STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G058	A. BUILDING _____ B. WING _____	R 11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTS & FRIENDS OF THE SLC	1450 CASEYVILLE AVENUE SWANSEA, IL 62226

(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 FIRST COMPLAINT FOLLOW UP TO SURVEY DATE OF 7/7/16, COMPLAINT #1643568/ IL86556	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: REPEAT Based on observation, interview and record review, the facility's governing body has failed to develop and implement general policy and operating direction over the facility which ensures: 1) Nursing will remain with individuals who are in medical distress until Emergency Medical Services take over for 1 of 1 individual (R13) who expired from Respiratory Failure. 2) Bed alarms are in working order for 3 of 4 individuals (R14, R16 and R17) who reside at Schloeman House. 3)A policy was in place for narcotics to be kept locked in a secure place this has the potential to affect 1 of 1 (R2) individual in the sample and 6 of 6 (R14, R16, R18, R19, R20, R21) individuals outside of the sample who have a physician order for narcotics. Findings Include: 1) Initial Report to Illinois Department of Public	{W 104}		

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

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{W 104}	Continued From page 1	{W 104}		

Health/ IDPH (dated 1/17/16) reports that R13 was taken to a local hospital by ambulance on 1/17/16 at approximately 5:38 AM due to respiratory distress and unresponsiveness. The report documents that R13 was pronounced dead at the hospital at 5:45 AM.

Resident Death Report (dated 1/22/16/ Facility's Final Report to IDPH) identifies R13 as a 37 year individual who functions at the Moderate level of Intellectual Disabilities with additional diagnoses of Diabetes. Hyperkalemia, Hypoglycemia, Status Post Cardiovascular Attack, Seizure Disorder, Pneumonia and Leukocytosis.

Nurse's Notes dated (Late Entry) for 1/17/16 per E7/ Direct Support Person(DSP) documented a second note regarding R13's incident, "At approximately 4:30 AM I was informed by DSP that client was not looking good. Noted clients breathing a little harder than usual. Client had opened his eyes when spoken to. In fetal position with head down. Put clients head on pillow and straightened him out. Breathing improved at this time. Client's (finger stick blood sugar) was 70. Went to the office to get a can of Glucerna. On returning to the house noted his breathing was labored. He was abdominal breathing with short rapid breaths. Asked DSP to call AOD(Administrator on Duty) and to call 911. Temp was 101.4. Unable to get pulse or (blood pressure) at this time. When AOD arrived I went to the office to get paperwork ready to send client out. As I was finished making copies, AOD arrived (to the nurse's office in a the separate building) and grabbed crash cart and AED stating client was worse. I ran back to the house to check client and on entering the room saw Z1/ RN performing CPR." (Typed as written. E7 did

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{W 104}	Continued From page 2	{W 104}		

not identify the names of the DSP or AOD.)

E8/ Direct Support Person's written statement (dated 1/17/16) documents, "In middle of changing R13 he looked sick and normal and slow/barely movement, notified E7 that something was wrong with R13 and snot coming out his nose. She checked he blood sugar it was 70. E7 stated that he normally looks pale all the time and that she doesn't see anything wrong with him and that his blood sugar wasn't bad and proceeded with administering meds to other clients. She then went back in R13's room gave his med oral, then asked me to notify AOD (because) she might need to send him out. I notified AOD. AOD arrived and nurse stated that R13 was then unresponsive and 911 was called nurse left (R13's) room and ran somewhere. Don't know RN came and (began) CPR."

In interviews with E2/ Director of Nursing on 10/24/16 at 2:05 PM and 10/25/16 at 9:50 AM,when asked if E7 should have left to prepare papers when R13 was having abdominal breathing and 911 had been called, E2 stated, "No, the paperwork could have been faxed to the hospital later." E2 confirmed that E7/ LPN should have remained with R13.

911 Policy and Procedure (dated 4/22/13) documents, "In the event a client is having difficulty breathing, loses consciousness, has loss of pulse or blood pressure, or is bleeding excessively, when a nurse is present, it is the nurse's responsibility to have a DSP/ staff call 911 for immediate crisis intervention."

Policy and Procedure for Emergency Treatment (dated 4/22/13) documents, "Do not leave

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resident alone. Stay with them until EMS arrives."

Procedure for Client Medical Emergencies (dated 4/20/10) documents, "One staff member trained in medically approved first aid procedures remains with the client and provides first aid treatment as required until nursing personnel arrive."

Review of facilities Policy and Procedures: 911 (revised 4/22/13), Emergency Treatment (revised 4/22/13) and Procedure for Client Medical Emergencies (revised 4/20/10) do not specifically identify that nurses are to remain with individuals who are in medical distress until outside emergency medical services take over or they are relieved by another nurse.

In an interview with E1/ Administrator on 10/26/16 at 3:30 PM, surveyor asked if the facility had any policy that identifies that the nurse should stay with an individual who is in medical distress until the EMS (Emergency Medical Services) arrives, E1 stated, "We made the policy that any staff member trained in medically approved first aid procedures remain with the client." E1 confirmed that E8 and E13 had not been trained in CPR at the time R13 became unresponsive. E1 confirmed that the policies were not specific in what nursing are to do once they arrive to the scene of an individual who is in medical distress. E1 stated, "The policy needs to be specific that the nurse will remain with the individual who is in distress until EMS arrives."

2) In review of the facility's investigations of unknown injuries, Injury Report (dated 4/27/16) documents that on 4/24/16 at approximately 6:50 AM, R16 was found with dried blood and a small

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bruise under her nose. R16 also had swelling to her upper/ lower lips and left side of face. The facilities investigation found that R16's bed alarm was not working due to a faulty sensor pad.

Observation on 10/18/16 at 6:00 PM, E4/ Qualified Intellectual Disability Professional and surveyor went to test the four bed alarms that are utilized at Schloeman House. R14's bed alarm was tested multiple times and only alarmed once. R17's bed alarm did not alarm when tested multiple times.

a) Individual Program Plan/ IPP (dated 4/7/16) identifies R16 as a 28 year old individual who functions at the profound level of intellectual disabilities with additional diagnoses of Cerebral Palsy, Insomnia and Seizure Disorder. The IPP also documents that R16 utilizes a bed alarm while R16 is in bed to alert staff when R16 is attempting to get out of bed without assistance. The IPP documents that R16 is a high risk for falls.

b) Individual Program Plan/ IPP (dated 1/21/16) identifies R14 as a 64 year old individual who functions at the Profound level of Intellectual Disabilities. The IPP also documents that alarm pads are provided to R14 to prevent falls due to hip fracture.

c) Individual Program Plan/ IPP (dated 11/19/15) identifies R17 as a 39 year old individual who functions at the moderate level of intellectual disabilities. The IPP documents that R17 utilizes a bed alarm while in bed to promote safety and to alert staff when he is attempting to get out of bed without staff assistance.

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{W 104}	Continued From page 5 First 5 Day Check List (facility form used for new employees/ no date) regarding bed mobility identifies that the employee read the directions for the bed mobility monitor, check out the monitor and is able to put on a bed for a resident and is familiar with mobility charting. There is no documentation that the employee were instructed on what to do if the monitors are not working. In an interview with E1/ Administrator on 10/18/16 at 6:25 PM , E1 confirmed that the facility did not have a policy or procedure in regards to bed alarms. E1 stated, "The AOD (Administrator on Duty) have batteries, staff are to call the AOD for batteries. " 3) Review of the facility resident roster dated 10/18/16 documents R2, R19, and R21 function at a Mild Level of Intellectual Disability. R18 functions at a Severe Level of Intellectual Disability; R14, R16, and R20 function at a Profound Level of Intellectual Disability. During observation of the medication pass on 10/18/16 beginning at 4:24 PM E10 (Licensed Practical Nurse) was observed administering a medication stored in a small white envelope with R21's name written on the envelope. When asked about the medication, E10 stated, "Control medications are all kept in the nursing office and we bring them to the unit in an envelope like this." During observation on 10/20/16 at 1:05 PM a small black storage box with yellow print/handle with a metal padlock was observed behind the nurses desk sitting on another plastic storage box. The surveyor went to the nursing office to get a medial record. The hallway door leading into the nursing office was locked. The surveyor then	{W 104}		

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{W 104}	Continued From page 6 asked office staff how to obtain the medical record. E16 (office staff) instructed the surveyor to go through the second door located between the office and the nursing office. This door was open, the surveyor walked in and observed the narcotics lock box sitting behind the nurses desk on the opposite wall of the door. There were no nurses present in the office at this time. During interview and observation on 10/20/16 beginning at 1:15 PM, E15 (Licensed Practical Nurse) opened the locked box and the following medications were observed located in the box; morphine, tylenol with codeine, phenobarbital, clonazepam, and ambien. E15 stated, "We usually keep doors into the office shut and locked but with everything going on it hasn't been lately." During interview on 10/20/16 at 3:20 PM E2 (Director of Nurses) gave the surveyor a policy titled, "Narcotic Storage" not dated. E2 stated, "We did not have a narcotic policy (until the surveyor asked for it). We are moving the narcotics back to the houses in the locked med carts in the locked closets."	{W 104}		