STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G073	A. BUILDING _____ B. WING _____	R 01/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LAWN CENTER	**5831 WEST 115TH STREET ALSIP, IL 60803**

(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 000}	INITIAL COMMENTS Follow-Up to 6/8/2006 Annual Recertification Survey	{W 000}		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview, record review and observation, the Condition of Participation is not met. The facility failed to prevent neglect when they failed to take the following action: 1. Ensure staff provide the level of supervision required by R1. 2. Ensure administration was notified of unwitnessed injuries and neglect for R1 3. Ensure policy for physician notification was followed for R1 4. Ensure policy for guardian notification is followed. 5. Ensure that R1 has a formal objective for the staff procedure of placing R1 in his wheelchair when he tries to walk without staff assistance. R1 was left in his wheelchair unattended and unsupervised on 12/28/06. He made his way to a stairway and was found at the bottom of the stairs. He sustained abrasions to his face as a result of the event.	W 122		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1 Refer to W 148- Notify guardian of significant events Refer to W149- Develop policies and procedures to prevent neglect. Refer to W 153- Ensure all allegations of abuse, neglect, mistreatment are reported immediately to the administrator.	W 122		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and file review, the facility failed to have evidence that R1's guardian was notified following his fall down a stairway where he sustained a contusion to his face. Findings include: Per review of R1's Individual Service Plan dated 9/17/06, R1 is a 33 year old male with a diagnosis of profound mental retardation. A nurses note dated 12/28/06 states that R1 was found on the floor at the bottom of the stairway. The note goes on to say that R1 was still strapped in his wheelchair and had a small cut to the bridge of his nose, two small cuts above his lip on the right and left sides and a bite mark was found on his tongue. When asked to present evidence that the guardian was notified of the incident, E1 did not	W 148		

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W 148	Continued From page 2 present documentation to the surveyer that the guardian had been notified of the incident. Upon review of the facility policy, the guardian is to be notified of significant injuries and incidents. There is no documentation showing that the guardian was notified by any staff member.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview, observation and record review, the facility staff failed to implement their policy to prohibit neglect when R1 was left unsupervised and was found injured and lying on the floor at the bottom of the stairs while strapped in his wheelchair. Facility failed to: 1. Assess need for and provide direct supervision for R1 when placed in the Kiwi area. R1 is known to be capable of moving his wheelchair even when locked. And, R1 is known to be capable of opening the stairway door. 2. Notify the administrator or designee of R1's unwitnessed fall with injuries. 3. Notify the physician of R1's injuries as per facility policy. Findings include:	W 149		

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W 149	Continued From page 3 R1 is a 32 year old male who, according to his Individual Service Plan (ISP) of 9/17/06, has a diagnoses of Profound Mental Retardation, Seizure Disorder, S/P skull fracture, and Angelman's Syndrome (marked limitations in all motor functioning). A mobility assessment incorporated in the ISP states, "R1 requires use of a gait belt (for ambulation) and a wheelchair for transportation. He also wears a helmet and uses the elevator between floors." R1's Personal Profile further states that R1 uses a wheelchair "for periods of unsteadiness." R1's ISP does not specifically address the supervision level required for his safety. On 12/28/06, per a nursing note written by E4, RN, "at 6:40 a.m. R1 was found on the floor at the bottom of the stairway. Resident was still in his wheelchair strapped in with helmet. Resident was noted with a small cut to bridge of nose, two small cuts above lip to right and left side. Bite mark to tongue, a moderate amounts of bleeding to nose and bleeding to tongue. Bleeding stopped and area cleaned." E4, per interview on 1/8/07 at 9:58 a.m., stated she was notified by one of the kitchen staff that R1 was laying on the floor at the bottom of the stairs. When asked if she notified the physician, E4 stated the physician was expected to come in anyway. Documentation in the nursing note of 12/28/06 reports the physician saw R1 at 8 a.m., an hour and 15 minutes following the fall. The physician's note reports, "contusion." There is no evidence that the nurse notified the physician of R1's fall immediately following the incident. No injury report could be found by E1, the	W 149		

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W 149	Continued From page 4 administrator, when requested by the surveyor. She was unaware of the injury to R1 until questioned by the surveyor. The incident was therefore not investigated. Further interviews with direct care staff and supervisors as follows shows that R1 was left sitting in the Kiwi area unsupervised. E5, DSP (direct service provider 11 pm-7:30 a.m. shift) told surveyor during interview on 1/8/07 at 10:15 a.m. that she was assigned to R1. " I got him dressed and wheeled him to the Kiwi area in his wheelchair and locked it. His helmet was on." E5 explained that she then went about other duties. E5 explained, "Later, I was told by E4 that she needed help with R1 who had fallen down the stairs." E5 stated that R1 can move his wheelchair even with the lock on. "He scoots his wheelchair." Further, E5 stated R1 is able to push open the double doors that separate the Kiwi area from the stairway and elevator area on the other side. Other direct care staff, E 6, 7, and 8, were interviewed on 1/8/07 (10:30-11:30 a.m.), they confirmed that R1 is capable of moving his wheelchair when it is "locked". Staff stated when they see R1 approach the doors, they have had to redirected R1 away from the doors before. Surveyor observed R1 sitting on a couch/bench with a gait belt on 1/4/07 at 3:45 p.m. following his return from the workshop. E3, the QMRP, reported during interview on 1/4/07 at 2:25 p.m., that R1 has an unsteady gait as he leans forward and his whole body twitches requiring use of the wheelchair for transport. This information was also verified by the direct care workers (E5, E6, E7, E8) during their interviews. R1 will try to walk	W 149		

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W 149	Continued From page 5 without staff assistance and may fall. Per staff, R1's gait is unsteady and when he is placed on the couch and continues to try and get up and walk without staff assistance, he is placed in the wheelchair. There is no evidence that this procedure has been incorporated in R1's ISP. Per review of the facility policy to prevent neglect, it states that the facility will provide services to prevent neglect. When there are injuries, the physician is to be notified. In addition, the administrator or his or her designee is to be notified in cases of abuse or neglect and an investigation is to be done.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report to the administrator and the Department, an incident of R1 falling down a stairway while restrained in his wheelchair and unsupervised by staff. Findings include: R1, per nursing note dated 12/28/06, was found at the bottom of a stairway at 6:40 a.m. by dietary staff. The note states R1 was bleeding from his nose and either side of his mouth and had bite marks on his tongue.	W 153		

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W 153	Continued From page 6 E4, RN, who documented the nursing note, told surveyor on 1/8/06 that she provided treatment to R1 by applying pressure to the bleeding areas and cleaning R1 wounds with saline solution. E1, the administrator, when documentation of investigation was requested by the surveyor, stated that neither she nor her designee were notified of this incident. E1 reported to the surveyor that she was on vacation when the incident occurred. In addition, there is no evidence that the incident was reported the the Department.	W 153		
{W 290}	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. This STANDARD is not met as evidenced by: REPEAT Based on interview and file review, the facility failed to address the use of restrictive procedures to control R1's inappropriate behavior (mobility). R1 tries to ambulate without staff assistance. When he does so, staff place him in his wheelchair. Findings include: R1, a 33 year old male whose diagnoses include Profound Mental Retardation, Seizure, S/P Skull Fracture according to his ISP dated 9/17/06. R1 sustained injuries during a fall down stairs on	{W 290}		

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{W 290}	Continued From page 7 12/28/06 according to a nursing note dated the same day. R1 was found at the bottom of the stairs strapped in his wheelchair. R1 requires staff assistance with a gait belt to ambulate per the QMRP on 1/4/07 at 2:25 p.m. Direct care staff, E5, E6, E7 and E8, in interviews on 1/8/07 stated that R1 will try to walk without staff assistance and may fall. When he is placed on the couch and continues to try to get up and walk without staff assistance, he is placed in the wheelchair. Staff also stated that they lock R1's wheelchair and that R1 is able to scoot his wheelchair when it is locked. R1's last physical therapy assessment was in 2001. The assessment, which is not current, does not state the types of supports R1 requires when in his wheelchair. Although staff state they are locking his chair, R1 is able to move the locked chair. Staff E3, E5, E6, E7, and E8 said he "scoots" the chair. The 9/17/06 personal profile in R1's ISP states he will move around freely in his wheelchair and will push open doors into areas that may be unsafe. The ISP of 9/17/06, when reviewed, does not have a formalized objective for staff to place R1 in his wheelchair when he continues to try to get up and walk without staff assistance.	{W 290}		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION Section 350.620a) Section 350.700	W9999		

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W9999	Continued From page 8 Section 350.3210o) Section 350.3240a)b)c)d) 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. 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 350.3210 General	W9999		

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W9999	Continued From page 9 o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. 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) 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 Regulations are not met as evidenced by: Based on interview and file review, the facility failed to: 1) have evidence that R1's guardian was notified following his fall down a stairway in which he sustained a contusion to his face. 2) implement their policy to prohibit neglect when R1 was left unsupervised and was found injured and lying on the floor at the bottom of the stairs while strapped in his wheelchair. 3) report to the administrator and the	W9999		

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W9999	Continued From page 10 Department an incident of R1 falling down a stairway while restrained in his wheelchair and unsupervised by staff. Findings include: R1 is a 32 year old male who, according to his Individual Service Plan (ISP) of 9/17/06, has a diagnoses of Profound Mental Retardation, Seizure Disorder, S/P skull fracture, and Angelman's Syndrome (marked limitations in all motor functioning). A mobility assessment incorporated in the ISP states, "R1 requires use of a gait belt (for ambulation) and a wheelchair for transportation. He also wears a helmet and uses the elevator between floors." R1's Personal Profile further states that R1 uses a wheelchair "for periods of unsteadiness." R1's ISP does not specifically address the supervision level required for his safety. On 12/28/06, per a nursing note written by E4, RN, "at 6:40 a.m. R1 was found on the floor at the bottom of the stairway. Resident was still in his wheelchair strapped in with helmet. Resident was noted with a small cut to bridge of nose, two small cuts above lip to right and left side. Bite mark to tongue, a moderate amounts of bleeding to nose and bleeding to tongue. Bleeding stopped and area cleaned." When asked to present evidence that the guardian was notified of the incident, E1 did not present documentation to the surveyor that the guardian had been notified of the incident. Upon review of the facility policy, the guardian is to be notified of significant injuries and incidents.	W9999		

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W9999	Continued From page 11 There is no documentation showing that the guardian was notified by any staff member. E4, per interview on 1/8/07 at 9:58 a.m., stated she was notified by one of the kitchen staff that R1 was laying on the floor at the bottom of the stairs. When asked if she notified the physician, E4 stated the physician was expected to come in anyway. Documentation in the nursing note of 12/28/06 reports the physician saw R1 at 8:00 a.m., an hour and 15 minutes following the fall. The physician's note reports, "contusion." There is no evidence that the nurse notified the physician of R1's fall immediately following the incident. E4, RN, who documented the nursing note, told surveyor on 1/8/06 that she provided treatment to R1 by applying pressure to the bleeding areas and cleaning R1 wounds with saline solution. No injury report could be found by E1, the administrator, when requested by the surveyor. She was unaware of the injury to R1 until questioned by the surveyor. The incident was therefore not investigated. E5, DSP (direct service provider 11 pm-7:30 a.m. shift) told surveyor during interview on 1/8/07 at 10:15 a.m. that she was assigned to R1. "I got him dressed and wheeled him to the Kiwi area in his wheelchair and locked it. His helmet was on." E5 explained that she then went about other duties. R1 was left unsupervised. E5 explained, "Later, I was told by E4 that she needed help with R1 who had fallen down the stairs." E5 stated that R1 can move his wheelchair even with the lock on. "He scoots his wheelchair." Further, E5 stated R1 is able to push open the double doors	W9999		

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W9999	Continued From page 12 that separate the Kiwi area from the stairway and elevator area on the other side. Other direct care staff, E6, E7, and E8, were interviewed on 1/8/07 (10:30-11:30 a.m.), and they confirmed that R1 is capable of moving his wheelchair when it is "locked." Staff stated when they have seen R1 approach the doors before, they have had to redirected R1 away from the doors. Surveyor observed R1 sitting on a couch/bench with a gait belt on 1/4/07 at 3:45 p.m. following his return from the workshop. E3, the QMRP, reported during interview on 1/4/07 at 2:25 p.m., that R1 has an unsteady gait as he leans forward and his whole body twitches requiring use of the wheelchair for transport. This information was also verified by the direct care workers (E5, E6, E7, E8) during their interviews. R1 will try to walk without staff assistance and may fall. Per staff, R1's gait is unsteady and when he is placed on the couch and continues to try and get up and walk without staff assistance, he is placed in the wheelchair. There is no evidence that this procedure has been incorporated in R1's ISP. Per review of the facility policy to prevent neglect, it states that the facility will provide services to prevent neglect. When there are injuries, the physician is to be notified. In addition, the administrator or his or her designee is to be notified in cases of abuse or neglect and an investigation is to be done. E1, the administrator, when documentation of investigation was requested by the surveyor, stated that neither she nor her designee were notified of this incident. E1 reported to the	W9999		

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W9999	Continued From page 13 surveyor that she was on vacation when the incident occurred. In addition, there is no evidence that the incident was reported to the Department. (A)	W9999		