STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G001	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 331	Continued From page 16 2/13/07 at 3:15 P.M. lying in her bed asleep. At 3:40 P.M., an urine odor was detected in R15's bedroom. R15 was awake and her bed was wet with urine. The staff on A Wing were observed in the A Wing classroom, and in the A wing bathroom assisting other clients. No staff were observed in the area of R15's room until 4:15 P.M.. Then E6 (Qualified Mental Retardation Professional Assistant) was observed to be outside R15's doorway. R15 did not receive personal care for her incontinence until the surveyor brought the incontinence to E6's attention at 4:15 P.M.. R15's Individual Habilitation Plan states she has potential for alteration in skin integrity, and she is considered high risk for skin breakdown.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060b)1)2) 350.1060c)1)2) 350.1060d) 350.1060e) 350.1060g) 350.1070 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 17 public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. 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. b) Each resident shall have individual evaluations which shall: 1) Be based upon the use of empirically reliable and valid instruments whenever such tools are available. 2) Provide the basis for prescribing an appropriate program of training experiences for the resident. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. g) Appropriate training and habilitation programs shall be provided residents with hearing, vision, perceptual, or motor impairments, in cooperation with appropriate staff.	W9999		

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W9999	Continued From page 18 Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by the following: 1. Based on interviews and record review, the facility failed to implement their policy to prevent neglect when they failed to investigate, develop and implement preventative measures for R18 who has had 12 falls since 03/2006 (7 of which have caused her injury) ultimately resulting in R18 sustaining a fractured left clavicle on 02/17/07. The facility failed to 1) Monitor the number of times R18 has fallen, 2)Investigate why R18 continues to fall, 3) Develop a system to monitor R18's falls and 4) Develop and Implement a system to prevent R18 from falling.	W9999		

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W9999	Continued From page 19 2. Based on interview and record review, the facility failed to implement their policy to prevent neglect for 1 of 1 client (R19) who choked on food. There is no evidence the facility has taken steps to prevent recurrence. Per review of the facility's Abuse and Neglect policy, presented to the surveyor during the surveyor, "Types of Neglect" includes, "Any failure by a community or facility or employee thereof to carry out required and appropriate clinical services, habilitation, or treatment as ordered by a physician or other authorized personnel that is the proximate cause of psychological harm or physical injury to an individual...." Findings Include: Per review of facility's, "Admission Sheet", R18 is a 50 year old female who functions at a Moderate level of mental retardation. Diagnosis includes Major Motor Seizures. Upon review of R18's Medication Administration Record dated 01/2007, R18 is currently receiving Depakote 1250 milligrams daily and Gabapentin 600 milligrams three times a day for seizures. During review of facility's Incident and Accident report dated 03/18/06, surveyor noted that on 03/18/06 at 6:45 a.m., R18 fell while putting her shoes on. Documentation states, "In her room trying to put her shoes on (and) fell backwards on floor - laceration to back of head." Documentation on the Incident and Accident report continues to say that R18 received a 1 1/2 inch laceration to the back of her head and was	W9999		

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W9999	Continued From page 20 taken to the emergency room of the local hospital where she received 5 sutures to the back of her head. Documentation is signed by E11 (Licensed Practical Nurse). Further review of facility's Incident and Accident reports identified that R18 fell again on 03/18/06, at 4:00 p.m. Documentation states, "(R18) walking across Dining Room, slipped against peer, fell over to buttock." Upon review of R18's "Nurses Notes" dated 09/23/06 at 8:30 p.m., documentation states, "R18 was getting ready for bed, sitting on side of bed. Slipped off bed, hitting (right) side of head on bed. Silver Dollar size hematoma 2" above (right) ear...." Documentation is signed by E10 (Registered Nurse). Per interview with E1 on 02/19/07 at 10:30 a.m., when asked what had been put into place after R18's fall on 09/23/06, E1 stated that nothing had been done to prevent future falls. Per interview with E3 (Assistant Administrator) on 02/19/07 at 9:20 a.m., E3 informed the surveyor that on 02/17/07 R18 had started to sit down on a bench, missed the seat and fell onto the floor landing on her left shoulder area. Per same interview with E3, E3 said that around noon on 02/18/07, R18 began complaining of pain in her left shoulder. R18's physician was notified and orders obtained to send R18 to the local hospital emergency room for evaluation. E3 stated that at that time it was discovered that R18 had a fractured left clavicle. R18 was placed in a left arm/shoulder immobilizer and returned to the facility.	W9999		

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W9999	Continued From page 21 During this interview, surveyor asked E3 what systems had been put into place to protect R18 from falling again. E3 said that she had told direct care staff to watch R18 when she went to sit down. E3 also said that no formal monitoring system had been put into place. Additional review of facility's Incident and Accident reports show that between 03/18/06 and 02/17/07 R18 sustained 12 falls (7 of which caused injury). Documentation within the Incident and Accident reports and Nurses Notes state that R18's injuries include numerous abrasions to knees and elbows, "Pump" knot on forehead, 2 inch hematoma above her right ear and a fractured left clavicle. Per review of R18's Fall Risk Assessment dated 11/2006, documentation states that R18 has had, "1 -2 falls within the past 3 months." Documentation on the Fall Risk Assessment also states that R18 is, "Jerking or unstable when making turns lurching/swaying." The total score on R18's Fall Risk Assessment is rated at "7" with 10 or above representing a high risk for falls. Documentation is signed by E1. During Interview with E1 on 02/22/07 at 5:10 p.m., E1 said that documentation on the Risk Fall Assessment does not include falls that are related to seizure activity. During same interview E1 stated that there was no quick way to identify the number of falls that R18 has sustained within the past year. E1 said	W9999		

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W9999	Continued From page 22 that she would have to go through all the Incident reports and count them. R18's Individualized Habilitation Plan dated 06/26/06 states, "...(R18) continues to walk rapidly/run and requires redirection but she has improved (somewhat) in this area and has had fewer falls and injuries...". In the area of mobility as identified in R18's Individualized Habilitation Plan, documentation states, "...Walks with head down at times and gait is a little unsteady...". Per review of R18's Nursing Assessment dated 11/2006, documentation states that R18 has poor balance and poor posture. Documentation is signed by E1 (Director of Nurses). Per interview with E1 on 02/21/07 at 4:05 p.m., E1 stated that R18 has never had a Physical Therapy Assessment regarding her unsteady gait and falls. Per interview with E1 on 02/22/07 at 5:10 p.m., E1 stated that R18 has never had an Occupational Therapy Assessment. Upon review of R18's Individualized Habilitation Plan dated 06/26/06, R18 is on programs for Non-compliance, Inappropriate social behavior, Eating, Money Management, Relaying personal information, Self medication, Bathing and Denture care. There is no documentation to show that R18's Individual Habilitation Plan includes any objectives for fall prevention. The facility failed to ensure that preventative measures are in place for R18's history of falls,	W9999		

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W9999	Continued From page 23 therefore allowing the falls to continue. 2. Per review of facility's, "Admission Sheet", R19 is a 51 year old male who functions at a Moderate level of mental retardation. Upon review of an Incident Report from the local day training site dated 02/02/07, R19 was taken to the emergency room following a choking episode. Documentation states, "(R19) was eating a piece of baked chicken (and) became choked, (and) then vomited in the plate (Liquids.) He (complained of) chicken being dry...He then complained of it not going down all the way, (and) he was still coughing, and talking, to staff. They encouraged him to cough. He began to vomit phlegm up again. Nurse (name of nurse) was called in. They encouraged him to cough (and) he continued to vomit up phlegm. This writer came into the room (and) he was vomiting a large amounts of phlegm and food particles. I performed 5 back blows (and) large (amount) of food (and) phlegm came up. His lungs sounded slightly congested. He seemed to be doing better, and we walked to the rest room, because his clothes were covered in vomit. He began vomiting (and) coughing again...911 called (at) around 1:05 pm. He continued to vomit...." Documentation also states that E1 was notified 02/02/07 at 1:05 p.m. Documentation on the Incident report, dated 02/02/07 regarding R19's choking episode states, "Staff reports (R19) tries to eat fast (at) times. He does not have a eating program (at) this time." Per review of R19's Nurses Notes dated 02/02/07 documentation states, "1:05 pm Received call from (local day training center). (R19) got choked	W9999		

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W9999	Continued From page 24 (at) lunch/throwing up - sent to (local hospital emergency room) (returned) to facility (at) 3:15 (with) no sign of aspiration...." Documentation is signed by E1. Per review of R19's Annual Nutritional Assessment dated 05/08/06, documentation states, "He eats rapidly." Per interview with E3, (Assistant Administrator) on 02/21/07 at 3:30 p.m., E3 stated that the facility had not completed an investigation into R19's choking incident on 02/02/07. E3 continued to say that R19 choked on a piece of dry chicken at the day training site so she knew what caused him to choke and did not feel that it needed to be investigated further. E3 also stated that R19 had not had a swallowing evaluation following the incident on 02/02/07. E3 said that nothing had been done to establish the cause of his choking. E3 also said that R19 eats fast at times but was not on a eating or pacing program. After the choking incident at the day training site, there was no evidence that the day training staff had been retrained on client safety and the administration of first aid to choking victims. Per review of R19's Individual Habilitation Plan which was faxed to surveyor on 02/22/07, surveyor noted that although R19 choked on a piece of chicken on 02/02/07 and was taken to the emergency room, nothing was put into place to prevent the potential for future choking episodes until 02/21/07, after surveyor had discussed the incident with the facility. (A)	W9999		