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W 240	Continued From page 25 supervision (i.e., should be within a staff members line of vision)." R1's 9/1/11 day training "Behavior Support - Refrain from PICA" program also states, "(R1) needs line of sight supervision at all times. This type of supervision is defined as having (R1) within your field of vision even when working with other individuals." Both programs state that if R1 places inedible items into his mouth, staff are to prompt R1 to remove the item; touching R1's mouth and jaw is often successful in encouraging him to spit out what he has in his mouth. In review of the above attempted and successful incidents of Pica behavior, the majority of this behavior has occurred in the vocational area at his day training site and during meals. In an interview with E1 (Administrator/Qualified Mental Retardation Professional - QMRP), on 12/30/11, at 3:00 p.m., E1 confirmed that staff could keep R1 in line-of sight supervision from across a room, and not be able to reach R1 quickly enough to intervene in a Pica incident. E1 further agreed that line-of sight supervision is not clarified in R1's behavior program plan, relative to R1's work or eating environments.	W 240		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS Section 350.620a) Section 350.700a) Section 350.1060e) Section 350.1610a)	W9999		

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W9999	Continued From page 26 Section 350.1620d)12 Section 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 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident Section 350.1060 Training and Habilitation Services 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. Section 350.1610 Resident Record Requirements a) Each facility shall have a medical record system that retrieves information regarding	W9999		

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W9999	Continued From page 27 individual residents. Section 350.1620 Content of Medical Records d) In addition to the information that is specified above, each resident's medical record shall contain the following: 12) Records of significant behavior incidents, reactions to any family visits and contacts, attendance at programs, and leaves from the facility. 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 Requlations were not met by as evidenced by: Based on observation, interview and record review, the facility has failed to implement their system to prevent neglect for 1 of 1 (R1),individual who has not received thorough and timely implementation of safeguards regarding his documented history of Pica/attempted Pica, resulting in the risk of additional injury for R1. R1 has required surgery for removal of swallowed items prior to his admission to this facility; and, since admission, has required emergency room services after swallowing a jelly packet, one successful colonoscopy for removal of ingested coins, and, one unsuccessful colonoscopy to attempt the removal of a hex nut (R1). The facility failed to implement their own policies	W9999		

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and procedures for neglect, when the facility failed to:
> investigate R1's 11/18/11 mustard packet Pica attempt at the day training site.
> ensure further training and/or a prevention plan after R1's 11/18/11 Pica attempt.
> ensure implementation of documented training for day training staff, relative to R1's immediate environment remaining free of small inedible items.
> ensure that the facility's and the day training's behavior support plans clearly identifies R1's level of supervision across environments, relative to his known Pica behaviors.

Findings include:

1). During a review of R1's behavioral documentation regarding his Pica, there is an 11/18/11 handwritten, unsigned note on plain paper that states, "Z3 - day training manager), called - (R1) attempted Pica @ (at) lunchtime. He got a mustard packet to his mouth but they stopped him before he ate it. She just wanted to let you know."

On 12/29/11, at 2:50 p.m., Z2 (day training trainer), stated that on 11/18/11 she was preparing lunches for the consumers and placed condiments out on the table. When Z2 turned to give another consumer his lunch, R1 grabbed a mustard packet and tried to put it into his mouth. Z2 was able to remove the packet from R1 before he was able to put it into him mouth.

An 11/16/11 day training document states, "Although previous training sessions with DT (day training) staff members included the following

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points another training session was held on November 16, 2011, and reiterated this information...(R1's) immediate environment should be arranged such that small inedible items are removed from the area...".

In a 1/4/12, 12:50 p.m., phone interview, with Z4 (Director/day training), Z4 stated that after the 11/18/11 attempted Pica with the mustard packet, the day training site has not provided any further staff training and/or prevention plan regarding R1's eating environment at the day training site, until this date (1/4/12) - after surveyor entry to the follow-up survey on 12/29/11.

1a). In review of an undated facility roster that validates level of functioning, R1 functions in the profound range of mental retardation.

His 3/24/11 "Social History" documents an admit to this facility on 2/2003.

R1's 3/24/11 Inventory for Client and Agency Planning (ICAP), documents R1's overall age equivalent at 1 year and 3 months.

His 7/10/03 psychological evaluation documents that R1 is non-verbal. The Slosson Intelligence Test documents his intelligence quotient (IQ), as less than 20.

Additional diagnoses (11/16/11 physician's orders) , include Pica, Manic with Psychotic Features, Dysphagia, Bipolar Disorder, and a History of Seizures/Epilepsy. R1 also requires a mechanical soft diet as related to his Dysphagia. R1 also receives medications to assist in behavior control.

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His 3/24/11 Individual Service Plan (ISP), states that R1 needs to be monitored at all times while eating, as he needs to be prompted to take bite size pieces and to eat slowly, "rather than shovelling food."

His 3/24/11 "Facesheet" validates that R1 has a state guardian.

During observations on 12/28/11, at 2:45 p.m., at the day training site, R1 is independently ambulatory.

R1's 3/24/11 day training ISP, documents R1's long history of Pica -
"(R1) had surgery in September 1998 (prior to his 2003 admit to facility), for exploration of an obstruction and the removal of swallowed items...On 7/9/09 (R1) went to the ER (emergency room) after swallowing a jelly packet...He has eaten a piece of plastic from his work, quarters (see 2/26/11 incident below), a possible candy wrapper and a piece of unidentified cardboard."

Recent successful Pica and attempted Pica are documented as follows:

- 2/26/11 - R1 had foreign objects in his incontinence briefs. X-rays revealed a small disc in the colon. An additional x-ray was performed on 2/27/11, with an order for Magnesium Citrate to clear R1's bowel. A colonoscopy was scheduled for 3/7/11, as a small disc remained in the bowel. Two quarters were removed during this colonoscopy (facility nursing notes of 3/4/11).

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Per E1, on 12/30/11, at 3:00 p.m., the investigation was not conclusive (2/26/11 coin incident). However, the conclusion was that R1 probably obtained the quarters while on the day training transport bus.

- 4/3/11 - attempted Pica with paper at the day training site (5/17/11 Special Interdisciplinary Team meeting {IDT}).

- 4/16/11 - attempted Pica with a sticker at the day training site (5/17/11 Special IDT).

- An 8/30/11 facility report to the Illinois Department of Public Health (IDPH), states that on 8/29/11, while at the day training site, R1 successfully obtained and ingested a small piece of wet material that is used for personal cleaning. Per the report, while in the lunch room, R1 opened a container of wet cleaning wipes. Staff removed the wipe from R1, but R1 was able to tear off and ingest a small piece of the wipe.

- A 9/1/11 facility report to IDPH states, that on 8/31/11, while at the day training site, R1 obtained and ingested a hex nut.

A 10/11/11 "Medical Visit Synopsis/Consultation" documents a physician's order for a colonoscopy to be completed on 10/25/11. A 10/26/11 hospital "Operative Report" states that the metal nut could not be removed. "Despite all maneuvers, including turning the patient to a supine position, the right lateral position, and then back to the left lateral position, it was not possible to safely get around the hepatic flexure into the ascending colon and cecum." This report provides options given - 1) do nothing and see (physician) in 6

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months; 2) "Advised to take him to (hospital in St. Louis) or (hospital in Chicago) for a second opinion, and maybe they will want to try repeating the procedure:" 3) A second opinion locally.

An 11/14/11 "Medical Visit Synopsis/Consultation" report recommends to repeat the x-ray 6 months after the last procedure.

In a 12/28/11 11:52 a.m. interview with E1(Administrator/Qualified Mental Retardation Professional - QMRP), E1 stated that as of this date, there has been no evidence that R1 has passed the hex nut through his bowel movements.

- An 11/7/11 facility "Special IDT for (R1)" document states that on 11/2/11, while at the day training site, R1 attempted to ingest a piece of his work, further defined on R1's 11/2/11 day training behavior charting, as a piece of "metal work".

Facility staff came to the day training site to pick up R1 and return him to the facility, due to his escalated energy/activity level. After R1 returned home, on this same day, he attempted to put a tube of glitter in his mouth, but facility staff were able to intervene.

In a 12/29/11, 10:30 a.m., interview with E1, E1 stated that the above 11/18/11 note was written by a facility staff, and left for him, after Z3 called regarding the incident. E1 further confirmed that this was the only information he has on this incident.

On 12/29/11, at 11:52 a.m., when asked, E1

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W9999	Continued From page 33 confirmed that the facility had not conducted an investigation for R1's 11/18/11 attempted Pica behavior. On 12/30/11, at 9:30 a.m., E1 stated that the day training site had faxed the 11/18/11 incident report for R1. The facility received it on 12/29/11, at 5:16 p.m., after surveyor had departed for the day. E1 agreed that it is not clear in the 11/18/11 day training incident report as to where the mustard packet came from (R1's lunch prepared by staff at the facility, or day training provision). E1 further stated that he understood that with no investigation, the facility could not determine if /or what action (staff training/retraining at the facility regarding packing lunches for day training?; staff training/retraining at the day training site?; alter the eating environment for R1 at lunchtime?), was necessary regarding R1's 11/18/11 Pica attempt. 1b). In an interview with E1, on 12/29/11, at 11:52 a.m., when asked, E1 confirmed that the facility has not ensured that a prevention plan has been provided and implemented regarding R1's attempted Pica with a mustard packet, on 11/18/11, at the day training site. In a 1/4/12, 12:50 p.m., phone interview, with Z4 (Director/day training), Z4 stated that after the 11/18/11 attempted Pica with the mustard packet, the day training site has not provided any further staff training and/or prevention plan regarding R1's eating environment at the day training site, until this date (1/4/12) - after surveyor entry to the follow-up survey on 12/29/11.	W9999		

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1c) On 12/29/11, at 2:50 p.m., Z2 (day training trainer), stated that on 11/18/11, she was preparing lunches for the consumers and placed condiments out on the table. When Z2 turned to give another consumer his lunch, R1 grabbed a mustard packet and tried to put it into his mouth. Z2 was able to remove the packet from R1 before he was able to put it into his mouth.

1d) In review of R1's 9/12/11 facility "Behavior Support Program", R1's Pica behavior is documented. Per this program, it states, "During waking hours at his residence and at his day training program...(R1) will require line-of-sight supervision (i.e., should be within a staff members line of vision)."

R1's 9/1/11 day training "Behavior Support - Refrain from PICA" program also states, "(R1) needs line of sight supervision at all times. This type of supervision is defined as having (R1) within your field of vision even when working with other individuals."

Both programs state that if R1 places inedible items into his mouth, staff are to prompt R1 to remove the item; touching R1's mouth and jaw is often successful in encouraging him to spit out what he has in his mouth.

In review of the above attempted Pica and successful Pica incidents for R1, the majority of his Pica has occurred in the vocational area at his day training site and during meals.

In an interview with E1 (Administrator/Qualified

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Mental Retardation Professional - QMRP), on 12/30/11, at 3:00 p.m., E1 confirmed that staff could keep R1 in line-of sight supervision from across a room, and not be able to reach R1 quickly enough to intervene in a Pica incident. E1 further agreed that line-of sight supervision is not clarified relative to R1's work or eating environments.

The facility's 7/26/10 "ABUSE AND NEGLECT POLICY FOR DETECTION, PREVENTION, REPORTING AND INVESTIGATING" was reviewed.

Per this policy, "Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. It is the failure by a long-term care facility to provide adequate medical or personal care maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition."

"The agency monitors the care and services of the residents to prevent abuse and neglect by the following outcomes...Incident reporting an analysis of all incidents to determine, if possible, if abuse or neglect exists and to identify patterns and trends...When any of the above activities deviate from the acceptable standards, a problem-solving approach will be initiated which includes: 1) plan for improvement by analyzing the extent of the problem, 2) engaging staff to determine the cause and extent of the problem and develop plans for improvement, 3) implement a plan for improvement, 4) evaluate the response, 5) revise the plan as needed, educate

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W9999	Continued From page 36 staff and residents when necessary and continue to study." "This agency maintains a proactive approach for identifying events and occurrences that may contribute to abuse and/or neglect...monitors internal operations and practices to identify situations or incidents that may be precursors to abuse and/or neglect...". The facility's 2005 "DAY PROGRAM" policy was reviewed. Per this policy, "the home's Qualified Mental Retardation Professional will monitor the individual's day program goals to ensure consistent program planning and implementation...Individuals receiving services are provided with professional programs and services in accordance with their needs...Programs and services provided...to the home by outside agencies or organizations...must meet the standards for quality of services as stated in the Illinois Regulations for ICF/DD (Intermediate Care Facilities for the Developmentally Disabled) facilities...". The facility's 2005 "GOVERNING POLICIES" was reviewed. Per this policy, "This home's Qualified Mental Retardation Professional (QMRP) along with assistance from the individual's Interdisciplinary Team is responsible for the health, safety, and welfare of each person living in an ICF/DD...in conjunction with vocational staff...evaluates...	W9999		

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W9999	Continued From page 37 (and) ensure appropriateness and quality of services offered." (B)	W9999		