IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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March 12, 2019

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

RE: Complaint #: IL00108083
Survey Date: January 17, 2019
Docket #: 19-C0098
Violation Type: Level A

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Iona Glos SLC.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

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

Enclosure
cc: Administrator
File
Iona Glos SLC/January 17, 2019//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant,	)	Docket No. 19-C0098
v.	)	
RAY GRAHAM ASSOCIATION FOR PEOPLE WITH DISABILITIES, D/B/A , IONA GLOS SLC, Respondent.	)	

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 Complaint IL00108083 Investigation conducted by the Department on January 17, 2019, at Iona Glos SLC, 50 South Fairbank Street, Addison, Illinois 60101. On March 11, 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 Febuary 03, 2019. The Facility's current license number is 0022996. The term of the conditional license shall be from April 11, 2019 to October 10, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER . THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON APRIL 11, 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: 350.1210, 350.1230b)7) 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 12th day of March, 2019.

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. 19-C0098

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 12th day of March, 2019.

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

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004782	A. BUILDING: _____ B. WING _____	C 01/17/2019

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
Z 000	COMMENTS COMPLAINT INVESTIGATION # 1878152 / IL108083	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: (1 of 1) 350.1210 350.1230b)7) 350.3240a) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. 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) (A, B)	Z9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Z9999	Continued From page 1 These requirements were not met evidenced by: Based on record review, and interview, the facility failed to ensure nursing met the health needs of the client by failing to provide consistent support interventions at all times for 1 of 1 client in the sample (R1), who was noted to have increased left leg swelling. R1 was assessed at the hospital, and diagnosed with a displaced distal left femoral extra articular shaft fracture, which required an open reduction, and internal fixation of the left distal femur. Findings include: The Emergency Room Transfer Form regarding R1, dated and timed 7/8/18 at 10:27pm was reviewed. The form notes that R1 had a fall to the head in the bathroom and was found on the floor, hunched over with an open area 3 x 2 cm (centimeters) near the frontal lobe with swelling noted. The IDPH final investigation regarding this same fall incident was reviewed. The investigation notes that R1 was found on the floor of the bathroom, next to the toilet. E5 (Direct care staff) brought R1 into the bathroom to sit on the toilet after his shower. He was in the shower chair, belted in with a seat belt. E5 left the bathroom, to give R1 personal privacy while he toileted. When E5 returned to the bathroom, that is when she discovered that R1 was on the floor. R1 was diagnosed with a head injury. E10 (Qualified Intellectual Disability Professional) revised R1's support needs in the bathroom, specifically with toileting. An IDT meeting was conducted, and it was decided that R1 is no longer allowed to be in the bathroom alone while on the toilet. All staff is to be trained on his new	Z9999		

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Z9999	Continued From page 2 supports. R1's Individual-Specific Support, Safety and Supervision Requirements (IS4R) Form dated 7/10/18 was reviewed. This form indicated the new support changes that R1 should not be left in the bathroom unattended at any time. While in the shower, R1 should be in a shower chair, and the team member must ensure that R1's seatbelt is secure. This form also indicates that R1 has a history of falls, and is on a Fall Risk Protocol. The protocol indicates that if R1 should attempt to walk, team members should provide R1 with his wheelchair, and ask him to use it. While transferring from wheel chair to sit in a chair, or his bed, team members should ensure his wheel chair is locked and assist him in the transfer by letting R1 hold onto team member's hands. If R1 should fall, staff must inform nursing, as well as the coordinator, and a reportable occurrence form must be completed. A second revision of R1's IS4R was noted on 7/16/18. Additions to this form indicate that R1 has dementia, and team members should provide R1 with time, and patience when working with R1. R1 may take longer to process information. Transfers are noted to be a one person pivot transfer, and a chest strap should be utilized as needed, with bed rails, bed rail pads, and a shower chair. The Physician Order Sheets were reviewed, and an entry from 7/19/18 was noted to have the above appliances added to his orders. A third revision of R1's IS4R was noted on 9/13/18. R1 still is noted to be a risk for falls, with the instruction to follow the Fall Risk Protocol. Again the protocol indicates that staff should provide two hands for stability to transfer R1. This same form indicates that R1 is now to be a	Z9999		

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Z9999	Continued From page 3	Z9999		

mechanical lift transfer (Physician Order Sheets dated 9/13/18 confirm a mechanical lift for transfers), and is not to be toileted in the bathroom at any time, yet the Fall Risk Protocol indicates that R1 should be transferred with two hands of a team member, and if he is in the bathroom, staff should ensure his pathways and entryways to the bathroom are clear of any items when walking to the bathroom. These two support interventions contradict each other, making it unclear to staff on how to transfer R1, and if he should or should not be toileted in the bathroom.

During an interview with E2 (Assistant Facility Director) on 1/2/19 at 1:15pm, E2 was made aware of the above interventions in conflict with each other. E2 was asked if Physical Therapy was involved in the decision making process when R1 was changed from a stand pivot transfer to a mechanical lift transfer. E2 stated that the only PT evaluation they have in the chart is from 7/21/18, and that was just his annual assessment in preparation for R1's staffing which was conducted on 9/12/18. This assessment does not indicate a mechanical lift is how R1 should be transferred. E2 was asked if there was a special team meeting to discuss making R1 a mechanical lift transfer. E2 stated that there were no IDT meetings for R1 in September. E2 was asked if Occupational Therapy or Physical Therapy were not involved at all in the decision making regarding transfers via the mechanical lift or the use of a chest harness. E2 confirmed that neither discipline were involved in the decision making process. E2 was asked if all staff were trained on the use of a mechanical lift for R1. E2 stated that she thought all staff was trained. E2 provided this writer with a list of staff members who were trained on R1's mechanical lift transfer,

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Z9999	Continued From page 4	Z9999		

and E5(Direct Care Staff), Z2(Agency Direct Care Staff) and E8(Direct Care Staff) were not on the list, indicating that these three staff members, who per E2, work with R1, were not trained on R1's new transfer support. E2 was also made aware that R1's transfer status is unclear on the latest IS4R, as it states to use a mechanical lift, but also states to follow the Fall Risk Protocol, which directs staff to transfer R1 with one person, and it also indicates it is ok to toilet R1 with staff support and clear environment pathways. E2 confirmed that this is conflicting information, and it would make it unclear to staff which way to transfer R1, and unclear whether R1 should or should not be toileted in the bathroom.

A fourth revision of R1's IS4R was noted on 11/1/18. This revision notes that R1 should have a chest strap as needed, but further down on the form, it indicates that R1 has a history of falls, and R1 must have a wheelchair with his chest strap on at all times.

During an interview with E2 on 1/2/19 at 11:45am, E2 was made aware of the above information regarding the conflicting information on whether R1 should have a chest strap on at all times, or only as needed. E2 acknowledged that the form is confusing, as it gives two conflicting directives regarding R1's chest strap. E2 stated that she has been made aware that R1's chest strap has not been fitting correctly, and when R1 leans forward in this wheelchair, it does not support his body weight. E2 stated that they are working on obtaining a new chest strap for R1. E2 was asked how long R1's chest strap has been ineffective for R1. E2 stated that she does not know, but thinks it's only been a few weeks. E2 stated that she has heard staff were leaving R1 in bed for meals, and not taking him to Day

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Z9999	Continued From page 5 Programming because his chest strap has been ineffective. During an interview, via the telephone with E7(Licensed Practical Nurse) on 1/3/19 at 9:00am, E7 was asked if she was aware that R1's chest strap is ineffective in providing the appropriate trunk support, to prevent R1 from falling out of wheelchair. E7 stated that she is aware. E7 was asked if she is aware how long his chest strap has been ill fitting. E7 stated that it has been for 3-4 months. The Emergency Room Transfer Form for R1 dated and timed 12/6/18 at 6:20pm was reviewed. This form indicates that R1 fell from a sitting position onto the floor. R1 sustained a 4 cm diameter (area of) swelling to the left forehead. The IDPH Reportable Event for this same fall incident was reviewed. The report indicates that while E11(Direct Care Staff) was assisting R1 out of his wheelchair, she unbuckled R1's seatbelt, and when R1 suddenly leaned forward, he fell out of his wheelchair, hitting his head on the floor. E11 called E5 (Direct Care Staff) for assistance. E5 stated during the investigation interview process, E5 and E11 assisted R1 back into his wheelchair and then called nursing for assistance. A CT scan was performed, and R1 was diagnosed with a head injury, with recommendations to follow up with a Neurosurgeon for neck arthritis, which was discovered on the CT scan. The conclusion of this report indicates that R1 should have been transferred using a mechanical lift, but since E5 transferred R1 without a lift, she will be trained on his current transfer status. The nursing notes were reviewed for the date of 12/6/18. These notes were authored by E12 (Registered Nurse), and state that she received a call from Home	Z9999		

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Z9999	Continued From page 6	Z9999		

2(R1's home residence) stating that R1 had bumped his head. When E12 went to assess R1, R1 was in his bed, with noted swelling to his left forehead.

A special team meeting was conducted on 12/11/18, where it was discussed that R1 fell out of his wheelchair when staff unbuckled R1's seat belt. R1 then fell forward, and hit his head on the floor. The team did not discuss where it occurred, if the chest strap was on at the time, and that staff did not use a mechanical lift to transfer R1 into his bed, nor that fact that staff transferred R1 without being assessed by nursing first. A follow up special staffing was conducted on 12/19/18, where it was discussed that R1 will be seeing a neurosurgeon for neck arthritis which was discovered on his CT scan during his Emergency Room visit on 12/6/18. There still is no mention about the transfer supports not being utilized, chest strap usage or where the incident occurred. This form also does not indicate if PT/OT were involved with any recommendations for additional support to prevent further falls.

During an interview with E2 1/2/19 at 1:15pm, E2 confirmed that staff did not use a mechanical lift, when assisting R1 from off of the floor. E2 was asked if it is their facility practice to move a client after a fall, before nursing can assess for injuries. E2 stated that both E5 and E11 should not have moved R1 prior to E12 assessing R1 after his fall. E2 stated that E4(Director of Nursing) had mentioned something to her about re-training staff regarding moving clients after a fall without nursing assessment, but to date that has not occurred. E2 was asked where the fall occurred, i.e. bathroom, bedroom. E2 stated that she is not sure, because she did not ask that question, and it is not on the injury report. E2 states she thinks

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Z9999	Continued From page 7	Z9999		

it was in his bedroom. E2 was asked if R1 had his chest strap on at that time. E2 stated that she does not know, as she did not ask that question either.

A fifth revision was noted to R1's IS4R dated 12/12/18. This form indicates that the chest strap should be used as needed, but again notes that R1 has a history of falls, and should have his chest strap on at all times. This is still conflicting information regarding R1's chest strap usage. (Again, R1's chest strap is ineffective in providing needed trunk support, and to date, is still not functional). The form indicates that R1 is a mechanical lift for transfers, but does not indicate how many staff members are needed to provide the transfer safely.

The Emergency Room Transfer Form for R1 dated and timed 12/15/18 at 9:00pm was reviewed. This form states that R1's left thigh was swollen with his left inner thigh noted with a reddish bruise, and cries when affected area is touched. The bottom of this form indicates that the ER diagnosis is possible left displaced femur fracture, with possible surgery.

The IDPH Reportable Event (Investigation) for 12/15/18 was reviewed. This investigation was authored by E2 (Assistant Facility Director). This form indicates that R1 was discovered to have noticed swelling to his left thigh, with scattered reddish bruising, when nursing was performing his prescribed foot treatment. The form indicates that when Z1 (Agency nurse) saw R1 at 3:30pm that day; R1 was sitting in his bed, covered with a blanket. R1 did not appear to be in distress at this time. Z1 went back to R1's Home at 5:30pm to assist R1 with his dinner meal, and at this time still appeared with normal affect, and did not

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Z9999	Continued From page 8	Z9999		

indicate any pain. Z1 returned to the Home again around 8pm, and at 8:30pm, when she went to perform R1's foot treatment, as she was removing the sheet from R1's leg, R1 started to cry. R1 was noted to be in an incontinent brief at this time, and Z1 noted a lump to R1's left thigh. Z1 asked Z2 (Agency Direct Care Staff) if she noticed his leg was swollen, and Z2 told Z1 that she was going to let her know. Z1 stated that no one reported to her at any time during her shift that R1 had any issues. Z1 also stated that she noticed bruising to his left inner thigh area. Z1 went to the core nursing building to ask another nurse, Z2, to look at R1's leg. After Z2 assessed R1's left leg, Z2 confirmed with Z1 that R1 should be sent out to the Emergency Room for evaluation. The investigation indicates that R1 sustained a left hip fracture. Additional information states that they are unable to determine who was assigned to R1 on 12/15/18 because the group assignment forms from 12/15/18 and 12/16/18 are both missing; and R1 should be transferred via a mechanical lift, but a mechanical lift was not utilized on 12/15/18; and that R1 ate breakfast, and dinner in his bed as it was noted that his chest strap does not support R1 properly, and that the QIDP, and Social Services are following up and researching a better fitting chest strap/support for his size. The conclusion of this investigation states that based on the interviews completed, R1 sustained a hip fracture sometime on 12/15/18 between 5:30pm and 8:30pm. The hypothesis is the injury occurred most likely during personal care (changing of an adult incontinent pad) due to his legs being rigid and contracted. Z2 denied changing or transferring R1 during second shift when R1 was assigned to her. However, R1 was noted to have no pants on when Z1 came into his room at 8:30pm. R1 is unable to remove his

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clothing independently. Z2 stated that R1 was dry from 2:30pm until 8:30pm, per her interview, but the facility determined that would be highly unlikely based on the fluids he had drank that day during meals. It was also discovered during an interview that an incident report was turned in on 12/14/18, which indicated that E8(Direct Care Staff) noticed swelling when changing him on this date, after R1 returned from Home 1, which was where he attended Day Programming that day. E8 reported that R1 did not seem right in addition to the left leg swelling. E8 stated that he informed nursing and informed the lead Direct Care Staff on duty at the time, who confirmed that E8 did inform her about R1's leg not looking right. E8 stated that E7 (Licensed Practical Nurse) was in the home on the 14th, but was not sure if E7 looked at R1's leg. Nursing was asked if E8 ever reported the swelling to them, but nursing stated that E8 only reported a decreased appetite. E7, when interviewed, stated she performed the regular treatment to R1's feet on 12/14/18 at around 8pm, but did not notice any swelling or discoloration to R1's left leg.

During an interview with E8 (Direct Care Staff) on 12/19/18 at 2:10pm, E8 was asked if he was the direct care member assigned to R1 on 12/15/18. E8 stated that he worked in Home 2 that day, first shift only, but he did not have R1's group. E8 told this writer that R1 was assigned to Z2 (Agency Staff) first and second shift, as she worked a double that day. E8 did confirm that he did get R1 up out of his bed for lunch that day, transferring R1 by himself. E8 did not transfer him via a mechanical lift. E8 stated that he did notice that R1's left leg was more swollen than his right on 12/14/18, after he brought him back from Home 1. E8 stated that he always transfers him by himself, and does not use a mechanical lift to

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transfer him. E8 stated that he made out a report. E8 stated that he gave the report to his Home Manager (E6), but also told the coordinator and nursing. E8 stated that he can go and get the report if I wanted to see it. (During interview with E2 on 1/2/19, E2 stated E8 did tell her that E8 made a report on 12/14/18, but she never received a copy. I informed E2 that I had a copy of the report. E2 stated that E8 gave the report to E6(Home Manager), who stated during her interview with E2 that she never looked at the report, or read it, and then forgot to pass it on to the coordinator). E8 also stated that when he went to get R1 up for lunch on 12/15/18, he never looked at R1's leg, because he had pants on. E8 stated that he put him back to bed, and then changed him. E8 stated that there was some bruising to his left thigh at this time, and his left leg was still swollen, but he didn't report it, because he had already done so the day prior (12/14/15 at 2:15pm).

The Reportable Occurrence Form, authored by E8, dated 12/14/18 at 2:15pm was reviewed. The report indicates that after E8 assisted R1 into bed, E8 noticed that his left leg looked larger than his other leg. The report indicates that he called and notified nursing and the coordinator, just as he had told this writer during our interview on 12/19/18. This new finding of an unwitnessed injury was not assessed by nursing, or reported to the Administrator or Public Health.

During an interview with Z2 (Agency Direct Care Staff) on 12/19/18 at 11:50am, via the telephone, Z2 was asked what shift she worked on 12/15/18. Z2 stated she worked first and second shift, but was only assigned to R1 on the second shift. Z2 stated that E8 got R1 up for lunch and back to bed after lunch, and also changed his incontinent

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pad at 2:30pm. E8 stated that she does not know how E8 got him up. Z2 stated that she did not get him up, but when asked how she transfers R1, she stated that R1 is a 2-person transfer. Z2 stated that E8 didn't ask for her help to get R1 up, so she assumes that E8 got him up by himself. Z2 offered that she changed R1 about 2-3 times that second shift. Z2 stated that when the nurse came to see R1 at 8:30pm, she asked me if his left leg was swollen. I said that it did look swollen. Z2 stated that when she changed him, she rolled him over, and she was on his right side, so she said she never saw any bruising or swelling. (The facility investigation notes that when Z2 was interviewed by E2 she reported that she only checked on R1 to see if he needed to be changed. Z2 told E2 that she checked for dryness by feeling his incontinent brief, and looked at the indicator line for wetness, but never needed to change R1. This is conflicting information).

During an interview with E6 (Home Manager) on 12/19/18 at 11:40am, E6 was asked if she ever transferred R1. E6 stated that she assisted with a transfer on 12/14/18. E6 stated that E5 (Direct Care Staff) asked for her assistance to transfer R1 from his bed to his wheelchair. E6 was asked to describe how she and E5 transferred R1. E6 stated that one of us lifted under his arms, and the other person went under his legs. E6 stated that R1 went to eat in the dining room and then went to Home 1, as he was not attending Day Programming. E6 saw R1 come back from Home 1 on 12/14/18. E8 was assisting him back to the home, pushing him in his wheelchair. E6 stated that he has a seat belt, but his chest strap is not strong enough to support him. E6 was asked how R1 should be transferred. E6 stated that if it is a male staff, R1 is transferred with just

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one staff, but if ladies are transferring R1, then it is safer to transfer with 2 people. E6 was asked how an Agency staff would know how to transfer R1. E6 stated that they can look at the IS4R, which is in a binder in the Home, but most Agency staff refers to the cheat sheet. E6 explained that the cheat sheet is a much shorter version, with just the pertinent information they would need to care for R1. E6 stated that she could bring that form for my review.

The "Cheat Sheet", untitled, for R1 was reviewed. The information on the sheet indicates that R1, if he attempts to walk, should be redirected to use his wheelchair. It also states that R1 has the behavior of refusing to be toileted after incidents of incontinence, so staff should follow support strategies as stated in is Positive Behavior Support plan. The form states that R1 can dress independently, but requires verbal prompts, and should not be standing for long periods at a time. This form does not indicate that R1 should not be toileted in the bathroom, that he should have a chest strap on, and should be transferred via a mechanical lift.

During an interview with E2 on 1/2/19 at 11:45am, E2 was asked if the information on the cheat sheet is correct. E2 confirmed that this information was not updated, and much of the information is incorrect. E2 confirmed that R1 should not be toileted in the bathroom, should be transferred with a mechanical lift, and should have a supportive chest strap on. During this same interview, E2 was asked if she ever received the incident report from E8 that he filled out on 12/14/18. E2 stated that she still has not received a copy of that report. E8 gave it to E6, and E6 reported to me (E2) that she never read it, or gave it to the coordinator. E2 stated that E8

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should have brought it to the coordinator, but when E6 received it, she knows it should go to the coordinator. E2 was asked if she was aware that E6, E8, and E5 were all transferring R1 either alone or with assistance of another staff, and not using the mechanical lift during this time period in question. E2 stated that she was not aware. E2 stated they should know to use a mechanical lift, but offered that the charging component for the mechanical lift in R1's home is not working. E2 stated that staff could go to another home, and borrow their mechanical lift though. E2 stated that they should know better, because she thought all staff was trained.

Z1 was interviewed on 12/19/18 at 10:15am. Z1 stated that when she saw R1 at 8:30pm, that was the first time she noticed that R1's leg was very swollen. Z1 stated that it was also bruised. Z1 stated that she asked Z2 if she thought his leg was swollen, and that Z2 acknowledged that it was. Z1 was asked if she asked Z2 if she knew how this swelling could have occurred. Z1 stated that she did not ask that question, but she thought that Z2 offered the statement, "I was going to tell you", but she cannot be sure. Z1 stated that she was just so determined to get R1 to the ER for assessment, that she really did not ask too many questions, other than if Z2 also thought that R1's left leg looked more swollen than his right leg. Z1 stated that when she went to take the sheet off, or move his leg just a little, R1 cried out in pain. Z1 stated that she noticed that his left leg had a bump or a lump. Z1 asked if she is aware on how R1 should be transferred. Z1 stated that R1 is a mechanical lift, but she offered that she does not watch the direct care staff when they transfer him, so she is not sure how the staff gets him into and out of bed or his wheelchair. Z1 stated that she asked Z3, who

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Z9999	Continued From page 14 was a nurse who was also working that night, to come to the home with her, and assess R1's leg. During an interview (via the telephone) with Z3 (Agency Nurse), Z3 confirmed that Z1 asked him to assess R1's leg. Z3 stated that when he saw R1's left leg, he knew something was very wrong right away. Z3 stated that his left leg was very swollen and bruised, and if you tried to move him, he was in a lot of pain, crying out. Z3 was asked how R1 should be transferred. Z3 stated that R1 can be transferred with 1 person, but you have to be very careful, as he is very contracted at the knee, hip and elbows. (Z3 also was not aware that R1 should be transferred via a mechanical lift). The Hospital Emergency Report for R1 dated 12/15/18 was reviewed. The report states, "(R1) was seen in the Emergency Department approximately a week ago for a fall out of a wheel chair. He had a CT of his head and his cervical spine that showed no acute injury. There were no other injuries discovered on exam. The patient's caregiver here today states that she had not seen him since before the injury, saw him again today and noticed his leg was swollen. She is unsure if this happened during the fall, or trying (during) some other event, perhaps while he was being transferred to the shower seat. This fracture of the femur does not seem consistent with a fall from the wheelchair. There is no evidence of any traumatic injury to the anterior lower extremities, no bruising or abrasions over the knee. I believe this injury is more consistent with perhaps an attempt to forcibly extend the knee by manipulating the lower extremities, and this injury is concerning in this otherwise non mobile patient."	Z9999		

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Z9999	Continued From page 15 The Orthopedic Consult for R1, dated 12/16/18 was reviewed. The report states that R1's diagnosis is a distal left femur fracture in a severely contracted Down's syndrome patient, who is nonambulatory. The postoperative diagnosis is displaced left distal femoral extra-articular shaft fracture that required an open reduction and internal fixation of the left femur with retrograde nail and cerciage wire. During an interview with E2 on 1/2/19 at 1:15pm, E2 was made aware that R1 was not diagnosed with a hip fracture as indicated in her investigative report. E2 stated that was what she heard from nursing, so she assumed that this was correct information. E2 was asked if she received any Emergency Room reports or any consults from the hospital. E2 stated that she had not, and did not ask for any. E2 stated that she thought what she heard from nursing was correct information. (A)	Z9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: IONA GLOS SLC COMPLAINT #: 0108083
LIC. ID #: 0022996
DATE COMPLAINT RECEIVED: 12/17/18 09:15:00

IDPH Code	Allegation Summary	Determination
602	CLIENT PROTECTIONS	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.