STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011985	A. BUILDING: _____ B. WING _____	03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANNER PLACE	321 CHESTNUT STREET PARIS, IL 61944

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Z 000	COMMENTS COMPLAINT INVESTIGATION 1940490 / IL108888	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: Section 350.1210 Section 350.3240a)d) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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. (Section 3-610 of the Act) These requirements are not met as evidenced by: Based on record review and interview the facility has failed to prevent neglect for 1 of 1 individual in the sample (R1) who requires close monitoring and failed to provide corrective action for 1 of 1 individual in the sample (R1) who requires closer supervision to prevent injury from recurring.	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 Findings include: Per facility Policy NO:W 5.24 Administration, Investigative Committee; adopted: 07/03, Revised: 01/16, page 5, states "Neglect: an employee's, agency's, or facility's failure to provide adequate medical care, personal care, or maintenance, and that, as a consequence, 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 of possible injury, harm or death." Per Policy NO: 5.29, Administration, Quality Assurance Committee, Adopted: 10/84, Revised 12/05, Purpose: "The Quality Assurance Committee assists Administration by ensuring practices and policies regarding medication administration, nursing services, home environment and individual safety meet regulatory standards and quality outcomes." 1. According to R1's Physician Order Sheet, dated 2/2019. R1 functions at a Moderate Intellectual Disability, with current diagnosis of Hypothyroidism, Schizophrenia, Hypertension, Hypercholesterolemia, Diabetes Mellitus type II, History of Seizures, and Depression. Documents found in R1's Medication Administration Record (MAR) titled "General Notes" for R1 from E3, RNT, dated 1/3/19, states "R1 is now on a fluid restriction of 1.5 L per day. This is the equivalent of 1 16 oz bottle 3 times a day (Approx.) For breakfast 4 oz of milk, 4 oz of juice or coffee. AM Med pass 5 oz water. Try giving meds whole in applesauce with an extra	Z9999		

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Z9999	Continued From page 2	Z9999		

bite of applesauce after each swallow, then a sip of water after. He will take a 16 oz of water for lunch. Afternoon med pass 5 oz water, use applesauce as above. Supper 8 oz of milk. Bedtime meds 5 oz of water, applesauce as above. Please follow as closely as possible, monitor all fluid intake and document on his specializing sheet."

In R1's Medication Administration Record (MAR) a document is present titled "Specializing Sheet" for R1's fluid restriction monitoring dated February 2019, from 2/1 to 2/14, staff has wrote "caught extra fluid back bathroom drinking from faucet".

According to Hospital Care Instructions undated, states "Hypotnatremia means that you don't have enough sodium in your blood. It can cause nausea, vomiting, and headaches. Or you may not feel hungry. In serious cases, it can cause seizures, a coma, or even death. Hyponatremia is not a disease. It is a problem caused by something else, such as medicines or exercising for a long time in hot weather. You can get hyponatremia if you lose a lot of fluids and then you drink a lot of water or other liquids that don't have much sodium."

Facility provided documents titled "Progress Notes" for R1 from 12/1/18 to 1/7/19 as follows:

12/1/18, states: "Staff was giving med's and came out cause R1 was going into the kitchen to try to get into the kitchen for coffee and tried to push staff to get in there."

According to staff schedule provided dated 12/1/18, 1 staff was scheduled for day shift and 2 staff scheduled for second shift with no cook

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Z9999	Continued From page 3 scheduled. 12/8/18, states "R1 kept getting up repeatedly going to the boys back bathroom and drinking from the sink." According to staff schedule provided dated 12/8/18, 1 staff was scheduled for day shift and 2 staff scheduled for second shift with a cook scheduled from 10:30 AM to 7:00 PM. 12/9/18, states "R1 got a coffee pack out of kitchen cabinet, opened it up and ate the grounds." According to staff schedule provided dated 12/9/18, 1 staff was scheduled for day shift and 2 staff scheduled for second shift with a cook scheduled from 10:30 AM to 7:00 PM. 12/14/18, states "R1 kept going to the guys back bathroom saying he had to go to the bathroom but he was putting his mouth on the faucet drinking water from it." 12/14/18, states "R1 went into the kitchen and was getting into things. He got a cup and got into the refrigerator. he said he was hungry and wanted it now." According to staff schedule provided dated 12/14/18, 1 staff was scheduled for day shift and 1 staff scheduled for second shift with a cook scheduled from 6:00 AM to 9:00 AM then again at 2:00 PM to 7:00 PM. 12/22/18, states "Direct Support Staff (DSP) noticed Constant drooling and shaky." E3, Registered Nurse Trainer (RNT), called at 6:30 PM ordered to take to hospital." Hospital	Z9999		

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Z9999	Continued From page 4 admission related to Hyponatremia. According to staff schedule provided dated 12/22/18, 1 staff was scheduled for day shift and 2 staff scheduled for second shift with a cook scheduled from 10:30 AM to 7:00 PM. 1/2/19, states "Cough noted, Individual seen in EZ care per RN, EZ care sent to ER regarding lab results showing Hyponatremia." According to staff schedule provided dated 1/2/1, 1 staff was scheduled for day shift and 1 staff scheduled for second shift with a cook scheduled from 10:30 AM to 7:00 PM, no staff was scheduled for midnights. 1/4/19, states "R1 is drinking water out of the faucet in the back boys bathroom. Nurse notified instructed to continue to monitor." 1/4/19, states "R1 gets up for short periods of time. Gets a drink then shortly after goes back to bed. Nurse notified, instructed to continue to monitor." According to staff schedule provided dated 1/4/19, 0 staff was scheduled for day shift and 2 staff scheduled for second shift with a cook scheduled from 6:00 AM to 9:00 AM and 2:00 PM to 7:00 PM. 1/5/19, states "R1 was caught in the back boys bathroom drinking water out of the faucet. E3, RNT, wrote continue to monitor." According to staff schedule provided dated 1/5/19, 1 staff was scheduled for day shift and 2 staff scheduled for second shift with a cook scheduled from 10:30 AM to 7:00 PM.	Z9999		

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Z9999	Continued From page 5 1/6/19, states "R1 goes in the bathroom and drinks from the faucet. Nurse wrote to continue to monitor." According to staff schedule provided dated 1/6/19, 1 staff was scheduled for day shift and 2 staff scheduled for second shift with a cook scheduled from 10:30 AM to 7:00 PM. 1/7/19, states "R1 drinking water out of sink faucet, nurse notified continued to monitor." According to staff schedule provided dated 1/6/1, 2 staff scheduled for second shift with a cook scheduled from 3:30 AM to 9:00 AM. Per IDPH policy, facility notified agency on 1/2/19 of Emergency Services for R1, relating to lab results showing Low Sodium level "Hyponatremia". R1's Behavior Management/Resident Rights Committee dated 1/9/19, states "Cogentin 1mg 1 tab 2x's a day, Escitalopram 10 Mg 1 tab daily. Behaviors include staring with a blank look on face, crying/laughing for no reason, inattentiveness, pacing, refusing to participate, withdrawn/ self isolation, taking cups from trash or others, and yells, shoves others." There is no evidence of any changes to R1's Behavior Management/Residents Rights Committee relating to fluid restriction, medication changes and behaviors. There is no evidence of level of supervision documented or any changes in supervision level to monitor R1 more closely relating to fluid restrictions.	Z9999		

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There is no evidence of a change in behavior modifying programs to direct how DSP's should redirect or discourage R1 from drinking from the faucet related to his fluid restriction.

In an interview with E2, Qualified Intellectual Disability Professional (QIDP), on 2/14/19, at 12:30 PM, E2 was asked did you change R1's supervision level? E2 stated "No". E2 was asked have you come up with a program to help R1 and staff with the fluid restriction so the response is consistent when he is drinking from the faucet? E2 stated "No". E2 was asked how is 1 staff member able to monitor R1's drinking from the faucet when he is on a fluid restriction while they are passing medications or cooking meals? E2 stated "I don't know, it's hard. We are short staffed." E2 was asked so how are you providing and ensuring the entire house is safe and properly supervised? E2 had no answer.

In an interview with E4, DSP, on 2/13/19, at 1:38 PM, E4 stated "When I come in at 3:30 AM, I am the only one here usually Monday through Friday. I do meds, breakfast, hygiene, and basically everything I can, but it's hard. I can't watch R1 and keep him away from the faucet. I am not able to monitor them all."

In an interview with E5, DSP, on 2/13/19, at 1:46 PM, E5 stated "I work here a lot. Sometimes I have to have the kitchen duties with meds and supervision is impossible."

In an interview with E6, DSP, on 2/13/19, at 1:58 PM, E6 stated "We have been short for at least 3 months. I have done some 12 hours and I have to do everything from passing meds to cooking. I am suppose to be part time but they only have 5

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of us so we are here doing our best." E6 was asked how many individuals need supervision and assistance during meals? E6 stated "we have 5 all together (R3, R5, R7, R8 and R10). It is hard to supervise them."

In an interview with E7, DSP, on 2/3/19, at 3:35 PM, E7 stated "Yes, I have been here alone, my normal is 2nd's 2:30 - 10:30 PM but I have been working a lot of 3:30 PM to 3:30 AM."

In an interview with E8, DSP, on 2/14/19 at 1:55 PM, E8 stated "I am typically a 2nd shift but because we are short I will try and pick up where I can. A lot of times there is one staff in the kitchen and the other staff is doing meds."

(B)

Section 350.620a)
Section 350.3240b)d)f)

Section 350.620 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.3240 Abuse and Neglect

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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. (Section 3-610 of the Act)
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. (Section 3-610 of the Act)
f)Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements are not met as evidenced by:

Based on record review and interview the facility failed to notify Illinois Department of Public Health facility and failed to do a thorough investigation of an allegation of physical abuse for 2 individuals (R4 and R5) for incidents of peer to peer. The facility, also, failed to do a thorough investigation of a resident (R4), who had a bruise to her left upper inner thigh area.

Findings include:

1. According to R5's Physician Order Sheet (POS), dated 2/2019, states "R5 functions at a Severe Intellectual Disability Level with current diagnosis of Autism, and Behavior Problems.

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Incident Report dated 2/8/19 from day training site states "R5 had finished his lunch, got up to throw away his trash. Once he had thrown it away he turned to where another individual from another home was sitting with his back to him. R5 then got an angry look on his face and put both hands around the individuals neck he then shook him 2 times, and staff yelled stop. R5 stopped and walked over by the lockers until the supervisor came into the room at which point he went to her office."

Incident report 1/23/19 from day training site states "R5 was sitting at small table behind myself. He was quiet with head down. Another individual was next to me writing on paper. R5 got up suddenly and started roughly rubbing the individuals back, then he started assaulting, and shaking roughly. I stood up and yelled stop. He was then removed from the room."

2. According to R4's Physician's Order Sheet (POS) dated 2/2019, states "R4 functions at a Severe Intellectual Disability Level with current diagnosis of Seizure Disorder, and Major Depression.

Incident report dated 2/1/19 from day training site states "R4 slapped another individual when he told her she had food on and around her mouth. R4 slapped his left hand and yelled at him. The two were separated."

There is no evidence of these incidents of peer to peer being reported to Illinois Department of Public Health.

Incident report for R4, dated 1/16/19 , states "R4 showed staff a bruise. Bruise is located at the inner left upper thigh, Silver dollar

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bruise,Individual confirmed she tickled too hard. E3, RNT, notified at 7:15 PM, instructed to monitor.

In an interview with E1, Acting Administrator, on 2/14/19, at 12:50 PM, E1 stated " I don't remember this" E1 was asked who tickled her, did she tickle herself, is there any medical reason she would do this, and how are we sure someone else didn't tickle her too hard? E1 stated " good questions, I am not sure."

In an interveiw with E1, Acting Administrator, on 2/14/19, at 1:40 PM, E1 stated "I was not notified of these incidents so I did not report or investigate them. We need to come up with a better system of reviewing incidents."

Review of facility policy 5.24, Investigative Committee, Revised: 8/17, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Under Procedure:, E. The committee members shall meet to review the allegations, conduct interviews and examine the information available that is pertinent to the incident."

(B)