

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/25/2021
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NAME OF PROVIDER OR SUPPLIER LINTON TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 330 LINTON AVENUE WOOD RIVER, IL 62095
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{Z 000}	<p>COMMENTS</p> <p>FOLLOW UP TO LICENSURE SURVEY OF 4/28/21</p> <p>Repeating: 350.610a), 350.1060a), 350.1610e)</p>	{Z 000}		
{Z9999}	<p>FINDINGS</p> <p>REPEAT Statement of Licensure Violation:</p> <p>350.610a) 350.1060a) 350.1610e)</p> <p>Section 350.610 Management Policies</p> <p>a)The facility's governing body shall exercise general direction of the facility, and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served.</p> <p>Section 350.1060 Training and Habilitation Services</p> <p>a)The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.</p> <p>Section 350.1610 Resident Record Requirements</p> <p>e) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.</p>	{Z9999}	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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{Z9999}	<p>Continued From page 1</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review, and interview the facility failed to ensure:</p> <p>1) COVID policy regarding mask protocol was followed, potentially affecting all individuals who were at the facility (R1-R3),</p> <p>2) that staff were trained to perform their duties efficiently & competently when staff failed to use accurate procedures to prevent abuse and neglect towards 2 of 2 individuals outside the sampe (R3, R4) who were restrained with a gait belt by a staff member,</p> <p>3) accurate documentation of the individuals program objectives for 2 of 2 in the sample. (R1 and R2).</p> <p>Findings include:</p> <p>Facility Roster dated 8/23/21 identifies R1-R4 as individuals who function within the Profound Range for Individuals with Intellectual Disabilities.</p> <p>1) Review of the Facility COVID-19 Policy dated 8/21: "The Infection Control Program (ICP) at this home recognizes Novel Coronavirus (COVID-19) as a highly contagious virus and a focus to reduce the risk of unnecessary exposure among individuals, staff, and visitors. The primary goal is to prevent COVID-19 from being introduce within the home. Prevention efforts include: f. Complying with Standard Precautions which include: Wearing of a surgical mask at all times and replace when compromised."</p> <p>On 8/23/21, Surveyor entered the facility at</p>	{Z9999}		

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{Z9999}	<p>Continued From page 2</p> <p>5:55am, E3 (Direct Support Person) greeted the surveyor without wearing a mask. E3 began passing morning medication at 6:25am and finished the medication pass at 7:23am. A mask was not placed on E3 until prompted by E1 (Administrator) at 8:00am.</p> <p>Interview with E1 on 8/23/21, E1 stated, " She was well aware E3 did not have a mask on when entered the facility at 8:00am. E3 told E1, that she had forgot."</p> <p>2) Facility Investigation undated documents, "E9 (Direct Support Person/DSP) was reported by another staff member (E6/DSP) to use a gait belt to restrain a resident in a chair. Timeline of Events: E2 (Qualified Intellectual Disabilities Professional/QIDP) observed R9 undoing a gait belt that was wrapped around a chair on 8/2/21. A staff meeting was held on 8/5/21 in which we reviewed proper use of gait belts and residents that should be using them. At 11 pm on 8/7/21 the facility representative (E1/Administrator) was contacted by the house manager to inform her of the following: the newest member of the staff had witnessed E9 using a gait belt to restrain two individuals of the home. the facility representative (E1) came in for E9's next shift to discuss this with her. During the interview E9 admitted to using the gait belt to restrain R3 once because he was a handful. E9 was immediately terminated."</p> <p>E9's Witness Statements dated 8/8/21 documents, "Have you ever used a gait belt to restrain a resident in a chair? Yes. Once. R3 is a handful."</p> <p>E6's Witness Statement dated 8/9/21 documents, "On 8/7/21 E9 put a resident in a gait belt wrapped around a dining room chair at 5:30 pm</p>	{Z9999}		

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{Z9999}	<p>Continued From page 3</p> <p>until 9:30 pm. At 9:30 pm E9 then moved this resident into the bathroom and left the resident in there until 10:30 pm. At 10:30 pm E9 then took this resident to bed. E9 also took a gait belt to another resident but only did that to that client for dinner then took this resident to the bathroom after dinner and left this client in the bathroom until 7:30 pm before taking the client to bed."</p> <p>Interview on 8/23/21 at 3:06 pm: E1 was asked when E9 started her shift that day? E1 stated, "She started at 3:00 pm." E1 was asked when she was called about the incident? E1 stated, "They called me at 11:00 pm. I came in the next day before her shift and terminated her."</p> <p>Interview on 8/23/21 at 3:27 pm: E6 was asked what individual was put in a gait belt from 5:30 pm-9:30 pm? E6 stated, "E9 sat R3 at the dining room table and put a gait belt around him and it stayed around him from 5:30 pm-9:30 pm." E6 was asked who the other individual was that E9 put a gait belt around? E6 stated, "E9 put R4 at the dining room table and put a gait belt around her while she was sitting there from 5:30 pm-6:00 pm. Then at 6:00 pm she walked her to the bathroom and left her there until 7:30 pm." E6 was asked who she told about the incident? E6 stated, "She told the house manager when she came in at 11 pm." E6 was asked if she has gotten any training or retraining since the incident happened? E6 stated, "No."</p> <p>Interview on 8/24/21 at 10:06 am: E1 was asked if staff have been re-inserviced on Abuse/Neglect? E1 stated, "No." E1 was asked if any inservicing has been done since 8/7/21 with staff? E1 stated, "No, inservice is going to be done next month."</p>	{Z9999}		

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{Z9999}	<p>Continued From page 4</p> <p>3a) Review of R1's program objectives and documentation: -R1 will tell the staff the time she takes her blood sugar medication. Program is to be implemented every morning at the 7am med pass Program not documented the last 14 days in August -R1 will count out 7 wash clothes. Program to be documented daily. As of 8/23, program not documented for 15 days in August. -R1 will exercise 3 day a week. As of 8/23/21, Program not documented on 6 different days. -R1 will turn on the hot water handle and feel the hot water with verbal prompts. Program is to be implemented daily. As of 8/23, program not documented 14 days in August.</p> <p>b) Review of R2's program objectives and documentation for the month of August: -R2 will swallow his medication with verbal prompts. Program will be implemented daily. Program not documented 18 times this month. -R2 will select 3 poker chips. Program is to be implemented daily. As of 8/23, Program not documented 13 times. -R2 will walk with hand over hand. Program is to be implemented 3 times a day. Program not documented 17 times this month. The documentation sheets only have an area to be documented 1 time a day.</p> <p>Interview with E7 (Trainer) on 8/24/21 at 11:00am, E7 stated when programs are to be implemented more than 1 time a day, the staff initials should be stacked to indicated it is implemented multiple times. E7 also stated, the facility is aware of inconsistence's with documentation.</p> <p>(B)</p>	{Z9999}		

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