to be careful about what she said. In a 3/14/07 phone interview with E4 at 11:25 a.m., E4 stated E11 called and left a message for her on 3/9/07, prior to E4 coming into work. Per the message, E4 was to tell state surveys that R3 was okay and was comfortable and had been given a blanket (regarding the 3/3/07 fall incident). E4 further stated when she came into work on 3/9/07, E5 called her into the office and instructed E4 again to tell surveyors R3 had a blanket and was made comfortable. In an interview with E11 on 3/14/07 at 2:00 p.m., E11 confirmed she had called E's 2, 3 & 4 on the date IDPH surveyors arrived at the facility (3/9/07). E11 stated she told the staff that IDPH was at the facility and to tell surveyors what they knew happened; if they did not remember then to say so and be honest. In phone interviews with E2 on 3/13/07 at 11:00 a.m.; E4 on 3/14/07 at 11:25 a.m. and E3 on	W9999		

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W9999	Continued From page 47 3/14/07 at 8:30 a.m., each staff confirmed they were aware of the abuse/ neglect procedures and knew they should have reported their concerns to administration. In a phone interview with E6 (Executive Director) on 3/27/07 at 9:10 a.m., E6 stated that all direct care staff are trained on abuse/neglect policies at new hire orientation and DSP (Direct Service Person) training. Facility policy 5.24 defines abuse as, "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish." Neglect is defined as the, "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Under the procedure section of this policy it states, any facility employee or agent who witnesses or suspects a violation of resident rights, abuse or neglect as well as injuries of unknown source shall immediately report the matter to facility management; the employee or agent must speak directly to one of the following managers: Administrator, Executive Director or Director of Operations, with the facility's investigation procedure to follow. Under facility policy 5.34 resident rights are addressed. This policy states individuals shall be free from mental and physical abuse; and that each individual shall be treated with consideration, respect, and full recognition of his/her dignity and individuality. Policy 5.22 entitled Staff training and orientation,	W9999		