STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 000	INITIAL COMMENTS COMPLAINT INVESTIGATION 1695561/IL88808	W 000		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement their policy to prevent neglect, and ensure adequate client protections were in place for 1 of 1 resident (R2) with a known and documented behavior of Pica. R2's level of supervision remained unchanged after an identified Pica episode occurred on 8/23/2016. On 9/21/2016, R2 had emergency surgery to remove multiple foreign objects from his stomach including 16 plastic gloves, gauze, wood, string, paper and hair. A paperclip was also discovered in the large bowel. Findings include: Refer to deficiencies cited under: W149: The facility must develop and implement written policies and procedures that prohibit neglect and the potential for neglect of the client. Develop an incident management system that assured all injuries are thoroughly investigated and corrective actions identified and implemented.	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 149	Continued From page 1	W 149		

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to implement their policy to prevent neglect, and ensure adequate supervision and client protections were in place for 1 of 1 resident (R2) with a known behavior of Pica.

1) R2's level of supervision remained unchanged after an identified Pica episode occurred on 8/23/16. On 9/21/2016, R2 had emergency surgery to remove multiple foreign objects from his stomach including 16 plastic gloves, gauze, wood, string, paper and hair. A paperclip was also discovered in the large bowel.

2) The facility does not have written procedures defining levels of supervision which govern the management of maladaptive behavior.

Findings include:

Facility policy, undated and titled, "Universal Healthcare Management: Prevention and Reporting; Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source and Misappropriation of Property" documents, "Neglect: Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. This presumes that instances of abuse/neglect of all residents, even those in a come, cause physical harm, pain or anguish."
"Additional means of providing protection may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C **10/20/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 149	Continued From page 2 include, but are not limited to; Provide 1:1 monitoring. Increase amount of resident supervision." "Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences." According to the medical assessment form, dated 10/16/15 R2 is a 22 year old male admitted from an abusive home, to the facility in 9/2015. R2 is ambulatory, non verbal, feeds himself orally and has the admitting diagnoses of Profound Intellectual Disability, Autism, and Cerebral Palsy. R2's admitting Individual Habilitation Plan (IHP), dated 10/16/15 lists his level of supervision (LOS) as 24 hour supervision, without enhanced monitoring. The IHP documents that R2 "will leave the area when left alone to return to his bedroom." A nurses note, dated 10/27/15, documents "Per staff, client put, what appeared to be a non-latex glove, in his mouth. Staff tried to retrieve it, but client became combative. Put glove in mouth and swallowed it". A Behavior Support Plan (BSP) dated 10/30/15, was written for the new diagnosis of Pica. The BSP lists R2's supervision as "under visual observation by staff during all waking hours and if he is awake at night, for Pica. As part of monitoring, 15 minute checks will be observed and documented beginning 10/27/15 to 11/30/15. If continued checks are needed after 11/30/15, they will be incorporated into the program..." According to E1 (Acting Administrator) on 10/3/16 at 11 am, R2 was on enhanced monitoring from 10/27/15 to 11/30/15. E1 said the enhanced	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 149	Continued From page 3	W 149		

monitoring was decreased to standard level supervision on 11/30 because there were no further incidents of Pica.
E1 said standard supervision is defined as staff being in the home, however the resident is free to move about unsupervised.
E1 stated the facility does not have specific policy or procedure guidelines defining LOS, but provided the policy titled "Developmental Training Program / Interdisciplinary" dated 10/7/16, saying LOS is mentioned in this policy. This policy mentions LOS in this sentence, "LOS required is determined by the Interdisciplinary Team members upon review of varies assessments..."

A nursing note, dated 7/11/16, documents, "Called to resident room, fecal impaction with foreign objects, unable to retrieve, sent to ER." The hospital record, dated 7/11/16, documents that R2 had stool with string, rubber bands, and multiple foreign bodies present, however the Xray was negative for any remaining objects and R2 was sent back to the facility.

The facility incident/investigative report, dated 7/11/16, includes staff training for R2's newly enhanced LOS, which was 15 minute checks when awake and in bedroom, and in line of sight while in the common areas.

On 8/23/16 at 9:30 pm, a nursing note documented, "Ate 100% of dinner with snacks. Abdomen is soft, non-distended, positive bowel sounds. Client had a moderate BM with strings...continues to place foreign objects in his mouth, attempted to remove a piece of plastic glove - he is uncooperative."

The next day, 8/24/16, nursing documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 149	Continued From page 4	W 149		

"Client still passing string through his stool."

An Inservice, dated 8/24/16, included, "Team discussion of the latest incident where [R2] has eaten string that staff have seen in his stool. Make sure to complete 15 minute checks (and sign off on the sheet) and provide line of sight when in the common areas..." The inservice included instructions for housekeeping staff to make sure his clothing and linen is free of holes and fraying.

The next nursing note dated 9/6/16, states R2 was refusing dinner and had vomiting.
On 9/7/16, nursing wrote R2 was no longer vomiting, but that he had spent most of the evening in his bedroom. The note stated R2 was seen by the Psychiatrist for Pica, and Clonazepam was ordered for the anxiety [which may be contributing to Pica].

The Psychiatrist note, dated 9/7/16, documented that overall R2's behavior of Impulsivity and Pica was worse, and that a trial of Clonazepam would be tried. He wrote an order on 9/7, however the Medication Administration Record (MAR) for the month of 9/2016, lacked documentation the Clonazepam was started.
A monthly nursing noted, dated 9/30/16 and written by E2 (DON), states pharmacy had requested a "hard prescription" for the Clonazepam since it is a controlled substance, however it was not obtained because R2's doctor did not respond to messages left for him.
As of 9/19/16, when R2 was emergently admitted to the hospital for ingesting multiple foreign objects, the Clonazepam had not been started.

After 9/7/16, the next note is dated 9/14/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 149	Continued From page 5 That nursing note includes, "[R2] refusing to eat dinner and was tearing up. Went to lie in bed. ...Placed on MD list for 9/16/16." There are no follow up notations, nor documentation that R2 was seen by an MD on 9/16. On 9/20/16, E2 (DON) wrote in the monthly review, that on 9/16/16 she attempted, but was unable, to contact R2's MD. E2 is out of the country and unavailable for interview. After 9/14/16, the next note was written 9/19/16, when nursing documented, "[R2] sent to hospital from Day Program for vomiting from his nose and mouth". "Admitted to Hospital Intensive Care Unit with diagnoses of following; Sepsis Syndrome, Severe Dehydration, System Inflammatory Response Syndrome, Severe Protein-Caloric Malnutrition. " The hospital record shows R2 arrived by ambulance at 2:07pm, on 9/19/16. The ER physician wrote, "Massively malnourished dehydrated...vomiting from mouth and nose. Appears in moderate distress." R2's emergency room lactic acid (breakdown of muscle) lab result was "Critical" requiring emergency treatment. The surgeon documented that because of a large amount of foreign objects seen upon Xray and scope, R2 had to be brought to the operating room on 9/22/16 for open abdominal surgery. The Surgeon documented upon opening R2's stomach, "a significant amount of foreign material was found, approximately 19 latex gloves were removed as well as pieces of cardboard, pieces of wood, hair ..." The Surgical Pathology Report lists the following found in R2's stomach; laminated paper, 16	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 149	Continued From page 6	W 149		

plastic gloves, multiple pieces of cotton material (12 x 9 x 4 cm), multiple plastic material (7 x 6 x 1 cm), paper pieces, and an elongated material measuring 23 cm long.
Also, the hospital abdominal/pelvic CT scan, dated 9/22/16, identified a paperclip in the large bowel, near the rectum.

E1 (Administrator) said on 10/11/16 at 11:00 am, that after the 7/11/16 Pica incident, R2's LOS was enhanced and R2 was placed on 15 minute checks when in his bedroom, and in line of sight when in the common areas. If R2 left the common area, the assigned staff was to follow him. E1 said this is not 1:1 because the assigned staff has other residents. R2's LOS is a team effort and if the person assigned to R2 is with someone else and R2 leaves the common area, R2's assigned staff tells another staff to keep an eye on R2. Everyone has been trained about R2's LOS.
After the 8/23/16 incident, when string was found in R2's stool, E1 said he did not change R2's LOS, but did the following; 1) Upon looking at the check sheets, E1 saw some holes in the staff's LOS documentation and reinforced documentation training with staff. 2) Because string was found in R2's stool, E1 told housekeeping to make sure none of his blankets / clothing was frayed. His roommate was moved so R2 was alone in his bedroom. 3) The room was stripped of any non-edibles which R2 may ingest. There is no documentation of room sweeps for potential non-edible ingestible objects.
E1 said he did not interview staff specifically about the LOS, because he felt R2 was ingesting the string from his clothing and blankets, and it could be solved with the above interventions.
E1 said that R2 is ambulatory and free to move

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 149	Continued From page 7	W 149		

about, including leaving his room. E1 said there is a chance R2 could leave his room between the 15 minute bedroom checks, but that staff who see him should immediately keep him in line of sight. The fifteen minute checks were documented by staff on a daily form.

This facility currently has 74 residents. Staff assignments were reviewed for 9/1-9/19/16. Direct care staff, including the staff person assigned to R2, were assigned between 8-13 residents.
The staffing included one or two Lead Staff / Supervisors each shift, however they also had resident assignments along with other tasks.

E6 (Lead Staff) stated on 10/12/16 at 1:50 pm, that staff assigned to R2 also had a full assignment of other residents. She said that all staff had been trained about R2's enhanced LOS, and are expected to assist R2's assigned staff as needed, such as if R2's staff is busy with another resident. E6 said it is a team effort, and that if R2 is in his bedroom on 15 minute checks and he leaves that room, any staff around should then monitor his whereabouts. E6 said R2 stays in his room a lot, but does walk around on occasion.

E7 (Lead Staff) stated on 10/12/16 at 2pm, that R2 spends most of his time in his room [on 15 minute checks], however when he leaves his room, any staff seeing this, should monitor him. All staff have been trained and it is a team effort.

E1 (Adm) confirmed, on 10/3/16 at 3:10 pm, the missing MAR documentation for R2's Clonazepam. E1 said the Clonazepam was never started because the doctor would not respond to the nurses' calls for a written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 149	Continued From page 8 pharmacy prescription. E1 said the facility now has a responsive physician covering the residents. E1 said that when R2 comes back from the hospital he will be on 1:1 LOS, which is under constant observation, within arms reach of staff.	W 149		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide adequate health care monitoring and treatment for 1 of 1 resident in the sample (R2) with identified, ongoing nutritional needs. After episodes of vomiting on 9/14 and 9/19/16, R2 was admitted from an off site day program, to the Hospital Intensive Care Unit with Severe Protein-Caloric Malnutrition, Anemia, Severe Dehydration, System Inflammatory Response Syndrome, and Sepsis Syndrome. 1. The Facility failed to ensure that; a) Nursing monitor, follow up, and document changes in R2's medical condition, after he was vomiting and refusing to eat. b) The Health Care Team, including the physician, nursing and the dietician, accurately monitor R2's weight. R2 was admitted to the facility underweight, and admitted to the hospital 10 months later with weightt loss and Severely Malnourished. c) The Health Care Team monitor and follow up a decrease below normal range of R2's nutritional	W 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 318	Continued From page 9 lab values. d) The Physician was available and responsive to R2's medical needs. Findings include: Refer to deficiencies cited at: W319 - The facility must ensure the availability of physician services 24 hours a day W322 - The facility must provide or obtain preventive and general medical care. W331 -The facility must provide clients with nursing services in accordance with their needs.	W 318		
W 319	483.460(a)(1) PHYSICIAN SERVICES The facility must ensure the availability of physician services 24 hours a day. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that physician services were available and responsive to the medical needs of 1 of 1 resident (R2) who had ongoing health issues, and was admitted to the hospital with Severe Malnourishment, Dehydration and Severe Anemia. Findings include: According to the medical assessment form, completed by the previous DON (E8) and dated 10/16/15, R2 is a 22 year old male admitted underweight from an abusive home, to the facility in 8/2015. R2 is ambulatory, non verbal, feeds	W 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 319	Continued From page 10 himself orally and has the admitting diagnoses of Profound Intellectual Disability, Autism, and Cerebral Palsy. The admitting Medical Comprehensive Functional Assessment, dated 10/16/15 and completed by the previous Director of Nursing / DON (E8), states that R2 was seen by Dietician (Z1) on 8/28/15, and his caloric intake and monthly weights will be monitored. R2's admitting Dietary Assessment, written by Z1 (Nutritionist) and dated 8/28/15, documents that R2's ideal body weight (wt) is 160 pounds plus or minus 10%. Z1's assessment identified that R2 was 69 inches tall, but was underweight at 97.6 lbs. R2's laboratory tests were ordered to be completed annually, as reflected on the physician order sheets dated 12/2015, 9/2016 and 10/2016. R2's lab values in 10/2015 were within normal range, including his albumin, protein, hemoglobin and hematocrit, all used for nutritional evaluation. However, the lab values drawn 4/27/2016 showed a drop below normal range of R2's albumin, total protein, hemoglobin and hematocrit. No action was taken by the physician. There is documentation that Z2 saw R2 on 5/18/16. On 7/11/16 and 8/23/16, there is documentation in the nursing notes that R2 had ingested inedible objects, which were noticed in his stool. He was sent to the ER on 7/11/16 and sent back to the facility after passing the foreign objects.. A nursing note dated 9/6/16, stated R2 was refusing dinner and had vomiting.	W 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE** **BELLWOOD, IL 60104**

(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 319	Continued From page 11	W 319		

On 9/7/16, nursing wrote R2 was no longer vomiting, and was seen by the psychiatrist for Pica, for which Clonazepam was ordered.
The Psychiatrist note, dated 9/7/16, documented a trial of Clonazepam would be tried. He wrote the order on 9/7/2016, however the Medication Administration Record (MAR) for the month of 9/2016, lacked documentation the Clonazepam was started.

E2's monthly nursing note, dated 9/30/16, states pharmacy had requested a "hard prescription" for the Clonazepam since it is a controlled substance, however it was not obtained because R2's doctor did not respond to messages left for him.
As of 9/19/16, when R2 was emergently admitted to the hospital for ingesting multiple foreign objects, the Clonazepam had not been started.

After 9/7/16, the next nursing note is dated 9/14/16.
That nursing note includes, "[R2] refusing to eat dinner and was tearing up. Went to lie in bed. ...Placed on MD list for 9/16/16." There are no follow up notations, nor documentation that R2 was seen by an MD on 9/16/16.
On 9/20/16, E2 (DON) wrote in the monthly review, that on 9/16/16 she attempted, but was unable, to contact R2's MD.
E2 documented in the nursing notes on 9/20/16, "[R2] Remains in hospital. Call was placed to [Z2]'s answering service 9/16/16 (day R2 was to be seen by Z2 at facility). ...[Z2's] group has not been here to see patient in 1 plus month (previous 3 months prior)."

There are no physician notes in the record after 5/18/16. There is a signature and check marks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 319	Continued From page 12 on a 90 day assessment dated 8/11/16, which on 10/3/16 at 3 pm, E1 said was a Nurse Practitioner. E2 is out of the country and unavailable for interview. E1 (Adm) said on 10/3/16 at 2:55 pm that Z2 and his medical group was not responding to the facility's calls. He said R2 never received the Clonazepam, and he was not seen by a physician on 9/16/16 (3 days before hospitalization) because of the inability to get in touch with Z2.	W 319		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that the weights and nutritional laboratory values were appropriately monitored, and action was taken as needed, for 1 of 1 underweight resident emergently admitted to the hospital with weight loss, and Severe Malnourishment and Anemia (R2). Findings include: Facility Job Description, undated and titled "Charge/Floor Nurse/RN/LPN" requires, "Checks daily for medical appointments. ...Reads and reviews laboratory test results in charts. ...Monitors residents for changes in physical and mental status and documents accordingly.	W 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 322	Continued From page 13	W 322		

...Monitors and physically checks all residents identified as ill, documents in medical charts and calls physician in case of acute change.

Facility Job Description, dated 3/1/12 and titled, "Director of Nursing" requires, "Monitors and evaluates collateral medical information / documentation entered into [facility's] medical charts.

Facility Procedure undated and titled "Nutritional Assessment" requires, "The licensed consultant dietitian provides in=depth nutritional assessments for residents whose conditions may place them at high nutritional risk. Nutritional assessment criteria may include...weight...nutrition-related lab values... The facility and consultant dietitian work together in determining level of nutritional risk."

According to the medical assessment form, dated 10/16/15, R2 is a 22 year old male admitted from an abusive home, to the facility on 9/28/2015 with diagnoses of Profound Intellectual Disability, Autism, and Cerebral Palsy. R2 was admitted to the facility, from the hospital where he was diagnosed as being malnourished and underweight. R2 is ambulatory, non verbal, and feeds himself orally. A Pica diagnosis was added in 11/2015 when he was observed eating inedible objects.
R2 was admitted to the hospital on 9/19/16 with wt loss, and diagnoses of Severe Malnutrition, Severe Anemia, Dehydration and ingestion of foreign objects.

The admitting Medical Comprehensive Functional Assessment, dated 10/16/15 and completed by the previous Director of Nursing /

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

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W 322	Continued From page 14	W 322		

DON (E8), states that R2 was seen by Dietician (Z1) on 8/28/15, and his caloric intake and monthly weights will be monitored.

R2's laboratory tests were ordered to be completed annually, as reflected on the physician order sheets dated 12/2015, 9/2016 and 10/2016. R2's lab values, drawn in the hospital 8/2015, and at the facility in 10/2015 were within normal range, including his albumin, protein, hemoglobin and hematocrit, all used for nutritional evaluation.

R2's admitting Dietary Assessment, written by Z1 (Nutritionist) and dated 8/28/15, documents that R2's ideal body weight (wt) is 160 pounds plus or minus 10%. Z1's assessment identified that R2 was 69 inches tall, but was underweight at 97.6 lbs, with normal lab results. Z1 recommended double portions and supplements three times per day.

Z1's nutritional note for October 2015, showed R2's wt was 98.8, however the November wt fluctuated between 95.4 and (98 lbs "re-weigh"). 12/10/15, Z1 documents that R2 refused December weight, and has had no wt gain since admission, and she would continue to monitor.
On 5/27/16, Z1 documented that R2 was having wt gain, but remained underweight. She documented his lab results had fallen below normal range, but made no further lab recommendations.
On 4/27/16, R2's previously normal values used for nutritional status dropped. R2's albumin dropped from 4.1 to 3.0 (normal >3.4) and total protein from 8.0 to 5.0 (normal > 5.6).
On 5/25/16, R2's labs used to evaluate anemia showed his hemoglobin was 11.2 (normal 14-18), hematocrit 39.7 (normal 42-52).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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W 322 | W 322

Continued From page 15

In July and august, Z1 wrote there were no new labs, continue to monitor.

There is no documentation that the physician was notified of these abnormal lab results.

No action was taken by the nursing or dietary department regarding R2's falling lab values. R2's lab order remained an annual draw.

The "[Facility] Monthly Weight Record" was reviewed.
R2's weight is recorded as follows; 12/2015 =97.1 lbs.
1/2016 = 96 lbs. 2/2016 = 99.6 lbs, 96 lbs, "average" of 97.8 lb.
3/2016 = Five weights between 95 lbs and 101 lbs, "average" of 97.8 lbs.
4/2016 = 92 lbs, 99.5 lbs.
5/2016 = Five wts between 89 lbs and 104.5 lbs, "average of 97.8 lbs.
6/2016 = Four wts between 94.5 lbs to 102, "average" of 98.5 lbs.
7/2016 = 103.5.
8/2016 = 107.5 lbs with "??" next to this wt.
9/5/16 = missing R2's wt. A "re-weigh" form, dated 9/12/16 documented 83.5 lbs for R2.

The physician order sheet (POS) dated 9/2016 and 10/2016 show R2's wt check remains monthly.

Facility Manager (E4) said on 10/11/16, that she was involved with wts before October 2016, but now is in charge of them, because of discrepancies. She said she was not sure why R2 missed the 9/5/16 wt day, and is not sure if anyone was notified when R2 was re-weighed on 9/12/16 at 83.5 lbs. She said the previous DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 322	Continued From page 16	W 322		

(E8) used to average the wts. E4 was unsure why R2 had multiple wts some months and when those multiple weights were taken during the month.
She confirmed that his Sept. wt showed a 24 lbs wt loss from August.
The staff member who took the weight could not be reached for interview.

E2 (DON) was out of the country and unavailable for interview.

E3 (Asst DON /LPN) said on 10/11/16 at 2 pm, that the "Weight Record" is used by the medical team and dietician for wt monitoring. She said R2 was on monthly wts, and is unsure what the multiple wts on some months are for.
She said the flow sheet wts are not dated, therefore she is unsure which ones came early in the month -the highest or lowest - showing wt gain or loss. E3 said the past DON (E8) used to average the weights, but is not sure why. E3 said she was not sure what weight was used since there were a number of them during the prior months.
E3 said she was not notified of R2's 83.5 wt. on September 12, so no action was taken. E3 confirmed the drop in lab values and that there was no order to repeat them before the next annual draw, 4/2017. E3 said at anytime, nursing can recommend an increase in wt frequency and re-draw of labs, however there is no evidence that was done.

Z1 (RD) was interviewed on 10/12/16 at 2:15 pm. She confirmed she is the consulting dietician and wrote the notes in R2's chart. Z1 said she is unsure why there were multiple wts, and said the past DON (E8) averaged wts, however that is not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

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BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

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W 322	Continued From page 17 a practice she would recommend or use. She said at any time she can recommend that wts and labs are done more frequently, however she made no such recommendation. She said she was not notified of R2's wt loss 9/12/16. When R2 was admitted to the hospital on 9/19/16, his albumin, protein, hemoglobin and hematocrit levels were below normal. R2 required intravenous nutritional support and intravenous treatment for severe anemia.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide adequate health care monitoring and treatment for 1 of 1 resident in the sample (R2) with identified, ongoing nutritional needs. After episodes of vomiting on 9/14 and 9/19/16, R2 was admitted from an off site day program, to the Hospital Intensive Care Unit with Ingestion of Foreign Objects, Severe Protein-Caloric Malnutrition, Anemia, Severe Dehydration, System Inflammatory Response Syndrome, and Sepsis Syndrome. 1. The Facility failed to ensure that nursing monitor, follow up and document changes in R2's medical condition, after he was vomiting and refusing to eat. Findings include:	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 331	Continued From page 18	W 331		

Continued From page 18

Facility Job Description, undated and titled "Charge/Floor Nurse/RN/LPN" requires, "Checks daily for medical appointments. ...Reads and reviews laboratory test results in charts. ...Monitors residents for changes in physical and mental status and documents accordingly. ...Monitors and physically checks all residents identified as ill, documents in medical charts and calls physician in case of acute change.

Facility Job Description, dated 3/1/12 and titled, "Director of Nursing" requires, "Monitors and evaluates collateral medical information / documentation entered into [facility's] medical charts."

According to the medical assessment form, dated 10/16/15, R2 is a 22 year old male admitted from an abusive home, to the facility on 9/28/2015 with diagnoses of Profound Intellectual Disability, Autism, and Cerebral Palsy. R2 was admitted to the facility, from the hospital where he was diagnosed as being malnourished and underweight. R2 is ambulatory, non verbal, and feeds himself orally. Pica diagnosis was added in 11/2015 when he was observed eating and excreting inedible objects.

According to the nursing note dated 8/24/16, R2 had strings appearing in his stool for 2 days. There were no nursing notes documenting R2's G-I status, until 9/6/16, when nursing documented R2 was refusing dinner and vomiting. On 9/7/16 at 8 am, nursing documented that R2 had no emesis through the night, and was eating again. No further notes were written until 9/14/16.

According to the next nursing note written 9/14/16, R2 refused to eat and was "tearing up",

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

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BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 331	Continued From page 19	W 331		

and went to lie in bed. Nursing wrote that R2 would be put on the physician's list to be seen on 9/16/16. There is no documentation monitoring R2's condition.

E1 (Administrator) said on 10/3/16 at 2 pm, that the physician did not see R2, because the physician could not be contacted and was not answering his messages.

After 9/14/16, the next note was written 9/19/16, when nursing documented, "[R2] sent to hospital from Day Program for vomiting from his nose and mouth". "Admitted to Hospital Intensive Care Unit with diagnoses of following; Sepsis Syndrome, Severe Dehydration, System Inflammatory Response Syndrome, Severe Protein-Caloric Malnutrition, Severe Anemia. "

The ER physician documented R2 appeared grossly underweight, malnourished and pale. They recorded his weight as 89 lbs, however E2 (DON) wrote on 9/30/16, that the hospital reported R2's weight was 81 lbs.

The hospital record shows R2 arrived by ambulance at 2:07pm, on 9/19/16.
The ER physician wrote, "Massively malnourished dehydrated...vomiting from mouth and nose. Appears in moderate distress." His ER lactic acid (breakdown of muscle) lab result was "Critical" requiring emergency treatment.

R2 was given intravenous (IV) fluid boluses in the ER, was started on High Caloric IV fluid, IV iron supplements, and IV lipids. The Surgeon documented that because of a large amount of foreign objects seen upon Xray and scope, R2 had to be brought to the operating room on

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING ______ B. WING ______	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 331	Continued From page 20 9/22/16 for open abdominal surgery. The Surgeon documented upon opening R2's stomach, "a significant amount of foreign material was found, approximately 19 latex gloves were removed as well as pieces of cardboard, pieces of wood, hair ..." E3 (ADON) confirmed on 10/11/16 at 2:30 pm, that there is a lack of nursing notes monitoring R2's condition after 8/24/16 and especially after 9/14/16. She said until an medical issue is resolved there should be at least daily documentation by nursing.	W 331		