

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2009
NAME OF PROVIDER OR SUPPLIER MILESTONE - ELMWOOD EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 2642 ELMWOOD ROAD ROCKFORD, IL 61103		
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W 440	<p>Continued From page 23</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure for 4 of 4 in the sample (R1, R2, R3, R4) and 7 of 7 outside the sample (R6, R7, R8, R9, R10, R11, R12) that evacuation fire drills were at least quarterly for the 2nd shift personnel.</p> <p>Findings include: According to the facility data sheet dated 9-8-09 there are 2 clients (R1 and R7) who function in the Moderate range of Mental Retardation, 6 clients (R2, R3, R6, R9, R11, and R12) who function in the Severe range of Mental Retardation, and 3 clients (R4, R8, and R10) who function in the Profound range of Mental Retardation. 11 clients (R1-R4 and R6-R12) are ambulatory and 1 client (R7) is nonverbal.</p> <p>Per Record Review of the Facility Evacuation Fire Drills for the 2nd P.M. Shift is dated as follows: May 28, 2009 at 8:23 P.M. February 20, 2009 at 4:21 P.M. August 30, 2008 at 4:00 P.M.</p> <p>Per interview with E2 (Resident Service Coordinator) on 9-8-09 at 1:41 P.M. stated that the A.M. shift is from 6:30 A.M. to 2:30 P.M., the P.M. shift is from 2:30 P.M. to 10:30 P.M., and the Night shift is from 10:30 P.M. to 6:30 A.M. When asked what was the P.M. shift for September, October, November, December 2008, and January 2009, E2 acknowledged that there was no P.M. shift due to the December 7, 2008 drill being done at 12:50 P.M. which is an A.M. shift drill. E2 stated that the drill on December 7, 2008 should have been a P.M. drill.</p>	W 440			

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W 440	Continued From page 24 E2 acknowledged that the facility did not have a 2nd shift P.M. evacuation fire drill for the months of September, October, November, December 2008, and January 2009.	W 440			
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060h) 350.1060j) 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 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 h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. j) Appropriate records shall be maintained for each resident functioning in these programs.	W9999			

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W9999	<p>Continued From page 25</p> <p>These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observations, record review and interview the facility failed to: 1) implement their policy on neglect for one of one resident outside the sample, R5, who expired after choking on food while unsupervised. 2) ensure that R5's behavior program was fully documented with certain behaviors of taking food from the kitchen, and 3) ensure that sufficient staff were available to manage and supervise R5 in accordance with his behavior plan which allowed him to eat unsupervised.</p> <p>Findings include:</p> <p>Per record review of the Individual Habilitation Plan (IHP) dated 11-6-08, R5 was a 28 year old male who was ambulatory with ritualistic movements and was nonverbal. Based on the Stanford Binet, R5 had an Intelligence Quotient of less than 20. R5's ICAP (Inventory for Client and Agency Planning) was 1 year and 5 months and functioned in the Profound Range of Mental Retardation. R5's list of diagnoses includes Autism and Cerebral Palsy.</p>	W9999			

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W9999	<p>Continued From page 26</p> <p>The Facility Policy on Abuse and/or Neglect to an Individual Served, dated 12/05, states that it is the policy and the responsibility of all facility employees to protect our individuals from abuse and/or neglect. Under number seven it states, "any willful failure to respond to an individual's obvious needs or to provide the appropriate supervision and care that the individual served should have." The definition of neglect means a failure in a long term care facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition.</p> <p>The Investigative Review dated 8-19-09 for R5 states:</p> <p>Methodology: E10 (Director of Nursing Registered Nurse) and E11 (Administrator) conducted a review of the death of R5. A review of his program chart, medical chart, and master chart were completed and interviews with appropriate staff were conducted.</p> <p>Medical Appointments / Evaluations: On 7-15 -09 R5's diet changed to include one half of a meat sandwich at P.M. and bedtime snacks.</p> <p>Review of Program Charts: R5's semi annual staffing completed 5-7-09 indicated that he had been in good health for the past six months. R5 was on a program to slow his pace when eating. The purpose of this program was to ensure that R5 ate at an appropriate rate and to improve his etiquette. Staff sat next to R5 at every meal and provided him with verbal cues. Staff would physically prompt him to slow down by gently putting their hand over his left hand and guiding it</p>	W9999			

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W9999	<p>Continued From page 27</p> <p>down until he chewed and swallowed what was in his mouth. R5 required an average of less than two physical prompts per meal to eat at the appropriate pace. Staff have noticed for the past six weeks a number of unusual behaviors for R5. R5 is eating more rapidly and stealing peers' food and he seems more determined to finish a behavior making him more difficult to redirect. This cluster of behaviors suggests increased agitation that is internally driven (psychotic).</p> <p>Interviews with staff: E9 (Direct Service Provider), E8 (DSP), E7 (DSP), E5 (Team Leader), and E4 (Director of Nursing) were interviewed in regards to the event of 8-19-09 with as follows:</p> <p>The facility interview with E9 stated that she worked the night shift and noticed R5 begin his usual morning routine of wandering around the house until breakfast. E9 reported that R5 had no history of taking food from the kitchen but of late would take food from others plates. E9 did serve breakfast to R7 and recovered the remaining food with aluminum foil and left it on the counter or stove top in the kitchen. E9 punched out at approximately 6:34 A.M. and recalls seeing R5 in his usual routine prior to leaving the work area.</p> <p>The facility interview with E8 stated that she worked the A.M. shift and punched in at 6:34 A.M. E8 went toward the kitchen to begin preparing breakfast. E8 reported that when she was walking to the kitchen, R5 was walking from the kitchen. E8 noticed R5 in the back lounge walking around. E8 went into the kitchen and noticed the aluminum foil had been pulled back from the pan. There was a breakfast sausage wrap on the counter and a few remaining in the</p>	W9999			

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W9999	<p>Continued From page 28</p> <p>pan. E8 proceeded to prepare breakfast.</p> <p>The facility interview with E7 stated that she worked the A.M. shift and punched in at 6:27 A.M. and remained in the office until 6:35 A.M. E7 saw R5 walking around the front lounge with no signs of distress. R5 proceeded to the back lounge area. At 6:55 A.M. E7 went to assist with R3 in her bedroom. E7 upon exiting R3's bedroom looked toward the back window and noticed some legs on the floor behind the table in the back lounge. E7 approached R5 laying on his side and prompted him to get up. E7 noticed R5's eyes were closed and ran to get help stating the R5 is on the floor and he won't move.</p> <p>The facility interview with E4 (Director of Nursing) stated she arrived at 6:25 A.M. and stayed in the office until 7:00 A.M. E4 ran to the living room area and noticed R5 lying on his back with approximately three teaspoons of chewed up food next to his head and that appeared to be the consistency of bread or pancake. E4 initiated cardio pulmonary resuscitation until paramedics arrived and transported R5 to a local hospital. The report states that after the paramedics departed that another clump of chewed up food was found in the hallway near R5's room.</p> <p>The facility interview with E5 (Team leader) stated that she punched in at 6:39 A.M. and did not observe R5 until the call for help.</p> <p>Cause of Death: R5's cause of death was asphyxiation caused by a sausage (size 5 cm x 1.5 cm) that was found lodged in this throat.</p> <p>Summary: After reviewing staff involved and reviewing all pertinent records it appears that R5</p>	W9999			

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W9999	<p>Continued From page 29</p> <p>likely had stolen the sausage wrap from the kitchen just before the A.M. staff (E8) had entered the kitchen that morning.</p> <p>Recommendations: Food that is not in the current process of being served should be kept inside of a warm oven. When making dietary changes attempt to ease toward gradual reductions when possible.</p> <p>Per record review IHP (Individual Habilitation Plan) dated 11-6-08 under Psychological Consultations states R5 is also on an eating program which focuses on staff restricting his left/ arm / hand if needed in order to get him to slow down and eat neatly.</p> <p>The Assessment Summary dated 11-6-08 states for strengths under Capacity for Independent Living that R5 is familiar with all areas of his home. The assessment summary also states that R5 requires 24 hour supervision. Under Self Care it states that R5 needs assistance with diet / portion control, cutting food, serving food and reminders to bring plate to sink. R5 needs verbal and physical prompts to use utensils and to eat at a slow rate.</p> <p>Per interview with E8 (Direct Service Provider) on 9-10-09 at 9:21 A.M., E8 stated that E9 told her that R7 was the only client that ate earlier for breakfast on 8-19-09. E8 stated that they usually catch clients going into the kitchen area. When asked if R5 had ever stolen food from the kitchen before, E8 stated that R5 "has stolen food from the kitchen before." When asked if she had documented this before she replied "no." When asked if she had ever seen R5 take food that was not his she replied "yes I have seen him take</p>	W9999			

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W9999	<p>Continued From page 30 food that was not his."</p> <p>The Diet Order dated 7-15-09 for R5 states his current diet is general. R5 had a diet change to add one half meat sandwich at P.M. and bedtime snacks. The diet order states that R5 has a current weight of 125 pounds with an ideal body weight of 128 to 143 pounds. This form also states that R5 seems to be hungry and eating very fast at meals.</p> <p>The family style assessment dated 7-16-08 states that R5 is on a general diet with double portions. R5 can independently feed himself with verbal and physical prompts to slow down and use utensils. R5 chews without difficulty and staff assist with cutting his food into small pieces due to his eating rapidly. R5 is diagnosed with Autism and has significant difficulty remaining focused and following directions. Staff assist with ensuring that he receives appropriate portions during meals.</p> <p>According to the Home/Neighborhood/Community Access dated 10-6-08, R5 does not have the ability to self protect inside the home and he may not recognize the dangers in leaving the home unaccompanied without structured assistance and supervision. R5 needs assistance with cutting food.</p> <p>According to the record review of the Individual Habilitation Plan dated 11-6-08, under social emotional, R5 indicates choice by reaching for and grabbing for items/objects. The needs and barriers are that staff assist with decision making and ensuring wants and needs are recognized and met. Under personal assessment of the IHP</p>	W9999			

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W9999	<p>Continued From page 31</p> <p>it states that staff will report any and all issues of concern to their supervisor and/or nurse with regards to his care.</p> <p>The IHP dated 11-6-08 under individual requests states that R5 appears to enjoy all meals, food outings, and outdoor activities. It also states that staff believe that R5 would benefit from continued eating programs to reduce the amount of staff assistance needed during meals. A desired outcome for R5 for the upcoming year was to continue to improve eating behavior.</p> <p>The Personal Assessment dated on 10-6-08 states that R5 is able to feed himself, however staff ensure that his food is cut into bite sized pieces and that he is following his diet. R5 is on an eating program at both settings that focuses on eating at a slower rate and using utensils.</p> <p>The Structured Program Plan for R5, dated 11-6-08, states that R5 will participate in family style meals with a slow pace when eating. The individual to staff ratio is one to one with the session at every meal. The purpose is to ensure that R5 eats at an appropriate rate and to improve etiquette and social skills. The training procedures state: At every meal 1. Staff will have R5's adapted scoop plate at his place setting. 2. Staff will sit near R5 at each meal. 3. When R5 begins to eat his meal too rapidly (takes numerous bites without chewing or swallowing, is shoveling food into his mouth) verbally cue him to slow down. Staff will ensure that he uses utensils when not eating finger food. 4. If he does not respond to repeated verbal cues, physically prompt him to slow down. This is</p>	W9999			

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W9999	<p>Continued From page 32</p> <p>done by gently putting your hand over his left hand and guiding it down to rest until he chews and swallows what is already in his mouth. Repeat as needed until his meal is finished.</p> <p>According to the Autism Project Minutes dated 8-13-09, staff have noticed a number of unusual behaviors for R5. R5 is eating more rapidly and stealing peers' food and he seems more determined to finish a behavior making him more difficult to redirect.</p> <p>According to the interview on 9-9-09 with E2 (Resident Service Coordinator) at 2:35 P.M. when asked if a staff member is responsible for overseeing the kitchen area prior to meals, E2 stated that usually one staff is doing medications, one staff oversees the kitchen area, and the other is helping other clients as needed. E2 stated that E5 was administering medications with clients, E8 had the kitchen area, and E7 was helping clients get dressed. When asked if the kitchen needed to be monitored, E2 replied that usually at meal times someone is in the vicinity and that morning 8-19-09 they had not yet started to eat breakfast. When asked if any staff were disciplined for this event, E2 replied none that I'm aware of. When asked if R5 would go into the kitchen should a staff member be with him, E2 replied if staff is aware that R5 is in the kitchen than they will observe what he is doing.</p> <p>Per interview with E8 (Direct Service Provider) on 9-10-09 at 9:21 A.M., E8 stated that the mornings are hectic with 12 people and that they could benefit from additional staff. When asked if it is possible to see the kitchen from where staff punch in for work, E8 stated "no." The Investigative summary report dated 8-19-09</p>	W9999			

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W9999	Continued From page 33 indicates that E8 (DSP) punched in at 6:34 A.M. in the office, E7 (DSP) punched in at 6:27 A.M. but remained in the office until 6:35 A.M., E5 (team leader) arrived at the facility late and punched in at 6:39 A.M., E4 (DON) was at the facility in the office at 6:25 A.M. and did not get out of the office until 7:00 A.M., and E9 punched out at 6:34 A.M. meaning that all staff were in the office and the kitchen was left unsupervised. (A)	W9999			