DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. RAY GRAHAM ASSOCIATION FOR PEOPLE WITH DISABILITIES, D/B/A , IONA GLOS SLC, Respondent.	))))))))))	Docket No. 18-S0546

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQURIED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the ID/DD Community Care Act (210 ILCS 47/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on November 02, 2018, at Iona Glos SLC, 50 South Fairbank Street, Addison, Illinois 60101. On January 02, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Intermediate Care for the Developmentally Disabled Code, 77 Ill. Adm. Code 350 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 350.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures

that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Iona Glos SLC, 50 South Fairbank Street, Addison, Illinois 60101 on Novemebr 20, 2018. The Facility's current license number is 0022996. The term of the conditional license shall be from February 03, 2019 to August 02, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER . THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON FEBRUARY 03, 2019 .

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License, provided Respondent substantially complies with their Plan of Correction.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$12,500.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 350.620a) 350.1210, 350.1235)3) and 350.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plan of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 03rd day of January, 2019.

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PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Plan of Correction Requried; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Kimberly Zoeller
Licensee Info:	Ray Graham Association for People with Disabilities
Address:	901 Warrenville Road, STE 500 Lisle, Illinois 60532

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 03rd day of January, 2019.

Sammye Geer
Administrative Assistant I
Long Term Care, Quality Assurance
Office of Health Care Regulations

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	IL6004782	A. BUILDING: _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IONA GLOS SLC	50 SOUTH FAIRBANK STREET ADDISON, IL 60101

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Z 000	COMMENTS ANNUAL FULL CERTIFICATION SURVEY ANNUAL LICENSURE SURVEY INSPECTION OF CARE COMPLAINT INVESTIGATION Complaint # 1875857 / IL105576 W154	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1210 350.1235)3) 350.3240a)	Z9999		

(1 of 1)

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 350.1210 Health Services

Attachment A
Statement of Licensure Violations

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Z9999	Continued From page 1 The facility shall provide all services necessary to maintain each resident in good physical health. : Section 350.1235 Life-Sustaining Treatments 3) procedures for providing life-sustaining treatments available to residents at the facility; 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) These requirements were not met evidenced by : Based on interview and record review, the facility failed to implement their policy to prevent neglect for 2 of 2 clients outside the sample (R12 and R8). The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client The facility must have evidence that all alleged violations are thoroughly investigated. Also, the facility failed to thouroughly investigate allegations of neglect and an injury of unknown origin affecting 1 of 1 clients in the sample (R5) and 6 clients outside the sample (R7, R8, R9, R12, R13, R14). Also, the facility failed to provide required health care services and monitoring for 1 of 1 clients outside the sample (R7) when, during a dressing change for R7's right ear, 20 maggots were observed coming out of his ear. 1) The facility failed to ensure staff implemented	Z9999		

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Z9999	Continued From page 2 R12's Safe Mealtime Protocol was on 9/23/18 during the breakfast meal. R12 became unresponsive after eating banana bread and was ultimately transported to the hospital, via emergency responders. R12 expired at the hospital on 9/29/18. 2) The facility failed to ensure staff immediately implemented CPR, including calling 911 when R12 was observed to be unresponsive. 3) The facility failed to ensure staff implemented safeguards to prevent injuries. R8 was diagnosed with a fractured ankle and soft tissue injury to right toes. Findings include: The facility's Policy titled, "Prevention of Abuse, Neglect, Mistreatment, and Exploitation Policy" approved by the facility's Board of Directors on 2/3/16 was reviewed. The Policy includes the following: "III. Policy It is the policy of (name of facility) to protect people with disabilities it served from abuse, neglect, mistreatment, and exploitation. The abuse, neglect, mistreatment, or exploitation of a person with a disability by employees of the Association, community members, family members, and other people with disabilities strictly prohibited. The Association assumes the responsibility to prevent abuse, neglect, mistreatment, and exploitation through a variety of aggressive methods..." "Neglect: An employee's, agency's, or facility's failure to provide adequate medical care, personal care of maintenance, and that, as a consequence, causes an individual pain, injury, or emotional distress, results in either an individual's	Z9999		

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Z9999	Continued From page 3	Z9999		

maladaptive behavior or the deterioration of an individual's physical condition, or places an individual's health or safety at substantial risk of possible injury, harm or death.
Examples include, but are not limited to the following:
Failure to follow the IS4R (Individual Specific Support Safety and Supervision Requirements), ISP (Individual Support Plan), and / or Positive Behavior Support plan resulting in the person becoming ill or injured. ..."

1) A facility "IDPH (Illinois Department of Public Health) Reportable Event" involving R12 was reviewed.
The report was reviewed and noted the following event that occurred on 9/23/18 at 7:30am:
Event Summary: On 9/23/18 a Medical STAT was called to Home 1 regarding R12. It was noted by E13 (Coordinator) that R12 had collapsed and fallen to the floor upon entering the bathroom. It was noted that R12 was not responding to verbal commands and 911 was called for further assistance.
E1 (Administrator) documented an interview of E13 that occurred on 9/24/18 with a follow up interview on 9/27/18. E13 stated that around 7:30am (on 9/23/18) he was assisting another client in the dining area by his seat and turned toward R12.
R12 had not eaten his oatmeal, but had eaten his banana bread. R12 turned and began to run toward the bathroom; R12 did not make any sounds, no gagging or choking. E13 stated that R12 did not point to his neck, hold his neck, or hold his stomach or chest. E13 followed R12 to the bathroom. R12 fell to his knees then to the floor, face forward. R12 did not respond to his name so E13 went to the phone and first paged for nursing to Home 1. E13 then hung up and

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paged "medical stat" to Home 1. E13 called the Coordinator desk and asked the Coordinator on duty to call 911.
E13 stated that R12 was unresponsive - not moving on the floor and not responding to being called. E13 yelled for help that "R12 is not responding!" to other staff in the home. E13 did not think R12 was choking or aspirating as there were no noises or indication. E13 stated that he did not want to move R12's head because he didn't want to make anything worse due to the way he fell. The nurse (E10) arrived to the bathroom where she checked R12 and began CPR.

E10 was interviewed on 9/24/18 and 9/28/18.
E10 stated that she heard the medical STAT about 7:30am and ran from Home 5 to Home 1.
E10 stated that upon entering Home 1, E13 directed her to R12.
E10 stated that she noted R12 to be unresponsive with cyanosis, he was not breathing but had a faint pulse. As she began CPR (compressions), she noted that there was something mushy in his mouth. She attempted to clear his airway and was doing chest compressions when she was relieved by temp CNA (Z4). Z4 took over CPR for E10. The local police then arrived and assisted in getting R12 upright to attempt abdominal thrusts. While doing this paramedics arrived and took over.

E15 (nurse) was interviewed on 9/27/18. E15 stated that she was in Home 3 conducting her med pass when she heard the page for med STAT to Home 1. E15 secured her medications, and ran to Home 1. When E15 arrived to Home 1 she found E10 with R12 on the bathroom floor with Z4. E10 directed E15 to get the nursing crash cart from the nursing station. When E15

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Z9999	Continued From page 5	Z9999		

arrived back in Home 1 the police were assisting E10, then the paramedics arrived and asked everyone to step back.

E16 (nurse) was interviewed on 9/27/18. E16 stated that she was in Home 2 administering meds, then was using the bathroom. After the bathroom, E16 went to the Core building and saw E15 with the crash cart heading to Home 1. E16 followed E15 to Home 1 and the paramedics were also arriving. E16 went back to the nursing station to pull R12's paperwork for emergency services.

The facility concluded the following:
The paramedic report obtained on 9/27/18 stated that there was a foreign body in R12's respiratory tract that had to be removed by the paramedics by using magill forceps.
R12's breakfast on the morning of 9/23/18 was within his diet parameter. It is believed that he aspirated that led to the asphyxiation which sent R12 into cardiac arrest. It is concluded based on the interviews that the direct care, nursing, and management staff immediately responded with a call to 911, assessment, intervention and support until emergency services arrived.

The paramedics response and report was reviewed. The paramedics report notes: Notified by Dispatch on 09/23/2018 at 07:39:3. Arrived on Scene at 07:41:02 and arrived at patient at 07:46:05.
Upon arrival found staff doing chest compressions on a 55 year old male patient lying supine on the floor. Staff state he was eating breakfast and banana bread and then they found him lying on floor not breathing and began CPR. Crew took over CPR and confirmed patient was pulseless and apneic. Crew moved patient to

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Autopulse and bagged him and moved him to the stretcher and to the MICU (Medical Intensive Care Unit). Monitor revealed patient was Asystole. Asystole protocols initiated. IO established in patients right tibial tuberosity. Marrow draw confirmed. Epi was given while CPR continued. Crew began intubation and then visualized wads of brown substance occluding patients airway. Crew suctioned and used magill forceps to remove what appeared to be wads of wet banana bread. Second round of Epi given. Intubation then attempted and was successful with a 7.0 ET tube 22 at the teeth. Crew felt tube pass and the lung sounds were confirmed in al quadrants left and right chest rise and fall was present. Tube secured with tube tamer. Autopulse was then switched to continuous CPR, a third round of Epi was given. Crew began transport with extra personnel. Local hospital was notified that a Cardiac Arrest was coming into their ED and to alert the team. Airway support and CPR continued during transport. Rhythm was checked again and patient not was in sinus brady with a pulse of 22. Pulse confirmed ROSC achieved. Bradycardia protocols implemented and Atropine given. Crew arrive and care was transferred to (hospital personnel).

R12's hospital Emergency Room Record, dated 9/23/18 was reviewed. History of Present Illness notes:
"55 yo (year old) male with pmh (primary medical history) of developmental delay presents today for cardiac arrest. patient was eating banana bread and had a witnessed aspiration event. patient had bystander CPR. EMS was called, patient was asystole for 15 minutes. he received epi X3. patient was intubated, large amounts of food were in the airway. patient was eventually brad

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Z9999	Continued From page 7 and given atropine in the field." R12's nursing progress notes were reviewed. The facility was notified that R12 expired on 9/29/18 at 1:25pm. R12's IS4R (Individual Specific, Support, Safety and Supervision Requirements), last revised on 9/21/18, was reviewed. R12's IDT (Inter Disciplinary Team) noted the following: - A mealtime protocol for eating very rapidly. - "He sometimes "shovels" food so staff should offer verbal prompting to help (R12) eat in a safe, slow way. R12 diet is a "Textured Modified Diet with high fiber, double portions with all meals." E4 (DON) was interviewed on 10/12/18 at 11:15am. E4 explained that this diet consists of soft / ground meat, soft moist bread / no crust and soft vegetable. R12's Safe Mealtime Protocol, last reviewed on 6/19/18, includes the following: 1. Prior to each meal - Team Members will remind R12 to eat safely 2. Team Members will review with R12 that eating safely means: eating slowly 3. Team Members will remind R12 that he needs to, "Chew all of his food up; take one bite at a time and to take a breath between bites." 4. If R12 is able to follow Team Members direction and eats safely, Team Members will verbally praise him and will encourage him to continue eating safely throughout the meal. 5. If R12 does not eat safely (stuffs mouth, eats fast, does not chew completely, or slouches) Team Members will ask him to stop and will remind him of safe eating habits (see #2) 6. Team Members will continue to monitor R12 to ensure that he is safely eating his meals.	Z9999		

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Z9999	Continued From page 8	Z9999		

Team Members should verbally prompt R12 as needed.

E2 (Assistant Director) was interviewed on 10/11/18 at 11:27am regarding the facility's investigation of the Incident of 9/23/18 involving R12.
E2 stated that she completed the investigation and wrote the summary with E1 (Administrator).
E2 verified that a medical STAT was called to Home 1 on 9/23/18 at approximately 7:30am due to R12 being unresponsive.
E2 stated that E13 was working as a direct care staff and was assisting another client. E13 turned around and saw R12 get up and run from the dining room. E2 stated that nursing staff performed CPR until paramedics arrived. E2 stated that R12 expired while at the hospital on 9/29/18.
E2 stated that R12 choked on banana bread that he consumed at breakfast. E2 was asked if R12's mealtime protocol was implemented, since R12 has a history of eating too fast and "shoveling" food in his mouth.
E2 stated this is not addressed in the facility's investigation. E2 stated that staff were not directly monitoring R12 at breakfast.
E2 was asked if R12 received the correct diet on the morning of 9/23/18. E2 stated that she knows that R12 received oatmeal and banana bread.
E2 stated that she did not know the size of the banana bread that R12 consumed.

E13 (Coordinator / DSP) was interviewed on 10/16/18 at 2:30pm. E13 stated that he had been working overtime on 9/29/18 (had worked 3rd shift - 9/28/18) in Home 1.
E13 stated around 7:30am he was assisting another client with his breakfast. E13 stated around 7:30am he observed R12 stand up and

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Z9999	Continued From page 9	Z9999		

run towards the living room area. E13 stated that he followed R12, for safety, due to his maladaptive behavior of drinking water and playing with feces in the bathroom. E13 stated that R12's family was scheduled to visit later in the morning and R12 had already showered. E13 stated he did not want R12 messing around in the bathroom.

E13 stated that he followed R12 into his bathroom and R12 collapsed to his knees and then to the floor. E13 stated that R12 fell forward, but did not hit his head. E13 stated that R12 was on his stomach after he fell.

E13 stated that he called R12's name but he was unresponsive.

E13 stated first he called for the nurse to come to Home 1, then he paged a medical STAT to Home 1.

E13 stated he did not check R12 to see if he was breathing, he just knew something was wrong because he collapsed.

E13 stated he called the Coordinator and told them to call 911.

E13 stated he did not initiate CPR. E13 stated he is certified in CPR.

E13 stated that he did not call 911. E13 stated that he called the Coordinator and asked them to call 911.

E13 was shown a copy of R12's Mealtime Protocol. E13 stated that he did not implement R12's Mealtime Protocol.

E13 stated he was not aware that R12 shovels food into his mouth.

E13 stated the piece of banana bread R12 ate was approximately 3 inches by 4 inches. E13 stated that he did not observe R12 put the banana bread in his mouth because he was not watching.

E13 stated that he has not been retrained, by Administration, since this Incident occurred.

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E1 (Administrator) and E4 (DON) were interviewed on 10/16/18 at 12:55pm. E1 was asked if E13 should have initiated CPR and called 911 immediately.
E1 stated that E13 should have initiated CPR and called 911. E1 stated the facility follows the American Heart Association guidelines for CPR.

2) Record review of facility document titled "Evaluation of a Reportable Occurrence Form" dated "July 15, 2018 at 8:25pm and July 16, 2018 at 01:30am" for R8 states that R8 sustained an unobserved injury requiring 2 separate emergency room visits. Report further states:
"Left foot: 1) Marked hallux vagus at the 1st MTP joint. 2) Healing fractures of the 2nd and 3rd Metatarsal heads."
" Right foot: 1) Marked hallux August at the 1st MTP joint. Soft tissue swelling at 1st MTP joint suggests a bunion. 2) Soft tissue swelling inferior to medical and lateral malleolus. Small right ankle joint effusion. 3) Soft swelling along the metarsal bones".

Review of facility "IDPH Investigative Report" for July15 and July 16, 2018 for R8 states:
1) R8 was referred to (Name of hospital) for evaluation due to inability to bear weight on right foot, however, xrays were taken initially of the left foot on 7/15/18 at 8:25pm. R8 returned to the facility at midnight on 7/15/18 and upon nursing assessment, it was noted that the right foot for R8 was not xrayed. R8 was returned to (Name of hospital) on 7/16/18 at 01:30am for right foot xray and returned to the facility on 7/16/18 at 4:15am with support shoes on both feet.

Final xray report for R8 is as follows:
A) Left foot: A lateral and 2 oblique views. The 1st

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Z9999	Continued From page 11 MCP joint is visualized and is remarkable for marked hallux vagus. No definite fracture the 1st metatarsal bone or proximal phalanx is noted. There does appear to be periosteal reaction along a healing fracture of the head of the 2nd metatarsal bone and possibly also of the head of the 3rd metatarsal bone. B) Right foot: Marked hallux August at the 1st MTP joint. Degenerative subchondral cyst formation and chondromalacia noted as described. Soft tissue swelling at 1st MTP joint suggests a bunion. Soft tissue swelling inferior to medical and lateral malleolus. Small right ankle joint effusion. 3) Soft tissue swelling along the metarsal bones. On 10/11/18 at 12:20pm, interviews were conducted with E1; Administrator and E2; Assistant Director in the office. E1 and E2 confirmed: 1. R10 has a known behavior of wheeling her wheelchair backwards over R8's feet. 2. R10 is hard to redirect and often has to be reminded to look behind her before moving in her wheelchair. 3. R10 does not have a behavior program to address this behavior. 4. A special Interdisciplinary Team (IDT) Meeting has not been held to put safeguards in place to prevent future occurrences and prevent injury. 5. The facility is aware that R8 has "old healing fractures to the left 2nd and 3rd toes", however "are not sure when the fractures occurred" and have not been able to provide reproducible documentation for the old fractures. 2) A facility "IDPH (Illinois Department of Public Health) Reportable Event" involving R5 was reviewed.	Z9999		

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The report includes the following event on 8/14/18 at 10:15am:
E9 (nurse) assessed R5 on 8/14/18 at 9am and noted the following: Redness and swelling to right cheek, measuring 2.2cm X 1.9cm. No drainage at present, vitals are documented except for blood pressure as client was not cooperating. Tylenol given via G-tube.
The physician was notified and orders were received to transfer R5 to the hospital.
E9 documented that R5 returned to the facility on 8/14/18 at 12:15pm with a diagnosis of Bacterial Infection.

On 8/16/18 the Physician assessed R5 and noted R5 was sent to the hospital on 8/14/18 for increased facial swelling around right molar abscess.

The facility's investigation does not address that R5 was diagnosed with a right molar abscess.

E2 (Assistant Director) was interviewed on 10/11/18 at 2:27pm. E2 reviewed the above noted incident and verified the facility's investigation does not address when R5 was diagnosed with a right molar abscess.

Conclusionary report of facility "Investigative Report" for July15 and July 16, 2018 for R8 further states through interview of E11; Coordinator, E22 (DSP), E23 (DSP), E24 (DSP) and E25 (DSP) that R10 has a known behavior of "pushing her wheelchair backwards and rolling over R8's feet." A thorough investigation was not conducted as evidenced by 3 possible justifications noted for R8's injuries, but no conclusion with safeguards have not been put into place to prevent future occurrences. Findings are as follows :

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Z9999	Continued From page 13 A) "Based on information received, it potentially can be concluded that R8 sustained the injuries to the toes on both of her feet when R10 accidentally ran over her feet. R10 has been observed running over R8's feet in the past while R8 is seated on the couch in the group room by E23, E25 and other staff in the home who have verified that E10 pushes herself backwards in the wheelchair, potentially backing up into R8's feet, resulting in the injury to her toes." B) "Based on information received, R8 plops herself down to the floor, but no known injuries were observed on R8's feet on 7/15/18 in the morning, however injuries were noted at 7pm on 7/15/18." C) "Based on information received, it is possible R8 sustained the injuries to her toes due to having Osteopenia; Osteoporosis." 4) Review of facility "Special Staffing Report" dated 7/17/18 is as follows: A) On 6/05/18, R7 had a radical mastoidectomy to his right ear and returned back to the facility on the same day. B) On 6/20/18, R7 was seen by Z1, who performed the surgery and noted some breakdown of the wound to the right ear. C) On 7/09/18, R7 was transferred to the hospital emergency room due to maggots in his right ear where the surgery was performed. R7 was admitted for surgery to clean out right ear. Right ear was covered with gauze and tape." Record review of facility document titled "Reportable Occurrence Form- Nursing" dated 7/09/18 states "During dressing, nurse on duty noted maggots in his (R7)'s right ear. Transferred to hospital emergency room for further evaluation. Right ear was covered with gauze and tape. "	Z9999		

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Z9999	Continued From page 14 Review of facility "IDPH Reportable Event" is as follows: 1) On 6/05/18, R7 had a same day procedure of a radical mastoidectomy to his right ear. "A pressure dressing was applied. Oflocacin 0.3% solution at night to bilateral ears daily was prescribed." 2) On 6/11/18, R7 was seen by Z6 for followup pain to mastoidectomy. "Pt reported to be grimacing at times, unable to verbalize pain." This note did not mention the aftercare services related to the ear dressing, nor the condition of the surgery performed on 6/05/18. 3) On 6/18/18, R7 was seen by Z6 for followup to mastoidectomy. "Right ear continues to have discharge. Patient does grimace with packing. Does not appear infected. Continue Cephalexin until 7 days consumed." Document further notes: "SLC Nursing monitor (R7) and change the dressing to his ear as ordered." Surveyor observed this note to be inserted in between the 6/18/18 note and 7/05/18 note without a date and no other notes documented until 7/05/18. 4) On 7/05/18 at 10:00am, E27 (LPN) noted "Right ear gauze packing removed. Greenish yellowish drainage noted on removed gauze. Ciprodex (Ofloxacin 0.3% twice a day until completed) instilled as ordered. Fresh gauze applied." 5) On 7/06/18 at 11:00am , R7 assessed by E5 (LPN) and note states "Followup to mastoidectomy. Right ear has no discharge, crater like wound has questionable slough. Pre medicate with Norco one hour before dressing change." 6) On 7/09/18 at 9:30am, E4 (DON) "noted the following: E28 (LPN) texted me that she did the dressing change to (R7)'s ear on 7/07/18. I spoke to Z2 (LPN) and she verified that she did R7's	Z9999		

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Z9999	Continued From page 15	Z9999		

dressing change on 7/08/18. She did not notice maggots at that time but noticed them this morning (7/9/18). I spoke with E12 (LPN), she stated that she did R7's dressing change on Friday evening 7/06/18. She took her flashlight and looked into his ear. No maggots noted."
7) On 7/09/18 at 12:00pm, E4 (DON) noted "(R7) to have right ear cleaned tomorrow and permanent stitches applied so they won't dissolve. Suction to be done to left ear for infection."
8) On 7/10/18 at 1:31pm, E10 (LPN) spoke with the hospital and states "(R7) had surgery on his right ear, which he is receiving special dressings. Resident also having drainage from left ear, which he is receiving ear drops."
9) On 7/13/18 at 10:00am, E30 (RN) spoke with the hospital and noted "Z7 (RN) stated that R7 has MRSA from the ears." Facility Investigative Report does not include a conclusion and recommendations for proactive and preventative measures.

Review of facility "Physician Orders" for R7 dated 6/05/18 does not have an order by the physician for the type of dressing/packing to be used post surgery, under what conditions, how many dressings/packing's are to be used, how often the dressing/packing is to be used, if and when the dressing/packing is to be removed and who is to remove it/them. Review of facility "Medication record" dated "5/29/18 - 6/27/18" states "Do Not Remove Packing from ears." Review of "script" from Z1 states "Rx: Oloxacin 0.3% otic solution. Place 5 drops in ear (S) daily directly on packing. Start 6/05/18."

Review of hospital discharge instructions for R7 dated 6/05/18 states "Please take care not to remove the packing material under the cotton. If

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Z9999	Continued From page 16 some sticks to the cotton and comes out, push it gently back in." Surveyor noted that these instructions were not transcribed onto the facility physician orders for R7 upon return to the facility. Physician Consult Report and discharge instructions for 6/20/18 states "Some breakdown of wound behind ears, otherwise replaced pack. Will see again next week. If recent surgery and sutures behind the ear, please also place the plastic sandwich bag." Physician Consult dated 6/27/18 states "F/U from 6/20/18 status post Radical Mastoidectomy right ear. Continue Ciprodex 4 drops to both ears twice daily." No further instructions were indicated, regarding the right ear for R7. Review of "Nursing Notes" dated 6/05/18 - 8/9/18 have inconsistent documentation and some days without documentation about the right ear for R7 for as long as 5 days with some notes interchangeably stating that packing was changed and/or removed. There were also days noted during this time period where the "ear covering" was off of the ear and moderate amount of odorous drainage noted. Interviews were conducted with E1 (Administrator), E2 (Asst. Administrator), E4 (DON), E9 (LPN), E10 (LPN), E5 (LPN) and E12 (LPN) on 10/09, 10/10 and 10/11/18 in the conference room. The facility confirmed that they failed to provide appropriate medical interventions, monitor client progress and provide treatments as ordered, document consistently client progress following illness or injury, failed to conduct assessments as indicated, and communicate with the client's physicians and other health care professionals for R7.	Z9999		

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3) Record review of facility document titled "Evaluation of a Reportable Occurrence Form" dated "July 15, 2018 at 8:25pm and July 16, 2018 at 01:30am" for R8 states that R8 sustained an unobserved injury requiring 2 separate emergency room visits. Report further states:
"Left foot: 1) Marked hallux vagus at the 1st MTP joint. 2) Healing fractures of the 2nd and 3rd Metatarsal heads."
"Right foot: 1) Marked hallux August at the 1st MTP joint. Soft tissue swelling at 1st MTP joint suggests a bunion. 2) Soft tissue swelling inferior to medical and lateral malleolus. Small right ankle joint effusion. 3) Soft swelling along the metarsal bones".

On 10/11/18 at 12:20pm, interviews were conducted with E1; Administrator and E2; Assistant Director in the office. E1 and E2 confirmed:
1. R10 has a known behavior of wheeling her wheelchair backwards over R8's feet.
2. R10 is hard to redirect.
3. R10 does not have a behavior program to address this.
4. A special Interdisciplinary Team (IDT) Meeting has not been held to put safeguards in place to prevent future occurrences.
5. The facility is aware that R8 has "old healing fractures to the left 2nd and 3rd toes", however "are not sure when the fractures occurred, and did not thoroughly investigate with recommendations for action both to safeguard R8 during the investigation and after the completion of the report. The facility was not able to provide reproducible documentation for the old fractures.

4) Review of facility "Special Staffing Report" dated 7/17/18 is as follows:

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Z9999	Continued From page 18 A) On 6/05/18, R7 had a radical mastoidectomy to his right ear and returned back to the facility on the same day. B) On 6/20/18, R7 was seen by Z1, who performed the surgery and noted some breakdown of the wound to the right ear. C) On 7/09/18, R7 was transferred to the hospital emergency room due to maggots in his right ear where the surgery was performed. R7 was admitted for surgery to clean out right ear. Right ear was covered with gauze and tape." Record review of facility document titled "Reportable Occurrence Form- Nursing" dated 7/09/18 states "During dressing, nurse on duty noted maggots in his (R7)'s right ear. Transferred to hospital emergency room for further evaluation. Right ear was covered with gauze and tape. " Review of facility "IDPH Reportable Event" is as follows: 1) On 6/05/18, R7 had a same day procedure of a radical mastoidectomy to his right ear. "A pressure dressing was applied. Oflocacin 0.3% solution at night to bilateral ears daily was prescribed." 2) On 6/11/18, R7 was seen by Z6 for followup pain to mastoidectomy. "Pt reported to be grimacing at times, unable to verbalize pain." This note did not mention the aftercare services related to the ear dressing, nor the condition of the surgery performed on 6/05/18. 3) On 6/18/18, R7 was seen by Z6 for followup to mastoidectomy. "Right ear continues to have discharge. Patient does grimace with packing. Does not appear infected. Continue Cephalexin until 7 days consumed." Document further notes: "SLC Nursing monitor (R7) and change the dressing to his ear as ordered." Surveyor	Z9999		

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Z9999	Continued From page 19 observed this note to be inserted in between the 6/18/18 note and 7/05/18 note without a date and no other notes documented until 7/05/18. 4) On 7/05/18 at 10:00am, E27 (LPN) noted "Right ear gauze packing removed. Greenish yellowish drainage noted on removed gauze. Ciprodex (Ofloxacin 0.3% twice a day until completed) instilled as ordered. Fresh gauze applied." 5) On 7/06/18 at 11:00am , R7 assessed by E5 (LPN) and note states "Followup to mastoidectomy. Right ear has no discharge, crater like wound has questionable slough. Pre medicate with Norco one hour before dressing change." 6) On 7/09/18 at 9:30am, E4 (DON) "noted the following: E28 (LPN) texted me that she did the dressing change to (R7)'s ear on 7/07/18. I spoke to Z2 (LPN) and she verified that she did R7's dressing change on 7/08/18. She did not notice maggots at that time but noticed them this morning (7/9/18). I spoke with E12 (LPN), she stated that she did R7's dressing change on Friday evening 7/06/18. She took her flashlight and looked into his ear. No maggots noted." 7) On 7/09/18 at 12:00pm, E4 (DON) noted "(R7) to have right ear cleaned tomorrow and permanent stitches applied so they won't dissolve. Suction to be done to left ear for infection." 8) On 7/10/18 at 1:31pm, E10 (LPN) spoke with the hospital and states "(R7) had surgery on his right ear, which he is receiving special dressings. Resident also having drainage from left ear, which he is receiving ear drops." 9) On 7/13/18 at 10:00am, E30 (RN) spoke with the hospital and noted "Z7 (RN) stated that R7 has MRSA from the ears." Facility Investigative Report does not include a conclusion and recommendations for proactive and preventative	Z9999		

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Z9999	Continued From page 20 measures. Review of facility "Physician Orders" for R7 dated 6/05/18 does not have an order by the physician for the type of dressing/packing to be used post surgery, under what conditions, how many dressings/packing's are to be used, how often the dressing/packing is to be used, if and when the dressing/packing is to be removed and who is to remove it/them. Review of facility "Medication record" dated "5/29/18 - 6/27/18" states "Do Not Remove Packing from ears." Review of "script" from Z1 states "Rx: Oloxacin 0.3% otic solution. Place 5 drops in ear (S) daily directly on packing. Start 6/05/18." Review of hospital discharge instructions for R7 dated 6/05/18 states "Please take care not to remove the packing material under the cotton. If some sticks to the cotton and comes out, push it gently back in." Surveyor noted that these instructions were not transcribed onto the facility physician orders for R7 upon return to the facility. Physician Consult Report and discharge instructions for 6/20/18 states "Some breakdown of wound behind ears, otherwise replaced pack. Will see again next week. If recent surgery and sutures behind the ear, please also place the plastic sandwich bag." Physician Consult dated 6/27/18 states "F/U from 6/20/18 status post Radical Mastoidectomy right ear. Continue Ciprodex 4 drops to both ears twice daily." No further instructions were indicated, regarding the right ear for R7. Review of "Nursing Notes" dated 6/05/18 - 8/9/18 have inconsistent documentation and some days without documentation about the right ear for R7 for as long as 5 days with some notes interchangeably stating that packing was changed	Z9999		

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and/or removed. There were also days noted during this time period where the "ear covering" was off of the ear and moderate amount of odorous drainage noted.

Interviews were conducted with E1 (Administrator), E2 (Asst. Administrator), E4 (DON), E9 (LPN), E10 (LPN), E5 (LPN) and E12 (LPN) on 10/09, 10/10 and 10/11/18 in the conference room. The facility confirmed that they failed to provide appropriate medical interventions, monitor client progress and provide treatments as ordered, document consistently client progress following illness or injury, failed to conduct assessments as indicated, and communicate with the client's physicians and other health care professionals for R7.

5) A reportable event dated 9/2/18 was reviewed. Under summary of event it includes; "On September, R13 went to the hospital for an injury noted to her left lower leg by Lead DSP (Direct Support Person), E29 on 9/2/18 at 2:30pm. R13 was assessed by E9(nurse) on 9/2/18 and the following was noted at 3:40pm: Staff reported left leg bleeding. Upon assessment, the same area with peripheral edema open, large area of skin hanging, bleeding. Attempted pressure dressing, not able to stop bleeding. No complaint of pain or discomfort. Kept reinforcing the pressure dressing...E7 (Medical Director), was contacted and orders were received to transfer to the hospital for further evaluation...R13 is being admitted with the diagnosis of cellulitis..."

The physical examination from the hospital emergency room records dated 9/2/18 at 4:46pm was reviewed. Under musculoskeletal it includes; "Lower extremity: left chronic skin changes , +4

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	IL6004782	A. BUILDING: _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IONA GLOS SLC	50 SOUTH FAIRBANK STREET ADDISON, IL 60101

(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
Z9999	Continued From page 22	Z9999		

pedal edema with surrounding cellulitis of the left foot. There is a large flap laceration at the left posterior calf that is 12cm. This is obvious bleeding and subcutaneous fat visualized."

The facility's conclusion includes; "...Based on information received, it is possible R13 may have hit her leg herself with her other leg, did not feel this as she cannot feel her left leg from knee down, and aggravated her leg resulting in the weeping and injury to the back of her left leg near the calf."

E9 was interviewed via phone on 10/11/18 at 12:20pm. E9 stated, "R13's laceration was going down the back of her calf. It was so much blood, it was deep. I just kept on putting pressure on it. I could not measure it, it was deep and there is a flap of skin. I tried to put it back in but there's so much blood."

E1, Administrator, was interviewed during the daily status meeting on 10/11/18 at approximately 2:30pm. E1 verified that it is not possible for R13's other leg to cause the laceration on her left leg.

6) A reportable event report dated 7/8/18 was reviewed. Under summary of event it includes; "Direct Support Person, E31, observed R14 on the floor next to the toilet at 10:10pm after placing him on the toilet to void and informed the nurse coordinator of the incident..."

Under reporting information and other relevant information it includes: "...E3, Assistant Director, spoke to E31 on 7/9/18 at 9:30am and obtained the following information about the incident: After R14 finished his shower, I put his shirt on then brought him to the toilet. I made sure R14 was

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Z9999	Continued From page 23 seat belted in the shower chair, which was over the toilet. I allowed R14 some time to use the toilet. I left the room to get bedsheets for R14's bed as new sheets were needed..." Further review of the report showed that there is no mention as to whether the seatbelt of the shower chair broke, was he still in the chair when he was found and should he have been left alone in the bathroom. E1, Administrator, on 10/11/18 at approximately 2:30pm verified that these information were lacking from the investigation. 7) An Evaluation of a Reportable Occurrence Form dated 8/23/18 at 12:39pm was reviewed. It includes under summarize team member response and any additional follow up: "Direct Support Person, E32, was changing R7 on the couch in the living room when he rolled and hit his head on her knee on 8/23/18 at 12:39pm..." Further review of the investigation showed that the facility did not address why R7 was being changed on the couch in the living room. E1, Administrator on 10/11/18 at approximately 2:30pm verified that this information in not written in the report. 8) The Occurrence Form for R9 dated 8/18/18 at 12:45pm, was reviewed. The report states that E5(Licensed Practical Nurse) assessed R9 after a request to see R9, from direct care staff(E6), and noted that R9 was in the middle of having his colostomy bag changed by E6. E5 noted that there was a circular purplish/reddish 6 x 6 cm(centimeter) discoloration to R9's left testicle, which was also hard and tender to touch. The discoloration was spread all over the entire left	Z9999		

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Z9999	Continued From page 24	Z9999		

testicle, and R9 voiced pain during palpation. E5 attempted to straight cath R9, but R9 refused as he was in pain. E6 had reported to E5 that R9 had not voided all morning, and the last known void was made on 8/17/18, sometime on the second shift per E6. E7(Physician) was contacted, and orders were received to send out to the ER for evaluation of his left testicle and urinary retention. The report continues, stating that R9 was admitted to the hospital with the diagnoses of left testicular abnormality, and urinary retention. R9 had a urinary catheter in place and was started on IV antibiotics. An ultrasound of the scrotum was obtained at the hospital, and R9 was diagnosed with a hematoma to the left scrotum. The report notes that R9 has a wound to the coccyx(0.8cm x 0.2cm). The report indicates that this wound was discovered when he returned back from the hospital on 8/22/18, when they did a complete body check.

There is no evidence that any staff, or R9 himself, had been interviewed, to determine how R9 might have received his scrotal hematoma, why no one reported to nursing that R9 had not urinated for almost 24 hours, and how R9's wound on his coccyx developed.

During an interview with E5 on 10/11/18 at 2:05pm, E5 was asked if she could explain what occurred on the afternoon of 8/18/18 at 12:45pm. E5 explained that R9's colostomy bag exploded, so he was placed into bed, from his wheel chair, so staff could clean him up. E5 stated it was then that staff noticed the bruising to R9's left testicle, so they called for me to come and assess him,. E5 stated that his whole left testicle was bruised, swollen and hard to the touch. E5 also stated that was when she noticed that his lower abdomen was very distended. When she asked

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Z9999	Continued From page 25 staff when the last time R9 had urinated, staff reported that he had not voided on first shift as of yet, and the last noted void was from the previous day, sometime on the second shift. E9 was asked if anyone interviewed her to determine how R9 might have obtained his testicular hematoma, why no one had reported to her that R9 did not void, and how R9 developed the open area to his coccyx. E5 stated no one asked her anything about any of the above issues. E5 offered that R9 will sometimes hold his urine, and not void unless he is with staff that he feels comfortable with. E5 stated that she herself was asking everyone how the scrotal injury occurred, and was surprised no one was trying to determine how it could have occurred. E5 stated she asked the direct care staff what happened to his testicle, and they all said that they did not know. E5 stated that she was the one who discovered the open wound when she was assessing his scrotum and abdominal distention. E5 confirmed that this open area did not develop at the hospital, like the investigation suggests. E5 showed this writer the skin assessment she started for R9, with the date of discovery being 8/18/18. E5 stated that it was a stage 2, because it was open, but on her assessment she indicated it was a stage 1, which measured 2cm x 1cm to the center of the coccyx. E5 stated to date, it is just about healed. E5 stated that R9 sits in a wheel chair while up during the day, and does not like to use the toilet to void. He will just have staff use a urinal, while he is up in his wheel chair. (A)	Z9999		