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| Z 000 | COMMENTS<br><br>ANNUAL<br><br>Statement of licensure Violations | Z 000 | | |
| Z9999 | FINDINGS<br><br>1 of 2 Licensure<br>350.620a)<br>350.1060e)<br>350.1210<br>350.1230b)<br>350.3240a)<br><br>Section 350.620 Resident Care Policies<br>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.<br>Section 350.1060 Training and Habilitation Services<br>e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.<br>Section 350.1210 Health Services<br>The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following<br>Section 350.1230 Nursing Services<br>b) Residents shall be provided with nursing services, in accordance with their needs, which | Z9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| Z9999 | Continued From page 1<br>shall include, but are not limited to, the following:<br>The DON shall participate in:<br>Section 350.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to ensure that each individual receives a continuous active treatment program, for 1 of 1 newly admitted individuals in the sample (R4), which assists the individual to function with as much independence as possible; and the facility failed to prevent skill deterioration as evidenced by their failure to ensure that R4's vocational developmental needs have been assessed and addressed in his Individual Support Plan (ISP) pending this assessment, as mandated by law, under the Workforce Innovation and Opportunity Act (WIOA) of 2014 for workers age 24 years of age or younger. R4 is 21 years of age and has not attended any type of vocational program since his 05/01/2017 admission to the facility.<br><br>The facility failed to ensure that:<br><br>1) Necessary vocational referrals are completed prior to admission and the Department of Rehabilitative Services (DORS) has been notified of the referral and the individuals' admission to the facility to assist in expediting the vocational development assessment requirements for R4 to attend a vocational and/or pre-vocational program;<br><br>2) R4's ISP addressed the delay in securing a | Z9999 | | |

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vocational assessment in identifying his vocational needs, work interests, work skills, work attitudes, work related behaviors and present and future employment options have been assessed; and

3) An active treatment program schedule is developed and implemented for the day time hours that R4 is at home awaiting his vocational assessment and placement in a vocational program or pre-vocational program.

Findings include:

The U.S. Department of Labor Fact Sheet #39H entitled, "The Workforce Innovation and Opportunity Act" (WIOA) states,
"WIOA is a comprehensive federal law enacted on July 22, 2014 which is intended to streamline, consolidate and improve workforce development and training services for various groups, including youth and workers with disabilities. Among other things, WIOA requires that workers with disabilities who are age 24 or younger (youth) complete various requirements designed to improve their access to competitive integrated employment including transition services, vocational rehabilitation, and career counseling services before they are employed at a subminimum wage". This fact sheet goes on to state that an employer who is an FSLA (Fair Labor Standards Act) section 14(c) certificate holder may not pay a subminimum wage to a youth hired after July 22, 2016 unless the employee has completed:

1) Transition services under the Individuals with Disabilities Act (IDEA) and/or preemployment transitions services under WIOA;

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2) Vocational rehabilitation (VR) as follows;
a) the youth applied for VR services and was found ineligible OR
b) the youth applied for VR services and was found eligible AND
i) had an individualized plan for employment (IPE) AND
ii) worked toward an IPE employment outcome for a reasonable period without success AND
iii) the VR case was closed, and

3) Career counseling, including information and referrals to Federal and State programs and other resources in the employer's geographic area.

R4's Psychological Evaluation dated 04/05/2017 identifies that he is a 21 year old male functioning at a severe level of intellectual disability with diagnoses which include,Scoliosis and Microcephaly. Recommendations within this evaluation report states, R4 "does not have skills and abilities necessary to reside independently due to significant limitation in is intellectual and adaptive functioning. As an adult he benefits from a residential setting that can provide him with ongoing supervision, as well as opportunities to improve his adaptive and work-related skills and interact with peers. A move to a community integrated living arrangement, intermediate care facility or similar group home facility would be appropriate for" R4. "Once he completes his schooling," R4 "will also profit from referral for a vocational evaluation".

The Individual Service Plan (ISP) report dated 05/16/2017 identifies that R4 was admitted to the facility on 05/01/2017. Further review of this report does not identify that the comprehensive

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functional assessment contained within this report includes a vocational development assessment. No documentation is noted identifying that R4's work interests, work skills, work attitudes, work related behaviors and present and future employment options have been assessed.

In review of his record, no preadmission assessment screening reviewed by the Interdisciplinary Team (IDT) is noted on record. There is no documentation within the ISP nor in R4's record as to why he doesn't have a vocational development assessment or why he is not attending a vocational and/or a pre-vocational program.

R4 was observed at the facility on 08/01/2017 from 10:30 A.M. - 11:45 A.M. to spend the majority of the time in his room. During the Entrance Communication on this date, E1 (QIDP - Qualified Intellectual Disability Professional) stated, that R4, "doesn't attend DT (day training) because the facility is waiting on assessments". On 08/02/2017, R4 spent the majority of his day in his room as observed at various times from 9:30 A.M. - 2:30 P.M. At 12:30 P.M. during this observation block, E2 (Social Services Coordinator) stated that R4 prefers to stay in his room during the day. At 1:00 P.M. R4 had not come out of his bedroom for lunch. After eating his lunch, R4 returned to his bedroom and remained there. No active treatment programming was observed to occur during these observations.

E1 (QIDP - Qualified Intellectual Disability Professional) was interviewed on 08/02/2017 at 2:14 P.M. regarding the lack of a preadmission assessment and an IDT review for R4. E1 stated that the PAS Agent had prescreened R4 prior to

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his admission and that she had contacted DORS (Illinois Department of Rehabilitative Services) regarding a vocational assessment. When asked if the facility had reproducible evidence of the prescreening IDT meeting and discussion regarding R4's admission to the facility, E1 stated, "No". E1 went on to say that R4 is not attending any type of vocational program at this time because of the new law (WIOA). E1 stated, "If an individual is under the age of 24 or 25 years of age, the DORS Coordinator must complete a vocational assessment before they can attend a vocational program". E1 stated that R4 has yet to be assessed by DORS.

Z1 (DORS Coordinator) was interviewed on 08/04/2017 at 2:13 P.M. via telephone and confirmed that R4 has not had a vocational development assessment completed by a DORS coordinator as required by WIOA. Z1 was asked if she had been contacted to complete a vocational development assessment prior to R4's 05/01/2017 admission to the facility, she stated, "No". Z1 stated that R4 most likely will not be assessed until September, 2017.

R4's ISP documents that he is currently working on the following objectives:

* R4 will brush his teeth when given 5 or less verbal prompts at 80% accuracy for three consecutive 30 day documentation periods;

* When asked to choose a specific coin, R4 will choose the correct coin from a field of 5 coins with 5 or less verbal prompts at 80% accuracy over three consecutive 30 day documentation periods;

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* When given instruction or appropriate communication methods, R4 will use his words to tell staff when he is angry, when he wants something... with 5 or less verbal reminders to use his words at 80% accuracy for three consecutive 30 day documentation periods;

* R4 will participate in family style dining by cleaning his area after meals with 5 or less verbal prompts at 80% accuracy over three consecutive 30 day documentation periods;

* When given a scenario, R4 will point to the specified body part of the model and rate how much pain the injury would cause using the pain scale with 5 or less verbal prompts at 80% accuracy over three consecutive 30 day documentation periods;

* R4 will display less 200 or less instances of noncompliance per 30 day period.

R4 has additional targeted behaviors of verbal aggression, physical aggression, self injurious behaviors and making false accusations, however no specific objectives are noted for these behaviors. Further review of R4's ISP does not identify a vocational developmental objective. R4's work interests, work skills, work attitudes, work related behaviors and present and future employment options are not addressed within his ISP. There is no service needs identified for a vocational developmental assessment and/or vocational training.

In continuing interview with E1 (QIDP) on 08/02/2017 at 2:14 P.M. E1 was asked if R4's need for a vocational development assessment was addressed anywhere within R4's ISP, she stated, "No". E1 was informed that the Health

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| Z9999 | Continued From page 7<br><br>Facility Nurse Surveyor had observed R4 watching television in his room and/or in the back room area during the mornings of 08/01/2017 and 08/02/2017 and that no active treatment programming was observed. E1 stated that R4 was receiving day programming at home including, shopping, housekeeping and money programming. When asked if there was a reproducible schedule identifying what programs and/or objectives are scheduled and conducted during the day while not attending a vocational program, E1 stated, "No".<br><br>On 08/04/ 2017, E4 (DSP - Direct Support Professional) was overheard attempting to get R4 to come out of his room for lunch at 11:30 A.M.. E4 then informed E2 (Social Services Designee) that she had attempted to get R4 to come out of his room without success. E4 was then told to keep trying every 15 minutes. E4 left the facility at 11:55 A.M. R4 was not observed outside his room from 11:00 A.M. until the surveyor left the facility at 1:00 P.M.<br><br>In reviewing R4's active treatment needs with E1 (QIDP) on 08/08/2017 at 12:55 P.M., E1 confirmed that no reproducible programming has been established and implemented for R4 during the day time hours when other individuals of the facility are attending a vocational and/or prevocational program since his admission to the facility.<br><br>(AW)<br><br>2 of 2 licensure<br>350.620a)<br>350.1230d)1)2)<br>350.3240a) | Z9999 | | |

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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 350.1230 Nursing Services
d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
2) Basic skills required to meet the health needs and problems of the residents.
Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to provide individuals with nursing services in accordance with their needs as evidenced for 1 of 1 individuals outside of the sample (R5) who fell on 07/04/2017 and sustained a head injury resulting in a subdural hematoma. R5 then sustained a subsequent fall on 07/28/2017 requiring surgery to evacuate the subdural hematoma. The facility failed to ensure that:

1) Policy and procedures are in place on how to provide care to an individual with a head injury after a fall;

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2) Nursing staff trained direct care staff on signs/symptoms to monitor after R5 returned from hospital on 07/06/2017. After returning, R5 fell again on 07/28/2017 and nursing staff, present at the facility on this date, failed to:
a) Document an assessment of R5 and implement neuro-checks as appropriate;
b) Notify the administrator (who is present at the facility the majority of the days) of the fall;
c) Ensure that a nursing plan for head injury was implemented and that Direct Support Professionals (DSPs) trained on this plan;
d) Ensure the DSP's were instructed in monitoring for signs and symptoms of head injury, documenting changes in R5's condition, and to notify nursing of any changes in R5's condition; and

3) R5's physician was notified of worsening changes in his condition after falling on 07/28/2017.

After these incidents, the facility does not have policy and procedures in place for head injuries.

Findings Include:

1) Review of the facility resident roster identifies R5 functions at a Severe Level of Intellectual Disability.

Review of the facility incident report form dated 7/4/17 documents R5 is a 69 year old male who was observed on the floor with lacerations to his forehead. Under Summary of event and actions taken the facility incident report documents, "taken to (name of local hospital) and transferred to (name of regional hospital) due to brain bleed." The facility Post Fall Root Cause worksheet (not

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dated) documents R5 has a history of falls with the last fall being on 6/25/17, and R5 is identified as being a fall risk on the care plan.

Review of the facility's neuro head/trauma assessment documents neurological checks were completed by DSPs intermittently for the first week following R5's first fall on: 7/4/17 at 1:30 AM, 1:45 AM, 2:00 AM, and 2:15 AM; 7/6/17-second shift; 7/7/17-first, second, and third shifts; 7/8/17- first, second, and third shifts; and at 7:00 AM on 7/9/17.
Except for the symptom of severe headache, none of the identified symptoms from the local hospital discharge instructions were checked.

Review of R5's discharge orders from the local hospital document R5 was discharged on 7/6/17 with a diagnosis of a head injury. Discharge instructions listed are; Avoid any contact sports or other activities that could easily cause you to bump your head .... Report to an Emergency Department if anything listed below occurs: unusual irritability, severe headache, confusion or unusual drowsiness, persistent vomiting, stiff neck, or fever, unequal pupils, clumsy walking or inability to use arms/legs, convulsions or unconsciousness. Discharge instructions continue to document a follow up CT (computed tomography) of the brain without contrast should be done within one month of discharge.

Review of R5's record on 8/02/17 did not document a repeat CT scan.

During interview on 8/02/17 at 9:45 AM E1 (Administrator) stated R5's repeat CT scan was scheduled for the end of August.

During interview on 8/2/17 at 9:45 AM

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E1(Administrator) and E2 (Social Services) stated the nurse did not train staff on signs/symptoms to monitor for after R5 returned from the hospital with the diagnosis of subdural hematoma.

During interview on 8/7/17 at 9:15 AM when asked what she does after she reviews information from a hospital discharge, E13 (Registered Nurse-RN) stated, "After I review it, I share it with the staff who are at the facility and they pass it on to the next shift." When asked how she ensures they share it, E13 (RN) stated, "I just ask when I go back to the facility." When asked if she had documentation of training completed with staff related to the signs/symptoms the staff should monitor R5 for E13 (RN) stated, "No, I didn't document it".

R5's Annual Physical Report dated 7/21/17 documents, R5 "has had an increased (sic) in falls, recently. The latest with a hospital admit. Immediate plan of care has been to set appointments with physical therapy for an evaluation and strength training. This is set up to begin 7/24/17". Presently, R5 "has been gave (sic) a regular walker upon his request. He is aware of his falls and the attempt to prevent them. He is trying his best to attempt to stop falls as well..."

Review of R5's record did not document a physical therapy evaluation.

During interview on 8/02/17 at 9:45 AM E1 (Administrator) stated she did not think therapy had been to evaluate R5.

Review of the facility incident reports document on 7/28/17 at 2:00 AM R5 had a fall in the bathroom. The facility Incident Investigation Form

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documents, "While staff was assisting client to bathroom staff requested client to stand flat footed and not on his toes. Staff also noted client was not stepping into his walker. When staff asked him to step into his walker the client instead tried to stand straighter without stepping into his walker, became unbalanced and fell backward into wall and slid down wall with staff assisting and client scraped his right elbow while trying to slide down wall. Staff was in front of client and did what she could to help decrease the momentum of clients fall".

Review of R5's nurses notes documents;
" 7/13/17 "Client alert and cooperative this morning area to top of forehead healing nicely scab healed he voices no complaints continues to be home from workshop".
" 7/28/17 "Saw (name of physician) for annual physical order received for overnight pulse ox".
" 7/28/17 "On 7/26 saw (name of physician) for annual dental exam tissue pink and healthy".

There is no documentation in R5's record of the nurse assessing R5 after the incident on 7/28/17.

During interview on 8/7/17 at 9:15 AM E13 (Registered Nurse Consultant) stated she had assessed R5 after the fall on 7/28/17. When asked where it was documented E13 stated, "I didn't write it down".

Review of the hospital history and physical note dated 8/1/17 documents, "Patient (R5) is a 67 YO (year old) M (male) with profound mental retardation. His sister who is POA (power of attorney) also stated that he fell asleep while talking to her on the phone a couple of days ago. She received a call from staff of health care group yesterday that he is not being himself

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|---|---|---|---|
| | IL6002158 | A. BUILDING: _____ B. WING _____ | 08/15/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COUNTRYVIEW TERRACE | 52 OLD ROUTE 45, PO BOX 116 LOUISVILLE, IL 62858 |

| (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) COMPLETE DATE |
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having some gait problems and shaking. Also patient became incontinent. Patient was taken to (name of local hospital) where CT scan showed an enlarged left subdural mass with mass effect....Patient underwent bur hole evacuation of L (left) side subdural hematoma today".

During interview on 8/02/17 at 9:45 AM E1 (Administrator/QIDP) stated the facility staff/Registered Nurse Consultant had not reported this incident to her and she was just being made aware of the fall R5 had on 7/28/17. E1 continued to state she had talked to the hospital and they had told her it was unlikely the subdural hematoma would have worsened unless there had been a subsequent injury. E1 stated she had told them there had not been one since she was not aware of R5's fall on 7/28/17.

During interview on 8/2/17 at 9:45 AM E2 (social services) stated she was not made aware of the fall R5 had on 7/28/17.

When asked on 8/2/17 at 9:45 AM if R5 was monitored between the fall on 7/28/17 and the hospitalization on 7/31/17 for possible symptoms related to the subdural hematoma E1(Administrator) and E2 (social services) both stated, "No."

Review of social service notes document;
" 7/28/17 He put head against door facing in kitchen area, with head leaning against the door. He rubbed wall while staff members attempted to talk to him, he would not acknowledge or respond to them. I observed the behavior and spoke his name loudly and sharply to get his attention. He came awake and didn't acknowledge the proper day.
" 7/29/17 I was called to relay the behavior of

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| Z9999 | Continued From page 14<br><br>R5 again not acting right by (E3). She reported he was very shaky, unsteady gait. She felt he needed 2 assist to bathroom, and other assist to perform the normal ADLs (activities of daily living) at that time.<br>" 7/30/17 Administrator came in and worked. She reported that R5 was having behaviors that broke his walker. While being redirected he set on top of his walker. There by (sic) breaking a leg off.<br>" 7/31/17 E3 again called at 5 am. Reported that R5 while laying in bed straightened to board stiff position. Told staff he could not move his legs in the proper position to get up. They assisted him back to bed in the proper position and waited on my arrival to determine if he needed ER with ambulance.<br>" 7/31/17 @ 5:45 AM I observed R5 B/P 170/84, pulse 98. He was able to move about freely, we determined with R5's agreement that he needed assist with the gait belt to walk to prevent a fall. He reported he was weak. It was noticed that he was very shaky at that time and several times throughout the day.<br>" 7/31/17 @ 10:00 AM After speaking with the nurse, Dr. (doctor) determined he needed to be seen in ER....<br>" 7/31/17 @ 11:30 AM R5 was in (name of local ER). He was later transported to (name of regional hospital).<br>" 7/31/17 spoke with (name of staff) from (name of physician) office...I reported R5 was appearing to decline in functioning. I gave her our combined observations, and time line.<br><br>Review of administrative notes document;<br>" 7/31/17 R5 has been displaying unusual behavior for close to a week. He has been leaning his head against walls and getting a blank expression on his face. Last night and this | Z9999 | | |

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| Z9999 | Continued From page 15 | Z9999 | | |

morning he started to shake. It was mainly his legs and looked like he was shivering, but he wasn't cold. This morning at around 5:30 AM. He yelled help and when staff went to his room, he was laying across the bed and he was stiff along with the shaking. He was still able to talk and in a couple of minutes it stopped. We called the neurologist and (physician) but the neurologist hadn't got back to us so (name of physician) advised us to take him to the emergency room. E2 took him and they did CT scan. It showed the hematoma was growing...
" 8/1/17 (Name of hospital) did not call yesterday so I called to talk to his nurse; bur hole placed to relieve pressure from subdural hematoma, hematoma is in the same place but has grown-usually caused by another fall.

During interview on 8/2/17 at 9:45 AM E2 (social services) stated the nurse had not been notified of R5's continued symptoms after the fall on 7/28/17. E2 (social services) stated E13 (RN) had not been notified on the morning of 7/31/17 when R5 could not move his legs until they were at the hospital with him approximately six hours after the incident occurred.

During interview on 8/7/17 beginning at 9:15 AM E13 (RN) stated she did not notify the physician of R5's symptoms after the fall on 7/28/17 because it was not abnormal behavior. When asked if she completed a neurological assessment on R5, E13 stated, I am not sure if we did vital signs. I did check his hand grips. When asked where that was documented E13 stated, I did not document it. I monitored him the rest of the morning. E13 stated she was at the facility from 7:00 AM to 11:30 AM on 7/28/17. When asked if she had trained the staff on signs/symptoms to monitor for E13 stated, I did

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| Z9999 | Continued From page 16<br>when he came back from the hospital. When asked where that was documented E13 stated, It's not. When asked if she was made aware of R5's continued symptoms on 7/29, 7/30, and 7/31, E13 stated, No.<br><br>On 8/7/17 requested the facility policy on falls with head injuries. The facility presented a policy "Fall Prevention." Review of the facility policy "Fall Prevention" (not dated) does not document guidelines on how to care for an individual with a head injury sustained during a fall. The facility failed to provide a policy specific to head injuries sustained during a fall.<br><br>During interview on 8/8/17 at 9:04 AM E1 (Administrator/QIDP) stated she was unable to locate a policy related to head injuries sustained during a fall.<br><br>During interview on 8/8/17 at 12:55 PM E1 (Administrator/QIDP) presented this surveyor with a head trauma policy that was sent to her by her corporate office on this date. E1 confirmed the policy was not in place at the facility prior to this date.<br><br>(A) | Z9999 | | |