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W 154	Continued From page 13 In review of a 3/14/13 Incident Report, staff heard a noise and found R1 on the floor. No injuries were noted from this fall. In further review of this Incident Report, it is documented that on 3/21/13 "bruising has appeared to buttocks." In review of an Incident Report, undated, it documents that R1 fell on her buttocks and hit her upper back. The "Incident Monitoring Form" started on 4/1/13 for a bruise on her bottom. In further review of this Incident Report, nursing documented on 4/21/13, "slight bruising to upper back." There is no evidence that the bruising to R1's buttocks on 3/21/13 and bruising to R1's upper back on 4/21/13 were investigated. In an interview on 5/10/13 at 12:30 PM, E1 (Residential Services Director) stated she could not find that these injuries of unknown origin for R1 were investigated.	W 154		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 350.620a) 350.1210 350.1220j) 350.3240a) 350.3240b) 350.3240d) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	W9999		

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W9999	Continued From page 14 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 350.1220 Physician Services 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. These requirements are not met as evidenced by: Based on observation, interviews, and record review, the facility failed to implement their system to prevent neglect for R1 when they failed to: 1) Implement their policy to prevent neglect for 1 of 1 individuals (R1) when they failed to prevent	W9999		

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W9999	Continued From page 15 R1 from falling and injuries of unknown origin. 2) Have an IDT (Interdisciplinary Team) meeting to develop and implement preventative measures for fall prevention and injuries of unknown origin. 3) Put sufficient safe guards in place to prevent R1 from falling and sustaining injuries of unknown origin. 4) Ensure nursing recommendations are made to the IDT regarding R1's falls and injuries of unknown origin. 5) Ensure the physician was notified of R1's falls and injuries of unknown origin for evaluation. Based on record review and interview, the facility failed to thoroughly investigate 2 injuries of unknown origin and the facility failed to notify the Illinois Department of Public Health (IDPH) of 2 injuries of unknown origin for 1 of 3 individuals in the sample, (R1). Findings Include: In review of January 1, 2013 Physicians Order Sheet, R1 functions in the severe range of mental retardation. She has additional diagnosis' of epilepsy and generalized anxiety. R1 has a high fall risk. The Inventory of Client and Agency Planning, dated 11/12/2012, documents an overall age equivalency of 1 year 1 month.	W9999		

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On 5/9/13 between 3:15 pm- 4:00 pm, R1 was observed being transferred by staff from the day training van to the facility by wheelchair. She then ambulated with the assistance of one staff member to the bath room. She had a helmet on her head and a gait belt around her waist. After using the restroom, R1 walked into the living room by herself, leaning forward, with a slow, shuffling, stomping gait.

Per an interview on 5/9/13 at 9:00 am, when asked if R1 was steady when ambulating and if she was a staff assist in ambulation, E2 (Direct Service Personnel) and E3 (DSP) both stated that R1 was unsteady in her ambulation and that she was not a staff assist during ambulation.

Per the Speech-Language Evaluation dated 10/30/12, R1 is non verbal but vocalizes in a non discript way.

The facility's Incident and Accident Reports were reviewed from 12/06/2012 until 5/13/13. R1 was noted to have the following falls and injuries of unknown origin:

12/6/12: Staff noticed redness under R1's right eye.

12/20/12: R1 fell in the bathroom while at day training and had a red mark on her right right side.

01/3/13: Staff noticed a bruise on R1's right upper leg and hip.

01/22/13: R1 fell when she attempted to get up from sitting position on couch. No injuries were

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noted.

01/30/13: Staff heard a thump and found R1 on the floor beside her bed. She had red scratch marks on her back which were noted to have disappeared by later in the day.

02/3/13: Staff noticed R1's left eye was swollen and purple.

02/12/13: Staff noticed R1 had a bruise on side of right calf.

02/22/13: R1 threw herself to the floor. No injury.

03/4/13: Staff noticed bruise on R1's left thigh/hip.

03/14/13: Staff heard a noise and found R1 on the floor by her bed. It was later documented that she had a bruise on her buttock.

In review of a 3/14/13 Incident Report, staff heard a noise and found R1 on the floor. No injuries were noted from this fall. In further review of this Incident Report, it is documented that on 3/21/13 "bruising has appeared to buttocks."

In review of an Incident Report, undated, it documents that R1 fell on her buttocks and hit her upper back. The "Incident Monitoring Form" started on 4/1/13 for a bruise on her bottom. In further review of this Incident Report, nursing documented on 4/21/13, "slight bruising to upper back."

There is no evidence that the bruising to R1's buttocks on 3/21/13 was investigated.

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W9999	Continued From page 18 There is no evidence that the facility reported these injuries of unknown origin to IDPH. In an interview on 5/10/13 at 12:30 PM, E1 (Residential Services Director) stated she could not find that this injury of unknown origin for R1 was investigated and she could not find that this injury of unknown origin for R1 was reported to IDPH. 03/26/13: Staff noticed bruise under R1's left bottom eyelid. 03/29/13: R1 went outside and dropped to her bottom, refusing to come inside. 04/01/13: Staff noticed bruise to R1's left thigh. In review of an Incident Report, undated, it documents that R1 fell on her buttocks and hit her upper back. The "Incident Monitoring Form" started on 4/1/13 for a bruise on her bottom. In further review of this Incident Report, nursing documented on 4/21/13, "slight bruising to upper back." There is no evidence that the bruising to R1's upper back on 4/21/13 were investigated. In an interview on 5/10/13 at 12:30 PM, E1 (Residential Services Director) stated she could not find that this injury of unknown origin for R1 was investigated and she could not find that this injury of unknown origin for R1 was reported to IDPH.	W9999		

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W9999	Continued From page 19 04/4/13: R1 fell in dining room and received a bump on her right eyebrow. 04/20/13: R1 fell straight back and scratched left elbow. 04/23/13: R1 dropped to floor. No injury. 05/13/13: Staff heard a thud and found R1 on the floor in the dining room laughing. No injury found. Per the Physical Therapy Evaluation dated 11/7/2012, it is recommended that R1 use a wheelchair to go to and from workshop in the van and when on outings, is contact guard assistance when outside and can be independent in ambulation at home while wearing her helmet, gait belt and with visual supervision. Per the Occupational Therapy Evaluation dated 11/6/2012, it states that R1 use a wheelchair to go to and from workshop in the van and when on outings, is contact guard assistance when outside and can be independent in ambulation at home while wearing her helmet, gait belt and with visual supervision. In further review however, it is documented that R1 fell onto knees when occupational therapy was working with another resident and it is recommended that contact guard assistance be used when ambulating. There is no evidence that the facility implemented the change in supervision during ambulation for R1. In an interview on 5/10/13 at 12:10 pm, E1 Residential Services Director (RSD) stated that per the physical therapy evaluation R1 could be	W9999		

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W9999	Continued From page 20 independent ambulation at home with visual supervision and at the day training, R1 is contact guard assistance. In an interview on 5/14/13 at 11:15 am, when asked if staff is required to stay in same room with R1 when she is sitting down, E1 (RSD) stated that staff can leave the room as long as R1 is sitting down. In an interview on 5/10/13 at 12:10 pm, when asked if R1 was to lose her balance and staff were not close by would she fall, E1 (RSD) stated that R1 would most likely fall and she would probably need to be placed on contact guard assistance again. When asked what safeguards have been put in place due to R1's increase in falls and injuries of unknown origin, E1 (RSD) stated that they are making a physical therapy evaluation to asses the supervision level needed for ambulation. The Behavior Development Program dated 01/1/2012, states the R1 has a maladaptive behavior described as follows: "Non-compliance defined as dropping to the floor and refusing to move." In further review the intervention technique states, "Since R1 is contact guard assist when not in wheelchair. As R1 attempts to drop to the floor staff will help her to the floor gently not allowing her fall. Staff will say "Stop. You need to stand up." There is no evidence that R1's Behavior Development Program has been reviewed or updated in regards to her change is ambulation assistance and frequent falls and injuries.	W9999		

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In an interview on 5/10/13 at 12:10 pm, when asked if R1's behavior plan had been updated at all since 1/31/12, E1 (RSD) stated that it had not been updated. When asked how often R1 has her behavior of falling to the floor and how staff were trained to address this behavior, E1 (RSD) stated about three times per year and two staff help her up.

In an interview on 5/14/13 at 11:15 am, when asked if a fall determined as a 'behavior' needed to be reported to the nurse and if there was a specific was staff were to determine if a fall is a 'gait' fall or a 'behavior', E1 (RSD) stated that staff only report 'gait' falls to the nurse and that there was not a specific way for staff to determine the difference between a 'gait' fall and a 'behavior'.

R1 is assessed for fall risk using the Morse Fall Scale. On 8/7/12, R1's fall score was 50 was means she is at high risk for falls. The nurse noted at this time to continue with physical therapy evaluation and allow R1 to be independent in her ambulation with in the home with visual supervision. On 11/5/12, R1's fall score increased to 75 which again means she is at high risk for falls. The nurse noted at this time to update the quarterly assessment and use gait belt and contact guard assist during ambulation. On 2/7/13, R1's fall score was again 75. The nurse noted at this time that R1 could ambulate independently at home while wearing helmet and with visual supervision from staff.

In review of the facility's Fall Risk Policy/Protocol, undated, it states that if the individual scores a 75 or higher, the following will be implemented: The registered nurse will review the fall risk

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assessment score quarterly. The residential service director will complete the environmental checklist. The fall risk assessment will be reviewed at the annual Interdisciplinary Team meeting and more often if needed. There will be an annual physical therapy evaluation and more often if needed. The fall risk will be documented in the physician orders. All disciplines involved in the client's care will be notified of the fall risk. Specific measures will be put in place to assist in fall prevention and these measures will be documented in the clients plan of care.

There is no evidence of any recommendations to ensure R1 has no further falls or injuries.

There is no evidence of Interdisciplinary Team (IDT) meetings being held or specific measures put in place in order to address R1's falls and injuries and to develop preventative measures since her Annual IDT of 11/16/12.

In an interview on 5/10/13 at 12:10 PM, when asked if there was any special meetings held to update the annual Individual Program Plan, E1 (DSP) stated that there had not been.

During an interview on 5/14/13 at 3:35 pm, when asked who the QIDP (Qualified Intellectual Disability Professional) was, E1 (RSD) stated E4 (QIDP/Administrator). When asked how the E4 is notified of incidences and injuries, E1 (RSD) stated, "We fax the incidences to her. She may call, send a fax, or e-mail back if there is anything we need to schedule, change or further investigate."

R1's Wheelchair Protocol was updated on

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2/13/13. It states that R1 can ambulate with visual supervision and is to be wearing her helmet and gait belt. Staff can implement contact guard assist if there is a potential for hazards or high fall risk situations.

In review of R1's 8/29/12 annual physical, there is no evidence of a neurological assessment and Z1 notes that R1 has an unsteady gait.

There is no evidence that R1 was seen by a physician or a neurologist for her frequent falls and injuries, despite her medical history of seizures.

In an interview on 5/15/13 at 10:40 am, E1 (RSD) confirmed R1's last visit to her primary care physician was 8/29/12.

In an interview on 5/10/13 at 2:10 PM, when asked if R1 has a neurologist to monitor her seizure activity and medications, E1 (RSD) stated, no her primary care physician takes care of it all since the neurologist left.

In review of the 1/1/13, Physician's order Sheet, R1 receives Divalproex Sodium 1250 mg (milligrams) daily and Levetiracetam 1500 mg daily for seizure activity.

In review of R1's laboratory work, R1 had a Divalproex Sodium level drawn on 1/25/13 and 5/9/13. R1's levels were with in normal range.

The facility policy entitled "Abuse, Neglect, Maltreatment Reporting and Notification Policy", undated, was reviewed. This policy defines neglect as, "An employee's, agency's, or facility's

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failure to provide adequate care, maintenance, or medical services that causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk."

In review the 1st Quarter 2013 Incident Reports for R1, documents a summary as follows:
1 bruise right upper hip
1 loss of balance and fell on buttocks
2 falls out of bed
1 bruise right thigh
1 incident of red and swollen eye
1 bruise right calf
1 bruise left thigh/hip area

This Quarterly Incident Report further states, "R1 has been moved to a larger room with a floor mat in front of bed to protect against falling out of bed injuries. R1 is sometimes unstable when she walks so she bumps into furniture causing bruising to her hip and thigh areas."

In an interview on 5/10/13 at 2:15 PM, when asked how the facility is tracking trends and patterns concerning R1's falls and injuries, E1 (RSD) stated, I do a quarterly report that gets signed by the physician, nurses and the RSD. If there are no concerns then it stops there and if there are then changes are made to address the concerns.

In an interview on 5/10/13 at 12:30 PM, E1 (Residential Services Director) stated she could not find that injuries of unknown origin for R1 were investigated.

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W9999	Continued From page 25 Based on review of R1's falls and injuries from 12/6/12 to 5/14/13, the facility did not implement their policy and analyze the falls and trends. The facility did not develop a strategy for reduction and / or elimination of R1's falls and injuries. Per review of the facility's policy entitled Investigation of Trends and Patterns of Incident Reports, Resident Injuries, Resident Behaviors dated 11/19/05, the RSD is supposed to complete a quarterly incident review report. The Administrator will review the report to determine if trends or patterns are noted and make a summary of them as well as include any actions taken to prevent further instances. This summary is to be reviewed by the Medical Advisory Committee for further recommendations. In an interview on 5/15/13 at 2:35 pm, when asked if the Administrator prepares a summary of the quarterly incident review reports, E1 (RSD) stated that the Administrator did not prepare a summary report however she was supposed to sign off on her (RSD) reports and make recommendations if needed. When asked who the Medical Advisory Committee was, E1 (RSD) stated that it was made up of the registered nurse, the license practical nurse, and the physician. There is no evidence that the 1st Quarter 2013 Incident Review Report was signed off by E4 (Administrator) and there were no recommendations made to prevent further falls and injuries of unknown origin. (B)	W9999		