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| W 331 | Continued From page 17<br>Practitioner does a breast exam when she does the pap smear/ gynecological exam. E1 stated that R7 would not have been examined by the nurse practitioner if she were no longer having pap smears. E1 confirmed that the facility has not provided a gynecological exam/ breast screening for R7 since her last pap test of 6/2/06. E1 stated , " The physician's annual physical states that he deferred the gynecological exam." E1 stated that the facility does not have a policy in place that addresses mammogram or pap smears. | W 331 | | |
| W9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>350.620a)<br>350.1210<br>350.1230d)1)2)<br>350.3240a)<br><br>Section 350.620 Resident Care Policies<br><br>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.<br><br>Section 350.1210 Health Services<br><br>The facility shall provide all services necessary to maintain each resident in good physical health.<br><br>Section 350.1230 Nursing Services | W9999 | | |

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| W9999 | Continued From page 18 | W9999 | | |

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. (Section 2-107 of the Act)

These Regulations were not met ase evidenced by:

Based on observation,interview and record review, the facility failed to ensure health care services are provided for prevention of injuries for 1 of 95 clients in the facility (R12), with potential to affect 84 additional clients (R's 1-3, 5-9, 11, 13-21, 23-36, 38-73, 76-86, 92-95, 97), when they failed to: 1) Identify negative side effects of pre-sedation medication/s; and, 2) Identify the need for an increased level of supervision after the administration of pre-sedation medication/s.

Findings Include:

R12 fell on 10/21/09, and was sent to the emergency room in the a.m. on 10/22/09 (facility injury report of 10/21/09). R12 required "heavy sedation" in order to complete a Computed Tomography scan (facility nursing notes of 10/22/09). When R12 returned to the facility on 10/22/09, the facility failed to implement safeguards to ensure the physical safety of R12, as related to his sedated state (E6 - Licensed

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| W9999 | Continued From page 19<br>Practical Nurse interview on 11/3/09 at 1:23 p.m.). R12 fell again on 10/23/09, at 2:05 a.m., requiring emergency room services and hospital admission (facility injury report of 10/23/09). R12 sustained a Right Periorbital Hematoma, and two (2) one (1) centimeter lacerations to his forehead (hospital record of 10/23/09 and 10/23/09 facility injury report).<br><br>In review of R12's Individual Program Plan (IPP) dated 5/7/09, R12 is a 70 year old male, who functions in the profound range of mental retardation. Additional medical diagnoses include Blindness, Scoliosis, Gait Disorder, Hypertension and Mood Disorder. R12 is non-verbal, and requires incontinence briefs 24 hours a day.<br><br>The "Motor Skills" portion of his IPP describes R12's standing balance as, "poor." An undated facility "Gait Belt Transfer List" documents that R12 requires a roller walker, gait belt and assist of one (1) staff when ambulating.<br><br>R12's 4/10/09 Wais-R psycholoical documents an intelligence quotient (IQ) of 7 on the WAIS-R.<br><br>His 4/10/09 Inventory for Client and Agency Planning (ICAP), documents an overall age equivalent of 0 years/8 months.<br><br>In an interview with E2 (Qualified Mental Retardation Professional - QMRP), on 11/12/09 at 1:15 p.m., E2 stated that R12 is, "pretty unsteady and is not cooperative" in using his walker. E2 further stated that R12 is, "wobbly all the time...scary sometimes."<br><br>In review of a facility injury report dated 10/21/09, | W9999 | | |

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| W9999 | Continued From page 20<br>8:30 p.m., R12 lost his balance and bumped his head on a door. R12, "had a bump and one cm. (centimeter) superficial mark on his forehead." The second typed page attached to the original report states that on 10/22/09, R12 was making crying, slight moaning noises and was sent to the ER (Emergency Room) at 8:30 a.m. R12 returned at 12:40 p.m. with a diagnosis of a Hematoma to the forehead.<br><br>Nursing notes of 10/22/09 at 12:40 p.m., state, "CT scan of head was done and client had to be heavily sedated for procedure - to rest for a day or two & (and) return to normal activities." There is no evidence in nursing notes of what sedative/s and what dosage R12 received at the hospital. Additionally, in review of R12's file there is no evidence of the hospital report from 10/22/09.<br><br>In an interview with E1 (Director of Nursing - DON), on 11/13/09 at 1:10 p.m., E1 confirmed that the facility had not obtained the 10/22/09 ER report, and did not know what sedative/s and what dosage R12 had received during this ER visit.<br><br>In an interview with E3 (Shift Leader), 11/12/09, at 2:15 p.m., E3 stated she worked 10/22/09 during the 2:15 - 10:45 p.m. shift, and that R12 returned from the 10/22/09 ER visit during her shift. E3 stated R12 was very off balance. R12 required two staff to get him to the shower and back to his bed, that he was, "out of it." E3 stated that normally one person is all that is needed to assist R12.<br><br>E4 (Technician), on 11/12/09, at 2:05 p.m., stated she worked 10/22/09 during the 2:15-10:45 p.m. | W9999 | | |

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| W9999 | Continued From page 21 | W9999 | | |

shift, and was present when R12 returned from the ER. E4 stated that R12 was, "mixed up and confused". R12 required two staff to get him to the shower and back to bed.

E5 (Technician), on 11/12/09, at 2:00 p.m., stated she worked 10/22/09-10/23/09 from 10:30 p.m.-9:00 a.m. E5 stated when she came on duty she was told by E4 that R12 was dizzy and light headed, and to keep an eye on him. No other instructions were provided.

In an interview with E6 (Licensed Practical Nurse - LPN), on 11/13/09, at 1:23 p.m., E6 confirmed she was on duty when R12 returned from the ER on 10/22/09 at 12:40 p.m. E6 did not remember what direct care staff were on duty, but told staff to let R12 lie in bed and let him sleep. E6 confirmed that no further written instructions were provided for staff regarding his level of supervision.

In review of a facility injury report dated 10/23/09 at 2:05 a.m., R12 fell again, (thirteen hours and 25 minutes after returning from the ER on 10/22/09), this time in the hallway, landing on his right side. R12 received a 5 centimeter Hematoma with two 1 centimeter lacerations. R12 was again sent to the ER and admitted to the hospital. Nursing notes of 10/23/09, at 2:05 a.m. state there was a, "moderate amount of bleeding noted."

Nursing notes of 10/24/09, at 2:30 p.m., document that R12 was returned to the facility at this time, with a diagnoses of Right Forehead Hematoma and Right Periorbital Hematoma.

In an interview with E2, on 11/12/09, at 1:15 p.m.,

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| W9999 | Continued From page 22<br>E2 stated she thinks R2 would not have fallen the second time if he had not been so heavily sedated. "Second guessing, someone should have sat with him."<br><br>In an interview with E1 (Director of Nursing - DON), on 11/13/09, at 1:15 p.m., E1 presented an undated facility roster to surveyor. Per surveyor request, E1 identified the following individuals who require pre-sedation medication/s to complete medical procedures. Eighty-four (84) additional individuals were identified - (R's 1-3, 5-9, 11, 13-21, 23-36, 38-73, 76-86, 92-95, 97).<br><br>In an interview with E1( DON), on 11/12/09 at 12:20 p.m., E1 stated that the facility does not have a policy or procedure regarding the level of supervision and monitoring for physical safety after individuals receive pre-sedation for medical procedures. E1 further states that she, "can see the benefit for this."<br><br>In an interview with E1, on 11/13/09, at 9:05 a.m., E1 stated R12 does not have a fall risk assessment, and the facility does not implement a fall risk assessment tool for any individuals of the facility.<br><br>In review of undated facility documents that validate individuals who require mobility assistance, and have an increased potential for falls, there are an additional 38 individuals who require mobility assistance in the form of gait belts, wheelchairs, walkers, protective helmet, orthotics, and staff, alone, or in various combinations there of (R's 3, 8-11, 13, 14, 17-19, 26-29, 32, 33, 39, 45, 47, 50-52, 54, 58, 59, 61, 63, 68, 69, 72, 73, 76, 77, 82, 92, 93, 97). | W9999 | | |

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| W9999 | Continued From page 23<br>In the undated "Mistreatment of Resident Policy & Procedures," it states, "The Parents and Friends of the Specialized Living Center do not tolerate any form of abuse, mistreatment and/or neglect of the clients in our care."<br><br>Neglect is defined as, "a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a client or in the deterioration of a client's physical or mental condition."<br><br>Under the section entitled, "Mistreatment of client's includes, but is not limited to", it states, "...Any willful failure to respond to a client's needs or to provide the supervision and care required."<br><br>The undated "Philosophy of Health Services Department," states, "Medical services are provided as necessary in accordance with the needs of the residents...to maintain an optimum level of health for each resident, and to prevent further disability."<br><br>The undated "Health Services Personnel Composition" policy states, "Responsibilities of the Director of Nursing include...formulation of written policies and procedures that directly or indirectly influence resident services...assuring that the heath needs of the residents are met...with particular attention to the identification of the health needs of each resident and planning to meet these needs...protection from accident and injury through appropriate safety measures...."<br><br>(A) | W9999 | | |