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	14G126	A. BUILDING _____ B. WING _____	10/25/2010

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W 331	Continued From page 17 tapped him and pinched him but got no response. E4 said he did this for 15 to 20 seconds. E4 stated that he did not turn R7 onto his back or check his airway. E4 said the paramedics arrived shortly after that. When asked where he was when the paramedics arrived, E4 said that he was standing next to R7. E4 then stated that the paramedics immediately flipped R7 over and started doing chest compressions. E4 confirmed with surveyor that he did not initiate CPR. Findings from the Chicago Fire Department's Incident Detail Report note that upon arrival of the rescue squad R7 had a patent airway but no spontaneous respirations and no chest wall expansion. R7 had no circulation, his skin was cold and dry and he was cyanotic. Impression : Dead on Arrival. During interview with E1, (RSD) on 10/07/10 it was confirmed that on 09/29/10 R7 was on full code status.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.670a)3) 350.1210 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 18 public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.670 Personnel Policies a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this Section. 3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. 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 as evidenced by: Based on observation, interview and record review the facility failed to have a system in place to prevent neglect and injury when the facility did not ensure residents are monitored when they board the bus and exit to and from day training for 2 of 14 residents who ride the bus, R4 and R5. This failure resulted in an injury to R4 who	W9999		

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W9999	Continued From page 19 was pushed from the bus by R5 and sustained a left hip fracture. . Findings include: According to the IHP (Individual Habilitation Plan) of 04/15/10, R4 is a 64 year old non verbal male with diagnoses including Profound Mental Retardation and Seizure Disorder. R4's ICAP (Inventory for Client and Agency Planning) in the medical record lists his Overall age equivalent at the level of a 1 year old. His Service Score/Level of 3 notes that he requires personal care and/or constant supervision. R4's undated DLA, (Daily Living Activities) assessment in the record notes that he has severe impairment or problems in the areas of : 1.) Safety- avoiding routine dangers, places, situations, actions and getting help in an emergency. 2.) Communication 3.) Problem Solving The IHP also notes that R4 requires physical assistance while getting on and off the bus. An incident report of 06/03/10 noted that R4 also had a fall while getting out of the shower on 06/03/10 resulting in a fractured left wrist. Review of another incident report dated 06/22/10 completed by E2, DSP (Direct Support Person) noted that she was told by the bus driver (Z1) that R4 was "pushed" and there was no one at the bottom of the steps to help or catch him. When E2 walked over to the bus R4 was on the ground in front of the steps. E2 tried getting him up but he would not put pressure on his leg. Nurse and 911 were called and R3 was sent to the Emergency Room.	W9999		

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W9999	Continued From page 20 Z1 (driver) and Z2 (bus attendant) both signed a completed incident report on 06/22/10 with the following information: At 2:55 PM the bus arrived at the facility. As the clients were getting off the bus they were not supervised by staff from the house so the driver got off the bus. As R4 got to the last stair of the bus he was pushed from behind by R5 causing him to fall off the bus. The driver (Z1) was unable to catch him and staff from the house still had not come outside to assist. Z1 then told staff from the home that they had to help. Two staff members then came to assist and sent one of the residents inside to get a wheelchair for R4. The statement concludes with a comment that this is not the first time they (facility staff)have not come to the bus in the afternoon. There is one aid that comes when she is working and there is an aid that does not come at all. After review of the incident reports on 09/27/10 E1 was asked about the procedure for monitoring the residents while boarding and exiting the bus. E1 replied that often she is the only staff in the house in the afternoon and if she is in the restroom or does not hear the bus she does not know that the residents are home. E1 also stated that the bus driver is supposed to ring the doorbell. When asked, E1 was not sure if there is an attendant on the bus with the driver and really was not sure exactly what the bus company's responsibilities were. Upon further questioning E1 confirmed that the facility does not have a system in place for monitoring the residents while boarding and exiting the bus for day training. On 09/28/10 surveyor observed residents as they returned home from day-training at approximately	W9999		

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W9999	Continued From page 21 3:00 PM. E2 was observed walking out to the bus when it pulled up to the facility. As residents were approaching the house surveyor observed R6 using a walker while walking backwards. R6 was also walking backwards as he descended the stairs that lead to the front door. R7 was observed being held by the hand of another resident while walking towards the house. R7 walked approximately 15 feet then fell to one knee. E2 was the only staff from the home assisting residents from the bus and did not observe R7 fall. R7 was helped up by E2 when she realized that he had fallen. E1 was asked on 09/27/10 and again on 09/28/10 to provide surveyor with information pertaining to the mobility status for each resident who rides the bus and how much assistance they require getting on and off the bus. E1 did not provide the information. E1 did state however that R4 needs staff to hold onto his arm when he gets on and off the bus. (A) 350.1210 350.1220e) 350.1220h) 350.1220j) 350.1235a)3)4) 350.3240a) 350.3750 Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health.	W9999		

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W9999	Continued From page 22 Section 350.1220 Physician Services e) All residents shall be seen by their physician as often as necessary to assure adequate health care. h) The facility shall maintain effective arrangements through which medical and remedial services required by the resident but not regularly provided within the facility can be obtained promptly when needed. j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 350.1235 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject, or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; Section 350.3240 Abuse and Neglect	W9999		

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W9999	Continued From page 23 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Section 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that 1 of 7 residents in the sample, R4 receive appropriate assessment and timely medical care after sustaining a fall from the bus while returning from day training. The facility also failed to ensure that CPR (Cardio Pulmonary Resuscitation) was initiated for 1 of 1 resident, R7 who required CPR when he stopped breathing. Findings include: 1) According to the IHP (Individual Habilitation	W9999		

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W9999	Continued From page 24 Plan) of 04/15/10, R4 is a 64 year old, ambulatory, non- verbal male with diagnoses including Profound Mental Retardation, Osteoporosis and Seizure Disorder. R4's ICAP lists his Overall age equivalent at the level of a 1 year old. His Service Score/ Level of 3 notes that he requires personal care and/or constant supervision. R4's undated DLA, (Daily Living Activities) assessment in the record notes that he has Severe impairment or problems in the areas of : 1.) Safety- avoiding routine dangers, places, situations, actions and getting help in an emergency. 2.) Communication 3.) Problem Solving The IHP also notes that R4 requires physical assistance while getting on and off the bus. Review of an incident report summary completed by E2, DSP (Direct Service Person) dated 06/22/10 at 3:00 PM noted the following; The bus driver stated that R4 was pushed [from the bus] and there was no one at the bottom of the steps to help or catch him. He was on the ground in front of the steps. E2 tried getting him up but he would not put pressure on his leg. He was then brought in with a wheelchair. The nurse and director were notified, 911 was called and R4 was taken to the Emergency Room. R4's Medical/Nursing progress notes from the facility were reviewed for 06/22/10 and an entry written by E3 (nurse) notes that after the fall E3 instructed staff to check R4's foot for swelling and pulse, no swelling was noted, pulse was present,	W9999		

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W9999	Continued From page 25 and R4 was sent to E.R. to rule out fracture or sprain. R4 was released from the hospital later with discharge instructions to follow up with personal physician as needed. The discharge record does not reflect the results of any x-rays performed at the hospital. Review of facility medical notes do not reflect that R4 was assessed by a medical person at the facility after his discharge. The next notation in the medical record was 2 days later, 06/24/10, by E2 stating, " the resident could not put pressure on his leg, so we were unable to obtain his weight." 06/24/10- E3 (Nurse) documents: "assessed pt., pt. would not stand without assistance and would not place left foot down to support weight. Pt. seems fearful, staff instructed to continue to get pt. up out of wheelchair to promote weight bearing, RSD aware." 06/28/10- E3 documents: RSD and nurse discuss pts. progress. Nurse recommends pt. to see M.D. for another evaluation, pt. exam. Patient still refused to place wt. on left foot and will only get up with assistance, fearful state noted on exam. 06/30/10- memo to Z3, (R4's attending physician), E1 requesting advice from Z3 because R4 will not put pressure on his leg. 07/01/10- Z3 wrote "Patient fell off bus last Friday. Now will not walk with legs. ? Fracture history of osteoporosis." An x-ray of both feet was ordered by Z3, x-ray report notes that a fracture is not seen. 07/07/10 - examined by Z3, Z3 documents:	W9999		

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W9999	Continued From page 26 received pt. unable to walk, x-ray both hips, home pt/ot. 07/15/10 - seen in Z3's office for follow-up, Z3 documents: patient still refuses to walk, had x-ray of hip, no recent falls. Further review of the follow-up by surveyor does not reflect that Z3 addressed the results of the hip x-ray that he ordered on 07/07/10. A memo sent to Z3 on 07/15/10 by E1 also asks for the results of the hip x-ray. Surveyor review of R4's medical record did not produce results of the hip x-ray ordered by Z3 on 07/07/10. 07/19/10 - E3 (Nurse) documents: spoke with RSD related to ortho consult, RSD awaiting call back from ortho, chart audit completed. RSD stated "there is nothing broken as to why [R4] won't stand. M.D. has not given any directives as to what is to be done with patient. Pt is on fall precautions. No falls or skin breakdown." 07/22/10 - E1 documents in a memo to Z3 - "Physical Therapy called and said they need guardian consent to treat R4. As of this date I haven't heard from them. I have also requested from your office a copy of the hip x-ray but I have not yet received it. Please fax to me as soon as possible and advise regarding the physical therapy." Surveyor review of medical notes in R4's record for August, 2010 show that R4 did not have an initial Physical Therapy assessment until 08/19/10 and the first therapy visit did not take place until 08/31/10. The initial order for physical therapy was written by Z3 on 07/07/10.	W9999		

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W9999	Continued From page 27 Physical therapy notes included in R4's medical record were reviewed by surveyor which include the following: 08/31/10- Ambulation: not feasible at this time Musculoskeletal System : positive signs of overt pain behavior noted as therapists perform tests/ measures on pt's left hip joint/musculature. Pt's left hip joint appears asymmetric and unequal as compared to pt's right hip joint upon inspection. Unable to tolerate single leg standing or prolonged weight bearing to left lower extremity. Telescoping sign on left hip. Upon patient evaluation therapist has found that the patient has presented with unusual signs and symptoms and patient's current condition appears to be beyond therapist's scope of practice. Therapist to coordinate with primary physician for further diagnostic tests, radiographs of left hip joint to rule out underlying condition such as hip fracture/dislocation. P.T. intervention on hold. 09/01/10- E1 documents that x-ray technician came at 5:00 PM and took x-ray of R4's left hip. The radiologist's findings from the x-ray report dated 09/01/10 were found in R4's record and are as follows: LEFT HIP: Examination reveals an impacted intertrochanteric fracture of the proximal femur with some varus deformity at the fracture site and no significant displacement. Clinical correlation is requested to determine the exact age of this fracture. The report also notes that the results were reported to Z3's office on 09/02/10.	W9999		

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W9999	Continued From page 28 09/08/10 -lab work and CT- scan ordered by Z3, lab work done 09/09/10, CT scan- left hip not completed until 09/20/10. The CT scan results of 09/20/10 were in R4's record and note the presence of the left hip fracture and also seen was a large inguinal hernia. Z3 wrote on the report the following: 1. needs ortho eval, 2. general surgery eval. 09/22/10 - E1 documented in the record that Z3's office called and said that R4 has a hernia and Z1 wants to see him in his office. An appointment was scheduled for 09/30/10. There is no documentation in the record at this time that refers to the left hip fracture. 09/27/10 - E1 documented in the record that Z3's office called to cancel R4's appointment on 09/30/10 because Z3 won't be there. Appointment re-scheduled for Monday, 10/04/10. There was no further documentation in the record regarding follow-up for R4's left hip fracture or the inguinal hernia On 09/27/10 at approximately 4:00 PM R4 was observed in the living room of the home sitting in a wheelchair. E1 was asked by surveyor why R4 was in the chair. E1 replied that R4 has been in the wheelchair since he fell on 06/22/10 because he is refusing to walk. E1 also said that before he fell he had no problems walking, he just needed staff to help him on and off the bus. E1 further stated that the wheelchair belongs to another resident but they have also been using it to wheel R4 out to the van for day-training.	W9999		

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W9999	Continued From page 29 On 10/19/2010 Z3, (attending physician) was intervewed by telephone at approximately 11:15 AM. Surveyor asked Z3 about the initial care that R4 received when he was pushed from the bus on 06/22/10. Z3 replied that this was the first time he was told that R4 had a fall. Z3 further stated that if he had known that there was a fall he would have treated R4 differently. "I thought he had a stroke." Z3 also confirmed that he did not initially examine R4 until 07/01/10. (Z3 documented on 07/01/10 that R4 had fallen from the bus.) Z3 also confirmed that he ordered hip x rays after he saw R4 on 07/07/10. Z3 was then asked why there was no mention of the hip x ray results during the next follow up follow up with R4 on 07/15/10. Z3 responded that the x- ray report was not available and he went on vacation after that. Z3 then confirmed that he spoke with an orthopedic surgeon at some point regarding R4's fracture. Z3 said that the ortho doctor wanted to do surgery but there was a mix up at the hospital regarding R4's admission. Z3 again stated that he was on vacation around this time and does not know any other details. Z3 was reminded by surveyor on 10/19/10 that R4 is currently in his home, in a wheelchair and unable to ambulate. Z3 then stated that he is going to call the ortho surgeon today (10/19/10) to make arrangements for the surgery. 7) According to the General Information form in the medical record dated 05/04/10, R7 was a 60 year old male with Diagnoses including Profound Mental Retardation, Downs Syndrome and Dementia. An initial incident report dated 10/01/10 completed by E1, RSD (Residential Services Director) was reviewed. E1 documented that on	W9999		

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W9999	Continued From page 30 09/29/10 at approximately 11:00 PM she received a call from E2 (program aid) who stated that she had called 911 after finding R7 on the floor of his room while doing her last room check. E2 stated that R7 was breathing but not responding. At 11:20 PM E2 called E1 back and told her that R7 was "gone." The paramedics and police were present at that time. E1 asked E2 if she performed CPR and E2 said no, after E4 (program aid) came into the room she ran and called 911. Surveyor interviewed E2 by telephone on 10/04/10. E2 told surveyor that she found R7 in his room lying on his side. E2 said she did not initiate CPR because she thought R7 was breathing, she thought he was breathing very "shallow" and had a pulse. E2 ran to get her co-worker (E4), called 911 and did not return to R7's room. Review of the facility's formal investigation dated 10/01/10 completed by E1 included E2's interview in which she stated that at 10:55 PM she found R7 on the floor of his room. There was mucous and blood on the floor. She called for help and checked his body which was "cold and clammy." E2's interview does not include any further details regarding her assessment of R7 prior to E4 (her co worker) entering the room. E4 was interviewed by telephone on 10/07/10 and again on 10/12/10. E4 told surveyor that he was called to R7's room at around 11:00 PM on 09/29/10. When he got to the room he saw R7 lying face down in a pool of blood and mucous around his head. E4 said he yelled R7's name, tapped him and pinched him but got no response. E4 said he did this for 15 to 20 seconds. E4	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G126	A. BUILDING _____ B. WING _____	10/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORE HOUSE	9135 SOUTH BRANDON AVENUE CHICAGO, IL 60617

(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 31 stated that he did not turn R7 onto his back or check his airway. E4 said the paramedics arrived shortly after that. When asked where he was when the paramedics arrived, E4 said that he was standing next to R7. E4 then stated that the paramedics immediately flipped R7 over and started doing chest compressions. E4 confirmed with surveyor that he did not initiate CPR. Findings from the Chicago Fire Department's Incident Detail Report note that upon arrival of the rescue squad R7 had a patent airway but no spontaneous respirations and no chest wall expansion. R7 had no circulation, his skin was cold and dry and he was cyanotic. Impression : Dead on Arrival. During interview with E1, (RSD) on 10/07/10 it was confirmed that on 09/29/10 R7 was on full code status. (A)	W9999		