STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G340	A. BUILDING _____ B. WING _____	06/16/2016

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CALUMET CITY TERRACE	**1380 RIVER DRIVE CALUMET CITY, IL 60409**

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W 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY / FUNDAMENTAL - EXTENDED TO FULL IN THE AREA OF CLIENT PROTECTIONS ANNUAL LICENSURE SURVEY INSPECTION OF CARE	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 follow their abuse and neglect policy, when they failed to thoroughly investigate the unexpected death of one of one resident who became unconscious and required ongoing CPR from the facility to the hospital Emergency Department (ED), where she was pronounced dead (R3). The facility failed to investigate whether: 1) Nursing was notified of R3's change of condition, in a timely manner. 2) Emergency medical services were summoned, and CPR was initiated, in a timely manner. 3) R3 received care according to her needs, in the days leading up to her Cardiopulmonary Arrest. 5) R3's level of supervision was adequate.	W 122		

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

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W 122	Continued From page 1 6) Any corrective action, identified in the course of a thorough investigation, was implemented. Findings include: Refer to deficiencies cited at: W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS 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 policies and procedures that prohibit neglect for 1 of 1 resident out of the sample, who suddenly became unconscious and required ongoing CPR from the facility to the hospital Emergency Department (ED), where she was pronounced dead (R3). The facility failed to: 1) Conduct a thorough Investigative Review of this unexpected death. 2) Conduct a Quality Assurance Review of this unexpected death. 3) Ensure that any identified corrective action is implemented following the Review Findings include: 1) Facility Policy #5.24, revised 12/2015,	W 149		

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W 149	Continued From page 2 "Administration / Investigative Committee" states: "Neglect: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." "The Investigative Committee shall be responsible for the following: ...A. To identify, review and determine if alleged violations of any rights, including abuse and neglect have occurred. C. To protect individuals from further harm. E. The Committee shall meet to review the allegations, conduct interviews and examine the information available that is pertinent to the incident." 2) Policy #5.57, revised 12/2016, "Administration / Physical Injury and Illness / Individual Medical Emergencies" states: "Individuals served by the agency shall receive timely and effective medical services for physical injuries, illnesses, and medical emergencies. ... Procedure: A. As soon as the injury or illness is determined to be a medical emergency, the DSP is to call 911... C. Notify the Nurse and QIDP or Administrator for consultation and direction. H. The QIDP/Administrator shall conduct any necessary interviews or inquires to establish the probable cause of the injury and document the finding on the progress note. J. The QIDP will transfer any pertinent information from the progress note onto the Quality Assurance (QA) Form for review at the QA meeting." 3) Policy #5.29, revised 12/2005 "Administration / QA Committee" states: "The home shall have a QA Committee to QA review medication records, ...medical issues and	W 149		

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individual incident reports. The Committee assists Administration by ensuring practices and policies regarding medication administration, nursing services...and individual safety meet regulatory standards and quality outcomes."
"QA review all medication orders...and administration records to ensure they were administered as ordered."
"QA review Nursing and or Medical concerns pertaining to the individual needs..."
QA review all incidents and accidents: including issues that pose a safety risk, such as change of condition and unusual incidents (either resulting in observable injury or not)... Committee will implement a plan of correction when necessary to prevent future incidents or accidents"
"Documentation of each QA review...shall be retained for at least 5 years."

4) Policy # 7.02, revised 1/2016, "Nursing Services" states:
"The following procedures shall be used to report minor illnesses or injuries to the RN Trainer; a. DSP observes an individual with a minor illness or injury. b. DSP relays the symptoms to the RN Trainer and documents on progress note. ...d. If symptoms worsen at any point, the RN Trainer shall be notified for further instructions. ...e. If the minor illness / injury requires a physician's visit ...f. The results of the doctor visit shall be documented in the individual's record and shall be relayed to the RN Trainer..."

According to the Individual Service Plan (ISP), dated 7/7/15, R3 was a 55 year old, ambulatory and verbal resident with diagnoses including Severe Intellectual Disability, Seizures, Impulse

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Control Disorder, and Intractable Partial Epilepsy. She had a vagal nerve stimulator (VNS) implanted to decrease seizure activity. Education documentation shows all home staff were trained on using the VNS device.
R3 had an unsteady gait needing staff assistance, her speech was hard to understand at times, and she wore a helmet, even in bed, due to a long history of injuries following seizure activity. R3 was able to complete some self care tasks.
The ISP Behavior section documents that "in the past year R3 has displayed the behaviors of throwing her body to the floor, kicking, spitting, throwing her helmet and pulling her hair out. ...She would refuse food on occasion... Incidents of aggression may occur more in the month before or during seizures. She can become confused and lethargic following seizures."
R3 had a history of severe maladaptive behaviors, for which she was on mood altering medications, and was followed by a psychiatrist.

Progress notes, written and dated by those listed, include the following history:

E12 (Resigned RN) -7/11/15 = R3 to ER for throwing herself onto the floor, causing a chin laceration which required sutures. R3 was having multiple behaviors of throwing self onto floor and thrashing about.
E12 - 8/10/15 = Maladaptive behaviors including refusing to walk and throwing self on floor continues. A fluid restriction was ordered for a blood sodium level of 127, within 7 days it was normal at 140.
Neurological Consultation - 10/9/15 = R3 to the hospital for seizure monitoring - required 72 hours of continuous brain wave monitoring for Seizures.

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W 149	Continued From page 5 Diagnoses include Continuous, Irregular, Diffuse, Multifocal Bilateral Slowing, and Frequent Right Fronto-Temporal Epileptic form Discharges. Plan to follow up with Neurologist. E3 - 11/17/15 = To Neurologist for follow up for unsteady gait change. Plan to change seizure medications. E3 - 11/25/15 = Refusing to walk and get off bus at day training, and upon arrival throwing self onto floor and rolling around. E3 - 12/3/15 = Had behavior of throwing self on floor and rolling around for 2 hours, afterward was calm. Still occasionally refusing to walk. Seizure medication continued to be tapered down. No seizure activity. Scheduled for follow up psychiatric and medical visits. E13 (covering RN) - 12/4/15 - seen in ED with a right ankle contusion. E3 - 12/8/15 = R3 having maladaptive behaviors of throwing self on carpet, rolling and kicking causing multiple abrasions. Staff to monitor, home from day program. E3 - 12/14/15 = Special Staffing regarding R3's maladaptive behavior - rolling on floor causing bruising and abrasions with R3, guardian and QIDP. Continue to monitor and follow up with physicians. E8 (Resigned QIDP) - 12/14/15 = A special team meeting took place including R3 and the guardian, regarding R3's maladaptive behaviors resulting in bruising and abrasions. "We spoke about one to one staff." There is no action plan documented. Neurological Consultation -12/7/15 = Follow up for medication changes and seizures. Plan: Continue with the medication changes and monitor. Neurologist's fax found in the record - 12/11/15 =	W 149		

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W 149	Continued From page 6 "...In addition, [R3's] sodium is low [131, normal is 136-145], please put her on a 1200cc fluid restriction and minimize water..." Plan to repeat labs in 2 weeks. There was no documentation this order was carried out. DSP Behavior Report -12/17/15 = R3 throwing her self to the ground and all over floor, causing bruising. DSP Progress note - 12/19/15 at 11:45 am = R3 was on the toilet and fell backward onto the railing, sliding to the floor where she began rolling around. R3 then got off the floor and ambulated to her room. There were no new wounds, but old scabs on legs re-opened. Nurse called. E3 - 12/19/15 = Notified by DSP of R3's maladaptive behaviors. No seizure activity noted, alert and speaking. Staff instructed to keep her in line of sight and continue to monitor for any changes in condition. "If any change in condition or worsening condition or increased agitation or aggression call 911. ...Admin notified per this RN- is agreeable with increase in staffing for individual. Condition stable at present." E3 - 12/20/15 = Admin notified this RN that [R3] is being coded, 911 has been called." An Incident Report /GP15, dated 12/20/15 and written by E7,(the overnight Direct Support Person / DSP), documents that throughout the night, R3 was rolling and flopping on the living room floor with periods of sleep between episodes. A mattress was brought into the living room for R3 to lay on, so E7 could observe her. E7 was the only overnight staff with R3, and 5 other residents, from 12/19 at 11:30pm to 12/20 at 9am. E7 wrote she stayed with R3 throughout most of the night, but at 6:30 am, she started helping the other 5 residents with morning care. E7 wrote that she continuously checked on R3	W 149		

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between assisting the others, that she could see her from the hallway.
At 7:30 am, E7 sat R3 up and assisted her with taking morning medication and eating a banana.
At 8:45am, E8 (resigned QIDP) called the home and E7 told her how R3 had been during the night. E8 instructed E7 to call the nurse. E7 left a voice mail for the RN, and called E8 right back saying R3 had a seizure, but was resting on her stomach, with her face to the right side. E7 wrote that after a few minutes, she checked on R3, turning her toward her side to make her more comfortable, when she noted R3 was "purple." E7 removed R3's helmet and initiated CPR, stopping to call 911, and then continuing CPR. E7 is a Certified Nurses Aid and has up to date CPR training.

The Investigation dated 12/28/15, and signed by the previous Administrator (E10) included interviews from staff and the residents for the 24 hours before R3's death.
E9 (House Manager) wrote when she entered the home at 9:27 am, she found E7 doing CPR, with the police present.
The ambulance team documented that the 911 call came in at 9:20 am, and they arrived at 9:24 am, observing E7 performing CPR. The ambulance team took over CPR, transferring R3 to the hospital Emergency Department (ED). The hospital documented that R3 arrived at 9:40 am, and was declared dead at 9:42, with a diagnosis of "Cardiopulmonary Arrest".
Staff interviews include the following:
E11 (Evening shift DSP) wrote that upon his arrival on 12/19/15, at 3:27pm, R3 was ambulating and verbalizing. R3 ate 50% of dinner and was watching TV. At 10pm, R3 had a seizure which stopped after 2 minutes, and that

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she slept until he left for the night, 11:30 pm.
E5 (Second evening DSP) wrote that after R3's seizure, "staff brought mattress from [R3's] room to the living room to monitor."
E8 (resigned QIDP) wrote she had called E7 at 8:45am on 12/20, to see how [R3] was doing, and E7 told her [R3] was restless during the night and throwing her body around. E8 instructed E7 to call the nurse. At 9:10am, E7 had called her back saying she left the nurse a message, but had not heard from her, and that [R3] was resting. At 9:25am, E8 said E9 (House Manager) called saying 911 had been called and CPR was in progress. E8 then called and alerted E10 (resigned Fac Rep/Administrator).

E10 who conducted the Investigation, documented, "Final Conclusion: After a thorough investigation of all staff and individuals, the Investigative Committee has determined staff responded to the emergency per policy 5.57 [Nursing]. The interviews and statements support this conclusion." Investigative members included E10 (Resigned Administrator/Facility Representative), E8 (Resigned QIDP). The RN was not listed on this investigation.

On 6/8/16, E1 (Executive Director) and E2 (Trainer) provided a QA review of R3's death, dated 1/25/16. They said that the only reviews of R3's death are E10's Investigation and the QA review.

E2 (Trainer) said on 6/9/16 at 12:50pm, that staff working at the time of this incident, E8 (QIDP), E10 (Admin, Facility Representative) resigned for unknown reasons.

According to the QA minutes, E2 led the QA

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W 149	Continued From page 9 review on 1/25/16. The QA documentation of R3's death review is as follows; "[R3] = On 12/20/15, [R3] had a seizure, was unresponsive. CPR was initiated, paramedics called, she was transported to [hospital] ER. The seizure resulted in her death." E2 said she led the QA meeting for R3's death, on 1/25/16. She said the QA Committee did not review any of the record, the staffing level, the physician orders, medication administration records, staff response to this change of condition, and the reason R3 was on her mattress in the living room. E2 said the facility does not have the ED records, including a written diagnosis of what may have contributed to this cardiac arrest, however confirmed the QA minutes list Seizure as a contributing factor. E2 said that she assumes E10 had completed a thorough investigation, including all the above issues, however has no reproducible documentation. E2 confirmed there is no reproducible documentation that there was any corrective action taken. E2 said staff should call the nurse or 911 for any change of condition or emergency situation. She said staff are only instructed to call QIDP for minor issues,such as a bruise, etc, before calling the nurse. E7 (night shift DSP) said, on 6/9/16 at 9:00a, that R3's episodes of thrashing about on the floor was the same as prior maladaptive behaviors, and that R3 was alert between. However, as the night led into the morning, E7 noted the frequency was more than before. She said it was not unusual for R3's mattress to be in the living room so R3 could be monitored for behaviors, seizures, and fall	W 149		

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prevention. E7 confirmed she was the only staff, and that when she was in the other residents bedrooms, she frequently observed R3 from the hallway. E7 said she did not call nursing because R3 has had this same behavior before, but the frequency was more this night. E7 said she had been trained to call the QIDP before the nurse, but that has changed and now she can call the nurse/ 911 directly.
E7 said between her talking to the QIDP and leaving a message for the nurse, R3 had 2 seizures. She said she lowered R3 from a sitting position, onto the mattress and that R3 had her eyes open and was breathing. R3 then turned over onto her stomach and turned her head to the side. She was breathing deep and appeared to be resting . E7 remained in the room, and then walked over to R3, to make her more comfortable, however noticed R3 was pale and slightly purplish, E7 said she immediately started CPR.

E4 (QIDP) stated on 6/9/16, at 9:30 am, that staff should always call the nurse or 911 for any medical concerns or change of condition. They call the QIDP if it is minor.

E5 (DSP) said on 6/9/16 at 9:50 am, that for any minor things we call the QIDP, then nurse, but for any serious issues, we call the nurse or 911.

E3 (RN) stated on 6/8/16, at 3:30 pm, that she does not have information from the ER regarding R3's death, and is unsure of any suspected or confirmed cause of death. She said at times, it was hard to distinguish between R3's maladaptive behaviors and seizure activity. She said she had spoken with the neurologist regarding the two, and medication adjustments

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W 149	Continued From page 11 were in progress. E7 said she was not aware of the neurologist's fax to the facility on 12/11/15, ordering a restriction of R3's fluids for a low sodium level [which can affect level of consciousness and seizure threshold]. E3 said staff should have called her during the night if they felt it was a change of condition, and that she told E10, who was conducting the investigation that she was not called until morning, but should have been called earlier. E3 said her note on 12/14 and 12/19 regarding staffing, was because of R3's increase in maladaptive behaviors. She said staff called her on 12/19/15, saying R3 was acting out and staff was stressed. E3 said she called E10 and told her extra staff would be appropriate, and that E10 said she was going to follow through. However, the 12/19 evening shift had two staff, and 12/20 night shift had one staff, which is routine. E1 (Executive Director) confirmed, on 6/9/16 at 1:15pm, that E10's Investigation does not, but should have included documentation that the record, including progress notes, orders, medication administration, and staffing was reviewed. E1 said the QA Committee should have identified the lack of reproducible documentation of a thorough investigation, and conducted one. He confirmed that E10 documented staff had responded appropriately to this change of condition, but is unsure if any additional training took place. E1 said in hindsight, additional training should have taken place. E1 also stated the QA review was not conducted according to policy, and that hospital ED notes should have been part of the death review.	W 149		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN	W 242		

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W 242	Continued From page 12 The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a formal training program was implemented for 1 of 1 sample resident with identified poor oral hygiene (R2). Findings include: According to the record, R2 is a 64 year old verbal and ambulatory resident. He is capable of completing most activities of daily living. The most current dental progress note, dated 5/16/16, includes "The soft tissues are moderately inflamed because of plaque, tarter, and food particles adhering to the teeth." The prior dental progress note, dated 2/27/15 includes the same documentation. R2's Individual Service Plan, dated 9/24/15, lacks an oral hygiene program. This was confirmed by E4 (QIDP) on 6/9/16 at 10:45am.	W 242		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 289		

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(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 289	Continued From page 13 The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure the Individual Service Plan (ISP) includes interventions to address an identified maladaptive behavior, for 1 of 2 sample residents with such a behavior (R1). Findings include: According to the record, R1 is a verbal, ambulatory 60 year old with diagnoses including Severe Intellectual Disability. The Individual Service Plan, dated 9/1/15, includes a Behavior section identifying inappropriate urination as a maladaptive behavior. R1's record includes a Behavior Intervention Program (BIP) addressing "Aggression". The BIP mentions inappropriate urination as a maladaptive behavior, but only included programming with intervention steps for aggression. A Urology Physician consultation report, dated 7/29/15, documents that R1 was seen for Incontinence, and a Cystoscopy (bladder scope) was done. The physician recommended, "This seems to be behavioral and not related to his bladder." A physician order, dated 3/25/16, included "pull ups" for R1.	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G340	A. BUILDING _____ B. WING _____	06/16/2016

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W 289	Continued From page 14 R1 was observed at his day training site on 6/8/16, at 12:45pm. He was observed without an undergarment beneath his pants. He did not have a pull up, and his underpants were in his pocket. Z1 stated R1 will not wear a pull up, and takes off his underpants. She said R1 has problems with urination and about 3-4 times per week he urinates on himself, on the floor, the wall, or another inappropriate area. Z1 said sometimes he urinates right on the work area floor. She said the facility is aware and data collection sheets are sent to the home with the number of times he inappropriately urinates, however Z1 has only a Behavior Intervention Program (BIP) for aggressive behavior. She said staff try to redirect R1, but do not have specific, written intervention steps to follow. E4 (Facility QIDP) said on 6/9/16, at 10:45am, that R1 does have continued problems with inappropriate urination, and won't wear his pull up or underwear. E4 confirmed that R1 does not, but should, have a BIP addressing this maladaptive behavior.	W 289		