STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 154	Continued From page 26 1/17/12 - This note documents that R127 had been eating pizza and chips the night before. There is a typed note from E10 (Qualified Mental Retardation Professional - QMRP), stating that R127 obtained the pizza from a trash can outside of his room. There is, however, no further investigation regarding this incident, relative to R127's 15 minute checks and/or his 1:1 supervision level at the time of this occurrence.	W 154		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1060a) 350.1060b) 350.1060c) 350.1060e) 350.1060f) 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 a) The facility shall provide training and habilitation services to facilitate the intellectual,	W9999		

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	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

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W9999	Continued From page 27 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. 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. f) There shall be a functional training and habilitation record for each resident, maintained by and available to the training and habilitation staff. 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	W9999		

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ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

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W9999	Continued From page 28 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 are met as evidenced by: Based on interview and record review, the facility has failed to implement their system to prevent neglect for 1 of 1 individual whose 1/03/12 choking incident at the day training site resulted in death (R206), when they failed to: > ensure a thorough investigation of R206's 1/03/12 choking incident at the day training site; > collect, maintain and monitor data relative to R206's maladaptive eating behaviors, identified in her current 11/1/11 behavior program, and for which interventions are provided; > re-assess and implement the possible need for corrective or preventive measures to prevent reoccurrences of choking and/or death from choking for 20 of 20 individuals who are on formal programs relative to unsafe eating behaviors (R's 6, 7, 17, 38, 41, 59, 115, 117, 123, 132, 142, 144, 148, 158, 159, 176, 181, 183, 188 & 205); and for 4 for 4 individuals who require informal monitoring due to unsafe eating behaviors (R's 95, 121, 131 & 187), all of whom attend the day training site. In addition, the facility failed to investigate or thoroughly investigate R127's six documented ingestion/possible oral ingestion of liquids/solids, for 1 of 1 individual who has current physician's orders for a g-tube, and is to receive nothing by mouth (R127). Findings Include: 1)A) In review of R206's Individual Service Plan	W9999		

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	14G049	A. BUILDING ____ B. WING ____	C 02/10/2012

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ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

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W9999	Continued From page 29	W9999		

Continued From page 29

(ISP), R206 functioned in the profound range of mental retardation. The ISP documents that R206 was verbal, generally spoke in short phrases, and walked independently. Her 12/1/11 physician's orders documents her age as 44 years old (date of birth - 9/21/67). Additional medical diagnoses include Organic Mental Disorder NOS (not otherwise specified) With Labile Mood and Aggressive Behavior. R206 received Abilify, 20 mg. daily, and Mellaril, 250 mg. twice daily, to assist in the control of her maladaptive behaviors. R206 also had physician's orders for a general diet.

R206's 11/7/11 Scales of Independent Behavior-Revised (SIB-R) documents an overall age equivalent of three years. Her 2/17/08 Leiter documents an intelligence quotient (IQ), of 13.

R206's 11/1/11 behavior program documents a number of "bizarre" behaviors exhibited by R206 - crying for unknown or no reason, yelling, pulling other's hair, being physically aggressive (hitting, choking, kicking, pushing, biting), improperly dressing (excessively layering clothing or wearing her underwear over her pants), being unresponsive, acting confused to the point that verbal prompts are not successful in redirecting her, property destruction, taking task or activity materials from others, and stuffing her mouth with food (usually with bread).

A 12/21/89 psychological report documents that at the time of this report, R206 was currently on a behavior program for a number of behaviors, one of which was eating too rapidly.

In a 1/19/12, 9:30 a.m., interview with E8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C **02/10/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

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W9999	Continued From page 30 (Qualified Mental Retardation Professional - QMRP), E8 stated that he had been R206's QMRP for a little over five years. E8 verified that R206's 11/1/11 behavior program was her most current. E8 described R206's behavior as "unpredictable," that her mental illness was a "big" component of her behavior. E8 further stated that R206 would forget standard tasks that she had been able to perform on one day, and be "back to normal" the next day. Per review of a 1/6/12 notification from the facility to the Illinois Department of Public Health (IDPH), R206 expired at the hospital, with cause of death as Severe Anoxic Encephalopathy. Per the facility's 1/3/12 investigation, R206 was at the day training site on 1/3/12, and choked at approximately 11:50 a.m. Z3 (day training staff) had assisted R206 with cutting up her sandwich, observed R206 place several pieces of food in her mouth, and prompted R206 to slow down. R206 did not respond to the verbal prompts and continued with the behavior. Z3 proceeded to verbally prompt R206 to let her know she was going to utilize hand-over-hand physical assistance with her lunch, which was also unsuccessful. R206 then proceeded to quickly place hand fulls of food into her mouth and Z3 attempted to block R206's mouth with her index and middle fingers. Z3 then observed R206 starting to turn blue and asked R206 if she was choking. R206 just stared at Z3. Z3 told R206 she was going to perform abdominal thrusts, started to initiate the thrusts, and R206 became agitated and began thrashing around and swinging her arms. R206 ran out of the room, into the hallway, followed by Z3. R206 collapsed	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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	W9999		

in the hallway and Z3 called for assistance. Z3 called for help and Z4 (day training staff) and Z5 (day training staff) came to assist.

Per the report, Z3 called nursing and an ambulance, and proceeded to attempt abdominal thrusts. Z4 felt breathing, rolled R206 to her side and proceeded to provide mouth sweeps, obtaining approximately 1/2 cup of food from her mouth. Z7 (day training staff) began performing rescue breaths. Cardiopulmonary Resuscitation (CPR) continued until ambulance staff arrived to take over. R206 was transported to the hospital and admitted.

In review of the 1/3/12 ambulance report, it states, "Found large amounts of solid food in the upper and lower airway. It took apx (approximately) 5 passes to clear airway. The food removed appeared to ham and bread."

In a 1/24/12, 1:05 p.m., interview with Z1 (Licensed Paramedic), Z1 confirmed that he was one of the responders to R206's choking scene on 1/3/12. Z1 stated that he removed what appeared to be ham, cheese and bread, "all through" R206's airway. Z1 further stated that the meat appeared to be, "more chunked than chewed."

Per the 1/3/12-1/5/12 hospital records, R206 had physician orders to keep R206 Hypothermic, to maintain temperatures around 92 degrees, with ice and cooling blankets for 24 hours. R206 was also placed on mechanical ventilation, with sedation orders of Morphine and Ativan for pain, anxiety and comfort. The 1/3/12 assessment documents Acute Cardiopulmonary arrest

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

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W9999	Continued From page 32 secondary to Aspiration and a Comatose state, probably secondary to Anoxic Encephalopathy. R206 experienced seizures during her physician evaluation on 1/4/12 and later experienced decorticate posturing, with "extremely poor" prognosis. Per a 1/5/12 "Termination of Life Support" hospital document, R206's guardian signed a consent to terminate life support. This document explained that R206 had no reasonable expectation of recovery and that there was no known medical treatment available to improve R206's condition and that the family therefore requested to terminate all life support measures. The 1/5/12 death certificate documents the immediate cause of death as Severe Anoxic Encephalopathy, with Cardio Pulmonary Arrest. Per the facility's 1/3/12 investigation, Z6 (Director of Operations for day training) stated that day training staff are trained and certified in American Red Cross procedures for choking and obstructed airways and that the protocol was followed for this incident, further stating that the day training site requires a review and competency of all staff every six months regarding care for the choking victim. In a 1/19/12, 8:44 a.m., interview with E2 (Director of Quality Assurance), surveyor requested the facility's complete investigation notes/interviews. E2 stated that she had spoken on the phone with Z6 (Director of Operations for day training), and had utilized the written report from the day training site to complete her report. E2 stated that the 1/3/12 typed facility report was	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

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W9999	Continued From page 33	W9999		

the facility's complete investigation, and that there were no further notes or interviews conducted. E2 further stated that there was no need to go to the day training site and repeat interviews conducted by the day training site.

In a 1/26/12, 1:34 p.m., interview with E2, E2 further verified that the facility did not review or request any evidence of the day training's data regarding certification in American Red Cross procedures for choking and obstructed airways.

Per Z8's (Physician) 1/4/12 hospital consultation, it states, "The question is the amount of time the patient was down and how long she had been anoxic for, as well as the cardiac arrest, between trying to dislodge the food from the airway and the EMT's (Emergency Medical Technician) arriving. There had to be a significant amount of time when this, unfortunately, was occurring."

B) R206's 11/1/11 behavior program documents a number of "bizarre" behaviors exhibited by R206 - crying for unknown or no reason, yelling, pulling other's hair, being physically aggressive (hitting, choking, kicking, pushing, biting), improperly dressing (excessively layering clothing or wearing her underwear over her pants), being unresponsive, acting confused to the point that verbal prompts are not successful in redirecting her, property destruction, taking task or activity materials from others, and stuffing her mouth with food (usually with bread).

Under the "Intervention" section of this program, it states that if any of the above mentioned behaviors are observed, staff should first verbally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

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W9999	Continued From page 34 prompt R206 to stop, and redirect her to another activity. Staff should then use the adaptive techniques to calm R206. If R206 does not stop, staff may use physical prompts to cease behaviors. Each incident of bizarre behavior should be recorded on the behavior graph at the facility, with a (/), and a brief narrative. At the day training site, incidents will be recorded on appropriate forms and sent to the QMRP monthly. On the data sheet, the day training site will use "P" for any physical aggression and (/) for all others. Behavior Management/Human Rights Committee (BMHRC) notes for R206 were reviewed. 4/7/11- state that since her last review, R206 has displayed 278 incidents of bizarre behaviors. These behaviors are not further defined. 8/4/11 - state that since her last review, R206 has displayed 390 incidents of bizarre behaviors. These behaviors are not further defined. 10/13/11 - state that since her last review, R206 has displayed 133 incidents of bizarre behaviors. These behaviors are not further defined. 12/8/11 - state that since her last review R206 has displayed 125 incidents of bizarre behaviors. These are not further defined. In a 1/19/12, 9:30 a.m., interview with E8, E8 confirmed that R206's 11/1/11 behavior program was her most current program. E8 further verified that the only specific data collected for her behaviors was the physical aggression, utilizing a "P" for the documentation. E8 further verified that a slash (/) was utilized for documenting all other behaviors described in the 11/1/11 program. E8 stated that R206 engaged in	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 35	W9999		

food stuffing very infrequently, and that if/when this occurred at the day training site, staff would send an e-mail. When asked for the documentation for these occurrences at the day training site, E8 stated that e-mails were purged periodically, and this information was no longer available. When asked, E8 agreed that data collection is required as part of the decision making process regarding regression/maintenance/progress of current programs, and assessing the need for creating new programs, revising or discontinuing programs for individuals.

C) In a 1/19/12, 1:15 p.m., interview with E9 (Residential Services Director - RSD), E9 confirmed that all individuals who reside at this facility attend one day training site, the same site that R206 attended.

Surveyor requested a list of individuals who attend the day training site and are on formal or informal eating programs as related to unsafe eating. Per the documentation provided on 1/19/12, by the facility, there are currently twenty (20) individuals who are on formal eating programs, and four (4) who require informal monitoring while eating. The data provided included identified unsafe eating behaviors of: a fast rate of eating; taking too large bites; food stealing, not pausing between bites and PICA. Physician's orders of 12/1/11 for the individuals validate medical diagnoses and prescribed diets, and the facility's 1/12 roster that validates level of functioning documents the following:

R's 17, 59, 115, 117, 123, 131, 176, 183 & 205

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 36 require pureed diets. R's 6, 38, 41, 94, 121, 132, 142, 158, 159, 181 & 199 require mechanical soft diets. R's 41, 59, 123 & 131 require honey thick liquids. R's 6, 17, 132, 142, 176, 183 & 205 require nectar thick liquids. R6 has a History of Aspiration Pneumonia. R's 17, 41, 59, 123, 132, 142, 176, 183 & 205 have a diagnoses of Dysphagia. R's 17 and 131 steal food. R's 17, 38, 59, 115, 117, 123, 142, 144, 148, 131, 158, 159, 181, 176, 199 & 205 function in the profound range of mental retardation, and R;s 6, 7, 95 and 132 function in the severe range of mental retardation. In a 1/19/12, 4:00 p.m., interview with E1 (Administrator), E1 stated that the facility did not see any deficiencies regarding the actions of the day training site regarding R206's choking episode, and confirmed that the facility had not provided any further follow-up regarding prevention of choking incidents for the remaining individuals who attend the day training site and have identified unsafe eating behaviors. The facility's 01/01/03 policy entitled "Administrator's Investigative Committee" was reviewed. Per this policy, neglect is defined as, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The facility shall ensure that all residents are free from abuse, mistreatment, and neglect. In order to do so, the facility shall establish an Administrator's Investigative Committee to investigate allegations of abuse, mistreatment,	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 37	W9999		

neglect, or theft, and to assist in the protection of individual resident rights and to provide a liaison between the resident and the administration of the facility.

The Committee is responsible for identifying, reviewing and determining alleged violations of any individual's rights, including abuse and neglect and, "To protect individuals from further harm."

The facility's 01/12 policy entitled, "Resident Incidents and Injuries" was reviewed.
Per this policy, "The facility shall investigate incidents of residents who incur injuries of unknown origin and any other matters that relate to the health, safety, and welfare of its residents..."

The facility's 10/11 policy entitled "Individual Service Plan (ISP) Development" was reviewed.
Under the "Content of the QMRP Summary" it states,
"Program Progress - Details the Individual's progress toward outcomes by comparing current and past data. Goals and objectives may be changed in response to the Individual's progress."
"Behavior - Includes information or how the Individual is doing with behaviors. Discuss any programs the Individual is on to address behaviors.

The 1/1/10 Individual Service Plan Development & Implementation training module was also reviewed.
Under the section entitled, "Your Role in Carrying out the Individual Service Plan", it states,
"Document all required behaviors, success and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 38 concerns related to the ISP - The ISP is constantly changing to meet the needs...of the individual for whom it is written. Documentation will help identify those areas that need adjustment." 2)A) In review of a January, 2012 facility roster that validates level of functioning, R127 functions in the profound range of mental retardation. His 1/26/11 Scales of Independent Behavior - Revised (SIB-R), documents his overall functioning level at 1 year and 11 months. His 11/13/11 psychological documents at intelligence quotient of 19. His 12/1/11 physician's orders document medical diagnoses of Dysphagia, G-Tube Placement, History of Aspiration Pneumonia, Congestive Heart Failure, Seizure Disorder, Obsessive Compulsive Disorder, Impulse Control Disorder, Cardiomegaly with Vascular Disorder, and is NPO (nothing by mouth). His birthday is 11/24/28 (84 years of age). A 1/5/12 special staffing documents that R127 has a state guardian. His 12/14 11 Individual Service Plan (ISP), documents that R127 uses a wheelchair for mobility, and a gait belt and staff assistance for transfers, and a mechanical lift for standing. A 4/11/09 videofluoroscopic swallow study states that R127 demonstrated a Severe Pharyngeal Stage Dysphagia due to weak and delayed pharyngeal swallow, resulting in severe penetration episodes after the swallow for even the most modified consistencies such as pudding. A copious amount of pharyngeal residue which	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

(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 39	W9999		

accumulated with consecutive swallows and did not respond to multiple swallows or liquid washes.

Under recommendations it states, "Based on the patient's unsafe and inefficient swallow patterns and current pulmonary condition, which could be the result of increased recurrent penetration and aspiration episodes, it is recommended that the patient remain n.p.o. (nothing by mouth), as the patient does have a G-tube in place for nutrition and hydration...that the patient be reevaluated before consistent oral intake, even for comfort measures, is reinitiated."

R127's 1/26/11's Eating Skills Assessment states, "(R127) will attempt to enter the dining room, take food from table, floors or dining trays."

"Program Progress Notes" for the following dates document R127's ingestion of liquids and solid food as follows:

6/5/11 - At 10:00 p.m. staff reported that R127 had a partial can of pop and three corn curls (snack food). In a 1/19/12, 11:02 a.m., interview with E2 (Director of Quality Assurance), E2 stated that this incident had not been investigated, as she had not been made aware of the 6/5/11 incident.

6/23/11 - At 8:30 p.m., R127 was caught drinking a half can of pop. In a 1/19/12 interview, at 2:18 p.m., when asked, E2 stated that the facility had investigated this incident, but confirmed that there was no reproducible evidence for an investigation. E2 further stated, "some (investigations) were just verbal."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 40 8/22/11 - At 8:00 p.m., it was reported that R127 may have eaten some popcorn. In a 1/19/12 interview, at 2:18 p.m., when asked, E2 again stated that the facility had investigated this incident, but confirmed that there was no reproducible evidence for an investigation. 9/21/11 - At 9:05 p.m., it was reported that R127 was possibly eating food, as food items were found in his room. Per the investigation, R127 had a soggy piece of bread in his lap and empty potato chip wrappers in his trash can. The investigation documents that R127 stole the potato chip bag from a peer. There is, however, no reproducible evidence of an investigation of trying to ascertain where R127 obtained the bread. 12/20/11 - At 5:00 p.m., R127 was observed drinking out of the bathroom faucet. Per the investigation, there is an e-mail from E2 to another staff person, asking who observed this and was R127 receiving 1:1 services at the time. Per the response, "Nursing witnessed him drinking from the faucet..." This response also identifies two staff were scheduled for 15 minute checks, and or 1:1 with R127. There is however, no evidence of any further investigation, regarding R127's 15 minute checks and/or his 1:1 supervision level. 1/17/12 - This note documents that R127 had been eating pizza and chips the night before. There is a typed note from E10 (Qualified Mental Retardation Professional - QMRP) stating that R127 obtained the pizza from a trash can outside of his room. There is, however, no further evidence of an investigation regarding this	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 41	W9999		

incident, relative to R127's 15 minute checks and/or his 1:1 supervision level.

B) In review of R127's 5/1/11 Behavior Compliance program, two of R127's unsafe behaviors are documented as: 1) placing any food/beverage item in his mouth, and; 2) being in possession of any food/beverage item.

Per the adaptive component, staff are to meet with R127 daily, review safety guidelines and remind R127 that he should not take anything that belongs to someone else; and, remind him that the doctor has said that he cannot eat/drink food/beverages through his mouth, because it will make him choke.

Staff are to be proactive as possible, to prevent R127 from getting food. R127 should not enter the dining room/kitchen food service area. If R127 enters these areas, staff will provide verbal prompting and personal interpositioning to prevent him from entering these areas.

If R127 is successful in obtaining food, staff are to ask R127 for the item. If he has not yet put the item into his mouth, staff should use blocking of his hands/arms. If he does not release the item, then item should be removed with a release from grasp technique. Physical holding may be required.

If R127 is observed with food in his mouth, staff are to provide verbal prompting. If the food is swallowed, nursing is to be notified immediately. If staff are uncertain as to whether food has been ingested, staff are to notify nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

(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 42	W9999		

There have been six documented incidents (Program Progress Notes of 6/5/11, 6/12/11, 8/22/11, 9/21/11, 12/20/11, and 1/17/12) of R127 having ingested or probably having ingested food and liquids through his mouth.

There is no evidence of addressing a revision of R127's Behavior program until 1/5/12, when a special staffing was initiated. Per the recommendations from this meeting, an addendum to his behavior program will be written to specifically address safety concerns with R127 regarding drinking from his bathroom faucet on 12/20/11, and a door alarm will be placed on R127's bathroom door to alert staff if he is attempting to go into the bathroom unassisted. This special staffing also states, "(E4 - QMRP), will become his new QMRP on the second floor.."

In review of the 1/5/12 special staffing, there is no evidence of addressing R127's ability to obtain and orally ingest solid foods.

In an interview with E5 (Residential Services Director - RSD), on 1/19/12, at 12:33 p.m., E5 stated that an inservice is in the process of being provided for staff of R127's living unit. Per the 1/18/12 document (In-Service Education Meeting Report), staff are not to bring food to the floor where R2 currently resides. All food is to be left and consumed in the break room on first floor and all food items/trash must be disposed of behind locked doors such as the in the break room. At no time should food or other food related items be disposed of in trash cans that are accessible by residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ___ B. WING ___	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 43 In an interview with E4, on 1/19/12, at 12:20 p.m., E4 stated that R127's 5/1/11 Behavior Compliance program is his current program and confirmed that this program has not been revised after R127's six documented ingestions, or at attempts ingesting food and/or liquids through his mouth. (A) 350.690c)3) Section 350.690 Disaster Preparedness c) Fire Drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 3) Evaluate the effectiveness of disaster plans and procedures. These requirements were not met as evidenced by: Based on observation, record review and interview the facility failed to evaluate the effectiveness of their disaster drills and procedures on the midnight shift with the potential to affect 205 of 205 individuals (R1-R205) who reside at the facility. Findings Include:	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

(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 44	W9999		

In observations made from 1/24/12-1/27/12 at the facility, residents reside on the 2nd, 3rd, 4th and 5th floors.

Resident roster (dated revised 1/24/12) state that R1- R205 reside at the facility.

Review of facility's "Fire and Fire Drill Report Form" (dated 2/25/11-1/17/12) the facility held fire drills on the following dates with the signatures of staff present as follows;

On 2/25/11 at 11:27 PM with 22 staff present.

On 3/18/11 at 4:00 AM with 23 staff present.

On 4/12/11 at 12:30 AM with 20 staff present.

On 5/16/11 at 1:32 AM with 21 staff present.

On 6/7/11 at 11:35 PM with 26 staff present.

On 7/9/11 at 3:15 AM with 23 staff present.

On 7/10/11 at 4:14 AM with 18 staff present.

On 8/12/11 at 5:30 AM with 65 staff present and has "Total Evacuation" written at top of page.

On 9/17/11 at 2:35 AM with 23 staff present.

On 10/17/11 at 3:05 AM with 19 staff present.

On 11/17/11 at 11:40 PM with 22 staff present.

On 1/17/12 at 1:35 AM with 22 staff present.

All fire drills reports had an attached page with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

(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 45 documentation written by the charge person that stated, "All staff and residents evacuated to the designated mustering area. No problems arose. The all clear was called at (time specific to that day)." The only evidence of a full evacuation was on the report dated 8/12/11 at 5:30 AM as identified by the "Total Evacuation" written across the top of the report form. The total evacuation was completed with 65 staff present. On all the fire drills outside of the drill done on 8/24/11 there were 18 - 26 staff present. In an interview with E9/Residential Service Director on 1/27/12 at 11:35 AM, E9 was asked about the midnight shift schedule. E9 stated that the midnight shift work from 11:00 PM-10:00 AM. When asked what time the evening staff get off and the day staff arrive to start their shift, E9 stated, "Evenings get off at 11:00 PM and days start arriving at 5:30 AM." When asked how many staff work the midnight shift E9 stated, "Around 20." Surveyor reviewed the fire drills that were completed on the midnight shift noting that 18- 26 staff were present on all the fire drills except the fire drill completed on 8/12/11 in which there were 65 staff present. E9 verified that 18- 26 staff would be present from 11:00 PM- 5:30 AM and that on the fire drill of 8/12/11 that the day shift staff assisted in the total evacuation in which all individuals were taken to a mustering area in the gym outside of the main building. When asked where the mustering area is for the fire drills outside of the 8/12/11, E9 stated, "They go to the area of refuge behind the fire barrier door on that floor." E9 confirmed that the fire drill completed on 8/12/11 was the only total evacuation on the midnight shift this past year. E9 could not provide evidence of a total evacuation being completed	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

(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 46	W9999		

by the midnight staff without assistance of another shift's staff.

(B)

350.1210
350.1220e)
350.1220j)
350.3240a)

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.1220 Physician Services

e) All residents shall be seen by their physician as often as necessary to assure adequate health care.

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 350.3240 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 47	W9999		

Continued From page 47

This Regulation is not met evidenced by:

Based on interview and record review the facility failed to provide nursing services in accordance with their needs when they failed to obtain a follow up assessment by a physician in a timely manner for injuries which resulted in fractures for 2 of 2 individuals reviewed for fractures. (R157, R207)

Findings Include:

1) R157, per current Individual Service Plan (ISP) of 9/07/11, is a 61 year old female with diagnoses of Arthritis, Osteoporosis, Osteopenia and Status Post left ankle fracture. R157's ISP of 9/07/11 under the section titled "Medical Comments" states, "08/19/11 (R157) noted to have reddish purple bruising on 3 toes on right foot. 08/20/11 To Emergency Room at (a local hospital) and returns with diagnosis Rt toe fracture, no new orders."

Under the section titled "Communication" R157's ISP of 9/07/11 states, "She does produce occasional one - and two-word phrases to communicate her wants and needs." Under the section titled "Functional Skills" it states, "(R157) has a diagnosis of Arthritis, Osteoporosis, Osteopenia..., S/P (status post) left ankle fracture; S/P left 5th metacarpal (sic, metatarsal) fracture that may affect ambulation." It also states, R157 "uses her wheelchair full time to ease the effects other medical issues effecting ambulation and assist with mobility. An ambulation program is recommended by Physical Therapy and is currently in place." Under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ____ B. WING ____	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

(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 48 section titled "Cognitive" it states that R157 "scored an IQ of 18" which "places her cognitive abilities at the profound range of functioning." Under the section titled "Program Goals" #8 states R157 "will maintain her ambulatory skills by doing leg strengthening exercises and ambulating with staff assistance using a gait belt for at least 25 feet." A facility "Incident Investigation" dated 10/13/11 regarding R157 states, R157 "presents with right inner aspect of foot with 3" (inch) light purple bruise noted." It states that R157 was "refusing to bare (sic) weight on her right foot." It states that R157 was admitted to the hospital on 10/13/11 for "diagnosis of possible pneumonia and a fracture to her right distal fibula." A discharge summary for R157 dated 10/17/11 states, "She did have a previous fracture of right lower extremity and was seen in consultation by (Z11, orthopedic doctor) who felt that no further treatment was needed." A progress note from Z11 dated 10/14/11 states, "Ortho [consult dictated] 61 y o (year old with) fx's (fractures) of unknown age of R (right) lateral malleolus, right distal tibular shaft (and) R 5th toe proximal phalanx. Assessment: All of these Fx's appear to be non-acute (and) require no specific Tx (treatment) (at) this time." Per progress note dated 10/17/11 at 2:15pm., R157 returned to the facility on that date from the hospital. The discharge summary from the hospital dated 10/17/11 states, "She is to resume her previous (facility) diet, activities, and labs." A facility "Incident Investigation" dated 10/28/11	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 49	W9999		

states, "On 10-28-11, at 9:00pm, (R157) presents with dark purple bruising to the inner aspect of her right foot. Nursing assessed the foot and noted that (R157) was complaining of pain at the arch of her foot. (R157) was placed on (list for in house doctor visit) on 10-26-11 due to difficulty with ambulation."

A nurses note for R157 dated 10/24/11 at 6:15pm. states, "TL (direct care staff) reports while transferring res (resident) from w/c (wheelchair) to toilet (with) gait belt, res legs 'gave out' (and) she was lowered gently to floor- NAI (no apparent injury) at this time."

A nurses note for R157 dated 10/26/11 at 4:00pm states, PD (Qualified Mental Retardation Professional) reports res. having diff (difficulty) (with) ambulation here lately. Will cont. (continue) to monitor res. (and) put res on (list for in house doctor visit)."

A nurses note for R157 dated 10/28/11 at 9:00pm. states, "presents (with) dk (dark) purple bruising inner aspect Rt (right) foot, c/o (complains) pain at arch of foot on (list for in house doctor visit)."

No other nursing notes are in R157's clinical record until 11/03/11 at 7:25pm which states, "(checked) bruising R foot, difficulty ambulating." The note continues that R157 had an X-ray taken. X-ray report dated 11/04/11 states, "Acute minimally displaced fracture of the distal right fibula."

A "Resident Progress Note" from Z9 (personal care physician) dated 11/13/11 states, "Patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 50	W9999		

was seen on 11/03/11." The progress note from Z9 of 11/13/11 continues "Examination at that time did reveal ecchymosis of the right foot particularly in the medial portion of the arch. She did have some tenderness at that time and an x-ray did subsequently reveal an acute minimally displaced fracture of the distal right fibula. She was referred to Z11 and apparently non-weightbearing has been ordered."

E3 (director of nursing) was interviewed on 1/27/12 at 10:12am. When asked what the statement from the nursing note dated 10/26/11 is about R157 having difficulty ambulating lately means, E3 stated, "I don't know, can't say, it doesn't give a time frame." When asked if there would be any other documentation, E3 recommended asking E9 (resident services director). The nurses note of 10/26/11 states that R157 was put on the list for an in house doctor visit. E3 was asked when R157 actually saw Z9. E3 stated that R157 was seen by Z9 on 11/3/11 and had the X-ray on 11/4/11. E3 was asked it there was any documentation of R157's bruising and ambulation difficulty in the nursing notes between 10/28/11 when the bruising was noted, and 11/03/11 when R157 saw Z9. E3 stated, "No there is not." When asked if nursing staff should have been tracking the bruise, E3 stated, "Yes." When asked if R157 was being ambulated during this time, E3 recommended asking E9.

E3 was asked why there was the delay from 10/26/11, when it was first reported that R157 was having trouble with ambulating and was put on the list to see the doctor and 11/3/11 when R157 actually saw the doctor. E3 stated, "That's a very good question, I cannot answer that."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 51 An imaging report on R157 from 8/25/11 states, "Low level of uptake within the right distal tibia in the area of smooth cortical thickening. Given the radiographic appearance and the low level uptake, this is likely a benign process." This bone scan was being compared to Right foot and ankle radiographs done 8/20/11. None of these showed any fracture of the tibia or fibula. The hospital reports from R157's hospital visit of 10/13/11 through 10/17/11 showed only fractures of unknown age of right lateral malleolus, right distal tibia and R 5th toe proximal phalanx. The Orthopedic progress note of 10/14/11 found that all of those fractures appear to be non-acute. The X-ray report on 11/04/11 showed an acute minimally displaced fracture of the distal right fibula. E3 was asked since x-rays in 8/11 showed no fracture of the tibia or fibula, and since the X-rays taken during the hospital stay on 10/13/11 showed only non-acute fractures of the right lateral malleolus and right distal tibia, then the X-ray of 11/03/11 showed an acute fracture of the distal right fibula, would the previous X-rays which discuss the tibia have shown the fracture of the fibula if present. E3 stated yes. When asked if this would lead to the conclusion that the fracture occurred between 10/13/11 and 11/04/11, E3 stated, "I'm gonna have to say yes." E9 (Resident Service Director) and E14 (Qualified Mental Retardation Professional) were interviewed on 1/27/12 at 1:48pm. They were asked if R157 was being ambulated per ambulation program between 10/28/11 and 11/03/11. E14 stated, "I had an inservice on	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 52	W9999		

10/26." E14 stated that she told staff to continue to use the stand lift. E14 stated that she wanted to look at the inservice. E14 stated, "I don't know if I specified no ambulation program."

R157's data sheet for her ambulation program for 10/11 was reviewed. Under the section titled "Ambulating exercises 25ft. (feet)" a "+" is documented for 10/27, 10/28, 10/29 and 10/31."

E9 and E14 provided "In-Service Education/Meeting Report" forms dated 10/26/11 for all three shifts. Under the section titled "Subject" it states, "(R157) ambulation difficulty." Under the section titled "Objectives" it states, "Until further notice, (R157) should be assisted by stand lift for all transfers. Her ambulation program will be suspended until further recommendation is make by the doctor and/or physical therapy." However, documentation for the ambulation program contains "+'s" for 4 additional days after the inservice date of 10/26/11.

E9 and E14 were interviewed on 1/27/12 at 3:23pm. When asked whether the ambulation program was supposed to be suspended, they stated, yes. When asked whether it was unable to be determined if R157 was actually being walked, E9 stated, "At this time, yes. I am investigating."

A nurses note for R157 dated 10/26/11 at 4:00pm states, PD (Qualified Mental Retardation Professional) reports res. having diff (difficulty) (with) ambulation here lately. Will cont. (continue) to monitor res. (and) put res on (list for in house doctor visit)." "In-Service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 53	W9999		

Education/Meeting Report" forms dated 10/26/11 for all three shifts, under the section titled "Subject" state, "(R157) ambulation difficulty." Under the section titled "Objectives" they state, "Her (R157) ambulation program will be suspended until further recommendation is made by the doctor and/or physical therapy." However, a "Resident Progress Note" from Z9 (personal care physician) dated 11/13/11 states, "Patient was seen on 11/03/11." The progress note from Z9 of 11/13/11 continues "Examination at that time did reveal ecchymosis of the right foot particularly in the medial portion of the arch. She did have some tenderness at that time and an x-ray did subsequently reveal an acute minimally displaced fracture of the distal right fibula."

2) A facility "Incident Investigation" dated 8/24/11 regarding R207 states, "On 8/24/11 at 5:45am., (R207) presents with purple bruising to the top of his left shoulder with a lighter bruise approximately 4 (inches) long going down the front of shoulder/chest area." The investigation states that R207 is "non verbal and unable to answer questions." It also states that R207 "utilizes a wheelchair for mobility with a harness for posture."

A nurses note for R207 dated 8/24/11 at 5:45am. states, "res. (resident) presents (with) a circle dark purple bruising to left top shoulder (with) a lighter tail bruise approx. (approximately) 4 inches (down) the front. Circle part on top is 2 cm." The note continues that the resident showed no discomfort on palpation.

Another nurses note for R207 dated 8/24/11 at 9:30pm. states, "Deep purple bruising - 6 (inches)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 54	W9999		

long X (times) 3 inches wide Lt (left) shoulder - moving arm as usual." It stated that R207 had no signs or symptoms of discomfort.

At 11:30pm on 8/24/11 a nurses note for R207 states, "follow-up to bruising on res. left shoulder area. Top circle area has gone from 2 cm to 3 cm (and) total length is approx. 6 (inches)." It states that R207 showed no complaints of discomfort.

A nurses note for R207 dated 8/26/11 at 12:00am. states, "bruising to left shoulder area now turning to a violet in color." It continues that R207 is exhibiting no signs or symptoms of discomfort and no "grimmance (sic)."

A nurses note for R207 dated 8/26/11 at 5:00pm. states, "bruising on Lt shoulder (upper) put on (list for in house doctor visit)."

A nurses note for R207 dated 8/27/11 at 12:00am. "Bruising conts (continues) approx 3 (inches) wide (and) seven (inches) long. All running together now as one bruise."

A program progress note for R207 from 8/28/11 from the in house doctor visit states, R207 check bruising left shoulder - obtain X ray of left shoulder and clavicle.

The "Patient Report" on the X-ray of the left clavicle for R207 dated 8/29/11, under the section titled "Findings" states, "There is a non-displaced acute fracture of distal clavicle."

E3 (director of nursing) was interviewed on 1/26/11 at 10:10am. When asked who is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 55 responsible for deciding when someone is referred to the doctor, E3 stated, "The nurse." E3 stated that they might put on the (list for the in house doctor visit). E3 stated, "He comes so often." When asked if these visits are on grounds, E3 stated, yes. When asked why the delay in obtaining an X-ray for R207, E3 stated, "I'm kind of wondering myself. I'm sure he (Z9) said obtain an X-ray." E3 stated that R207 saw Z9 on 8/28/11 and the X-ray was on 8/29/11. R207's as needed Medication Administration Records (MAR) were reviewed. For 8/11, R207 started receiving Tylenol on 8/24/11 at 6:00am. for discomfort. R207 received Tylenol, either 650mg or 40cc per G-tube on 8/24 at 6:00am., 8/25 at 12:00am., 8/26 at 8:00am., 8/27 at 3:00am., and 8/28 at 3:00am. The reasons listed for giving the Tylenol were either discomfort or possible discomfort, except 8/26 which stated, complained of headache. On 1/26/11 at 10:10am, E3 was asked why the Tylenol was given. E3 looked at the 8/11 as needed MAR and stated, "For possible discomfort." R207's as needed MAR's for 7/11, 6/11, and 5/11 were reviewed. R207 did not receive Tylenol during any of those months. The facility investigation of R207 dated 8/24/11 states that the bruise was first noticed on that date at 5:45am. A nurses note for R207 dated 8/26/11 at 5:00pm. states that R207 was put on the list for the in house doctor visit. A program	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY GALESBURG, IL 61401**

(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 56	W9999		

progress note for R207 from 8/28/11, and verified by E3 during interview on 1/26/12 at 10:10am., states that R207 was seen by Z9 on 8/28/11 and to obtain X ray of the left shoulder and clavicle was ordered. According to the "Patient Report" on the X-ray of the left clavicle for R207 dated 8/29/11, the findings were a non-displaced acute fracture of distal clavicle.

(B)

350.620a)
350.760a)
350.1230c)

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 350.760 Infection Control

a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 57 Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. Section 350.1230 Nursing Services c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. These requirements were not met as evidenced by: Based on observation, record review and interview nursing failed to provide training of staff to ensure manufacturer's recommendations were followed in the use of a declogger (device to obtain patency of a blocked gastric enteral tube) for 1 of 2 individuals (R27) observed receiving medications through their gastric tube. Findings Include: Physician's Orders/POS (dated 12/1/11-12/31/11) identifies R27 as a 59 year old individual who functions in the Severe range of Mental Retardation with additional diagnosis of Obsessive Compulsive Disorder and Dysphagia. The POS states that R27 is NPO (nothing by mouth) and has a g-tube (gastric enteral tube) through which he receives his nutrition and medications. The POS states that R27 receives Carbamazepine, Omeprazole, Oyster Shell Calcium with Vitamin D and Zyprexa at 4:30 PM per g-tube. On 1/25/12 at 3:40 PM, E11/Licensed Practical Nurse prepared R27's medications of	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 58	W9999		

Omeprazole, Carbamezapine, Oyster Shell Calcium with Vitamin D and Olanzapine by crushing and mixing with water. E11 then had R27 go to his room to administer his medications per his gastric enteral tube. E11 auscultated for placement, then aspirated for residual. E11 then flushed the gastric tube and began to administer the medications mixed in water per gastric tube. About half of the medication solution instilled when the gastric tube became clogged. E11 then attempted to unclog the gastric tube by milking the tube and applying some pressure per use of a syringe, which was unsuccessful. E11 left the room and came back with a gallon size clear self sealing plastic bag which had a thin piece of yellow plastic, approximately 12 inches long by 1/8th inch wide, which had grooves around the tip. The clear plastic bag did not have any writing/label on the outside with a name or date. E11 inserted the yellow plastic device into R27's gastric tube and twisted and attempted to unclog the blockage without success.

In an interview with E11 during the medication pass on 1/25/12 at 3:40 PM, when asked if the yellow plastic device that she was using to unblock R27's gastric tube belonged to R27, E11 stated, "No, we have to reuse, there's not a whole lot of these around. We sanitize and put back in bag." When asked further about sanitizing the device E11 stated, "We clean it with (disinfectant) and rinse with hot water and put back in bag." When asked if she had problems with R27's gastric tube becoming blocked, E11 stated, "No."

In an interview with E3/Director of Nursing on 1/25/12 at 4:55 PM when asked for the name of the yellow plastic device used on the blocked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 59	W9999		

gastric enteral tube, stated, "Declogger." E3 confirmed that the facility approved the use of the Declogger. E3 and this surveyor then walked into the 3rd floor medication room. E3 confirmed that the bag which had the plastic device used on R27 did not have any identification on the outside.

On 1/26/12 at 3:20 PM, E3 provided surveyor with the manufacturer's guidelines for the use of the Declogger found on the outside of the box containing individually wrapped Decloggers (yellow plastic devices). The manufacturer's guidelines (dated 5/11/11) state, "The Declogger should be disposed of after a single use."

In interviews with E3/Director of Nursing on 1/26/12 at 9:30 AM,10:10 AM and 3:20 PM, E3 confirmed that the facility could not provide evidence of having a policy/procedure that identifies the use of the Declogger (device used to unblock gastric enteral tubes) or evidence that the nursing staff were trained on the manufacturer's guidelines for the use of the Declogger. E3 confirmed that the Declogger's manufacturing guidelines are that the Declogger should be disposed of after a single use.

(B)

350.620a)
350.1210
350.3220f)

Section 350.620 Resident Care Policies

a) The facility shall have written policies and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 60	W9999		

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 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

These Regulations were not met as evidenced by:

Based in interview and record review the facility failed to ensure the safety of 1 individual (R14), inside sample, who requires a life saving medication readily available for use during transportation and during facility off site activities.

Findings Include:

The Physician's Order Sheet (POS), dated 12/01/11, identifies R14 with an allergy of bee stings. The POS further states R14 has "Epinephrine 0.3 MG (milligram) Auto-Inj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING ______ B. WING ______	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	**239 SOUTH CHERRY** **GALESBURG, IL 61401**

(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 61 (Automatic Injection), Sub (substitute) For: Epipen 0.3 MG, Use as directed for allergic reaction." During an interview with E3, Director of Nursing (DON), on 01/24/12 at 2:14 PM, E3 confirmed that R14 does not have an Epipen available for use during transportation to day training. During an interview with R14 on 01/24/12 at 4:45 PM, R14 stated he did not know whether an Epipen was available during his transportation for day training. During an interview with E12, Qualified Mental Retardation Professional (QMRP), on 01/25/12 at 3:12 PM, E12 could not confirm that R14 has a Epipen readily available when R14 goes on facility outings. On 01/25/12 at 9:05 AM, E3 confirmed that now, after surveyor discussed the R14's Epipen availability, that a nurse will attend all outings with R14 so an Epipen can be administered if needed. E3 further stated that the facility is working on a process of an Epipen being available for day training transportation. (B)	W9999		