IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 18, 2019

J. Michael Bibo, Registered Agent
Pioneer Concepts, Inc.
285 S. Farnham Street
Galesburg, Illinois 61401

RE:	Complaint #:	IL 106050
	Survey Date:	November 21, 2018
	Docket #:	19-C0007
	Violation Type:	B Violation with Fine

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 Broadway Terrace.

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
Broadway Terrace/November 21, 2018/19-C0007/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: BROADWAY TERRACE COMPLAINT #: 0106050
LIC. ID #: 0043182
DATE COMPLAINT RECEIVED: 09/24/18 12:26:00

IDPH Code	Allegation Summary	Determination
602	CLIENT PROTECTIONS	1
606	HEALTH CARE SERVICES	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.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PIONEER CONCEPTS, INC. D/B/A BROADWAY TERRAACE, Respondent.	)))))))))	Docket No. NH 19-C0007

NOTICE OF TYPE "B" VIOLATION(S); 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 "B" VIOLATION(S)

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 Investigation conducted by the Department on November 21, 2018, at Broadway Terrace, 43 Broadway, Chicago Heights, Illinois 60411. On January 17, 2019, the Department determined that such violations constitute one or more Type "B" 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.

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

A Plan of Correction is required to be submitted by the facility within two weeks from the date the violation notice was sent. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice. Please email the Plan of Correction to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Sammye Geer, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$ 550.00**, as follows:

- **Type B violation** for violating one or more of the following sections of the Code: 350.620a), 350.1210b), 350.1220j) 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 "B" Violation(s); 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. **Please email the hearing request to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Sammye Geer, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.**

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. **Please email the waiver to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Sammye Geer, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.**

Sherry Barr

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

Dated this 18th day of January, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. PIONEER CONCEPTS, INC. D/B/A BROADWAY TERRACE, Respondent.	))))))))))	Docket No. NH 19-C0007

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); 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:	J. Michael Bibo
Licensee Info:	Pioneer Concepts, Inc.
Address:	285 South Farnham Street
	Galesburg, Illinois 61401

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 18th day of January, 2019.

SGeer

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012959	A. BUILDING: _____ B. WING _____	C 11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY TERRACE	43 BROADWAY CHICAGO HEIGHTS, IL 60411

(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 SURVEY 1896299/IL106050	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.1210b) 350.1220j) 350.3240a) 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 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: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. 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 are not met as evidenced by: Based on record review, observation and interview: 1. The Governing Body failed to take action to prevent neglect when they failed to a) identify and resolve systematic problems related to supervision, neglect, resident injury; b) implement policies/procedures regarding investigation of physical injuries, including injuries that require residents to leave the facility immediately to prevent harm to themselves or others; c) follow the facility's policy/procedure regarding resident physical injuries, nursing services and investigation/reporting of physical injuries; 2. The Governing Body failed to a) ensure resident records contained an accurate account of all information relevant to the resident, including significant incidents such as falls, assessment, and pain management following a fall; b) implement corrective action plan to maintain resident safety. 3. The facility failed to a) seek medical treatment for R3 for several days after the injury; b) ensure	Z9999		

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Z9999	Continued From page 2	Z9999		

falls with injuries for one of one resident (R3) were reported immediately to the Administrator; c) promptly notify resident's guardian of significant incidences. This occurred for 1 of 1 (R3) in the sample who obtained a fall with injuries and required hospitalization.

These failures affect 3 (R1, R2, R3) of 3 residents in the sample and 13 of 13 (R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14 and R15) residents outside the sample.

Findings include:

1. Facility Policy number 5.24, dated August/2017 titled, "Investigation Committee" states, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness" ..."C. To protect individuals from further harm." ..."A. Any home employer or agent who witnesses or suspects a violation of individuals rights, peer to peer incidents, reasonable suspicion of a crime, abuse, or neglect as well as injuries of unknown source shall immediately report the matter to home management using the following protocol: 2. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: Administrator, Executive Director, Director of Operations" ..."4. The employee or agent will write a detailed, factual statement regarding the incident on a progress note (Form #GP-15) prior to leaving the shift." ..."B. If the allegation is that the employee committed an act of abuse or neglect, the employee shall be suspended from duty until such time as the, 1. Investigation is complete and 2. The Administrator considers the report and takes Administrative action." ..."E. The committee members shall meet to review the allegations,

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Z9999	Continued From page 3 conduct interviews and examine the information available that is pertinent to the incident." Facility Policy dated October 2017, number 6.12 titled, "Transfer/Discharge" states, "Purpose A. To identify that person eligible for discharge. B. To provide a mechanism for movement of individual. C. To provide a framework for communication concerning discharge. D. To provide follow up service." The policy includes "Emergency Discharge to State Home (references state operated facilities)" and "Discharged to other than state homes." The policy failed to include directives to staff of what to do in the event of an emergent or urgent need for residents to leave the home immediately other than medical issues. The policy also failed to give directives regarding communication and documentation of events involving emergent or urgent transfers , notifications to guardians, facility Administration, state officials, forms to complete, consents to obtain, medication and personal belonging distribution. "Emergency Order of Protection" issued on 8/18/18 at 2:30pm signed by clerk of the circuit court of Cook County states, "R1 is prohibited from entering or remaining at (address of facility) and R1 is ordered "absolutely no contact with R2 by any means." Incident report dated 8/17/18 at 9:30pm, unsigned by writer of the report states, "R2 reported that R1 kissed him without consent and tried to have sex with him. R2 was separated from R1, R2 stayed with staff and played (card game) until R1 fell asleep," contact to Z4 (Qualified Intellectual Disability Professional/QIDP) 9:40pm and 9:40pm no response."	Z9999		

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Z9999	Continued From page 4 Incident report (day after above incident), time of occurrence dated 8/18/18 at time of 7:06 (scratched out with single line), 9:30 (scratched out with single line), 7:06 (am scratched) pm circled written by Z4 states, "via telephone in the dining room with staff. R2 reported that R1 kissed him without consent and R1 tried to have sex with him. Staff was informed to keep R2 in sight at all times." "Z5 (Administrator) notified at 7:20pm." However, Z4 does not indicate on the incident report if the Administrator was notified on 8/17/18 (day of incident) resulting in inability to assess when directives were given to staff from the Administrator regarding this incident. Individual Service Plan dated 12/22/2017 states R1 is 41 years old with an Intellectual Function level of Moderate, Intelligence Quotient of 41 and a Broad Independence score of 6 years. R1 has a state appointed public guardian. A health history and assessment dated 2/14/18 states R1 is 6 feet in height and weighs 268.2 pounds. R1's supervision is recorded as "in home with staff." General note dated 8/18/18 (not timed) and written by Z4 (QIDP) states "R1 spoke with the QIDP and stated he did kiss R2 without his permission. R1 stated he took his clothes off but R2 kept his on." "The QIDP contacted R1's family and arrangements were made to pick R1 up to keep him at home until a CST (community support team) can be held on Monday, August 29th, 2018." The note failed to include what policy or procedure directed Z4 to decide R1's family should pick R1 up from the facility. Review of R1's record, electronic mail communication, report to Illinois Department of Public Health, and facility documents identified an	Z9999		

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Z9999	Continued From page 5 8/17/18 incident of sexual inappropriateness from R1 to R2. The records failed to include documentation of what action occurred following the incident from 8/18/18 to 8/28/18 (ten days), such as under what conditions did R1 leave the facility, R1's residential status change, if R1 will remain with guardian or R1's mother, if R1 will be transferred, and administrative directives and/or meetings regarding R1. Surveyor was unable to identify a framework of communication regarding R1's urgent departure from the facility on 8/18/18. E1 (Administrator) was interviewed on 10/22/18 at 1:00pm. E1 reviewed the stated policies and confirmed the policy did not address procedures for urgent/emergent resident departure from the facility for short term/long term and/or permanent basis other than medical. E1 also states she would check any information regarding staff, guardian, administrative communication and or documentation of R1's residential status from 8/18/18 to 8/28/18. E1 was unable to provide surveyor with any evidence. E1 was also unable to show evidence of facility's policy/procedure that staff would follow in the event R1's family lived out of town or could not be contacted once order of protection was received for R2. 2. Facility Policy number 5.27, dated October/2017 titled, "Physical Injury and Illness/Individual Medical Emergencies" states, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness" ..."Individuals served by the agency shall receive timely and effective medical services for physical injuries and illnesses and medical emergencies" ..."Procedure: In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action	Z9999		

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Z9999	Continued From page 6	Z9999		

consistent with the policy: A. As soon as the injury or illness is determined to be a medical emergency, the Direct Support Person/DSP shall conduct observation and take appropriate action consistent with the following: A. As soon as the injury or illness is determined to be a medical emergency, the DSP is to call 911 and follow the steps E of this policy. B. Observe the individual to determine basic information necessary for nurses or physicians to make further judgment. C. Notify the RN for consultation and QIDP or Administrator for direction." ..."c. Notify the nurse for consultation and Qualified Intellectual Disability Professional/QIDP." ..."F. The QIDP will notify the guardian and/or relative designated by the individual of the situation as soon as possible" ..."G. In the case of abuse, neglect, or injury of unknown origin, the staff who witnessed or first became aware of the incident shall report the incident according to policy 5.24." ..."In the case of injury the staff who first became aware of the injury shall document the incident on a separate progress note (GP-15)."

Facility Policy number 7.02, dated August/2017 titled, "Nursing Services" states, "Purpose, 1. To provide quality healthcare 24 hours per day to individuals in need. 2. To maintain an optimal level of health care to all individuals via Registered Nurse Trainer intervention. 3. To serve as a primary resource of health care and provide education to direct care personnel." "Procedure: 1. The Registered Nurse, Trainer as a Registered Nurse or Advance Practice Nurse in Illinois shall provide care for minor illnesses, injuries, and emergencies," "4. The RN Trainer shall complete individuals' health assessments, review monthly physician's orders and lab results, provide concise documentation with appropriate medical professionals and management staff

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Z9999	Continued From page 7 during routine scheduled and as needed visits to facilities." Per record review, R3 is a 60 year old male admitted to the facility on 2/1/2016. Per Individual Service Plan (ISP) dated 2/8/17 (no current ISP provided upon multiple requests), Intelligence Quotient (IQ) is 70, Intelligence function is Mild and a Broad Independence score of 10 years and 9 months. R3's diagnoses include Asperger's Syndrome, Depression and Psychosis. Risperdal 2mg is prescribed for Psychosis. Communication skills are listed as verbal and "good communication skills." R3 has a state appointed public guardian. On admission, R3 was recorded to walk with a "slightly shuffled feet." A physician note written by Z11 (Neurologist) dated 9/18/17 states, "R3 has apparently become worse." "Impression: Acute onset gait disturbances." "Trial Myrbetriq 25milligrams due to contraindication with anticholinergics, especially with his unsteady gait, frequent falls requiring walker." R3 used a walker on the day of his fall (9/11/18). Per review of R3's record, nursing monthly summary, nursing quarterly notes from October 2017 to August 2018 and the health care nursing contribution to the ISP dated 2/8/17, all failed to include a nursing care plan or safety measures initiated based 9/18/17 neurologist assessment (over a year ago) that R3 has become worse in ambulation and have unsteady gait disturbances. Review of R3's record from 9/11/18 to 9/13/18 failed to include nursing assessment of these fall risk factors for R3. Per Incident report review dated 9/11/18, E3 (Direct Support Person/DSP) states, "R3 said he	Z9999		

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Z9999	Continued From page 8	Z9999		

slipped in the shower."
"Cause: slipped" "witnesses: none" "location of occurrence (be specific): 7th - 8th rib on left side."
"Conclusion/resolution: Body was checked. No visible bruising or injury."
"Persons notified: Z4, Qualified Intellectual Disability Professional, (QIDP) and E2 (Registered Nurse) on site."
"Instructions(s) given: monitor and assess changes."
"Instructions(s) given: nurse on site at time report was given. Head to toe assessment performed no visible injuries noted." E3 DSP signature.
"All lines must have an entry. If something does not apply please put non applicable."

The same Incident Report:
a) is blank for area requesting Administrator name and time of notification.
b) failed to include R3 reported a fall, report states "slipped"
c) not completed by the staff who received first knowledge of the incident E2 (RN) as required by facility policy.
d) lacked instructions E2 (RN) gave to staff of what to monitor R3 for.
e) failed to include R3 complained of pain at the time he reported fall to E2 (RN).

The incomplete incident report was not addressed in the facility's Investigation completed report dated 9/19/18

The investigation report failed to include/address the following:

a) Environmental assessment of shower room where R3 fell (see observations made by surveyor).
b) Staff failure to notify guardian in a timely

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Z9999	Continued From page 9	Z9999		

manner.
c) Incident report inconsistencies and not completed as policy required.
d) Administrator notification as required by facility's policy.

The Investigation Committee Report conducted by E17 and E18 (both Regional Trainers), dated 9/19/18 was reviewed. The report states, "1. E2 (RN) "needs to be retrained on what incidents/accidents constitute that an individual should be taken for medical services at local hospital per policy 7.02. 2. Also E2 needs to be disciplined and retrained on completing nursing notes per policy 7.02. 3. Staff need to be retrained on how to assist R3 with his shower so that all staff follow the same procedure to ensure he does not fall in the bathroom again. 4. Staff need to be retrained to notify the nurse when an individual is transported to the hospital. 5. E2 needs to be disciplined for not making the decision to send R3 to the emergency room immediately and R3 waited 3 days before he went to the hospital."

An interview with E2 (Registered Nurse/RN) on 10/10/18 at 11:00am and again on 10/24/18 at 10:45am confirmed that 1) R3 reported his fall directed to her on/9/11/18, complained of pain to the area and identified the pain to his left side on both 9/11 and 9/12/18 during a visit to the home; and 2) E2 did not notify the physician. E2 states she received a call from Z4 (QIDP) on 9/13/18 that R3 was still in pain and she was taking him to the hospital.

Per review of "Employee Disciplinary Action" dated 9/11/18 and 9/18/18 states E2 (Registered Nurse/ RN) received "written warning" and was not suspended as facility's policy requires. The

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	IL6012959	A. BUILDING: _____ B. WING _____	C 11/21/2018

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Z9999	Continued From page 10 same document signed by E1 (Administrator) and E6 (Executive Director) includes E2 "neglected to direct staff to send an individual to the hospital/urgent care after being notified that the individual took an unwitnessed fall and complained of pain." E2's work schedule was reviewed for September 2018 and includes un-interruption of work to the facility. Per interview with E1 (Administrator) on 10/25/18 at 2:15pm, E1 was asked if E2 was suspended at any time once the allegation of neglect to R3 occurred on 9/17/18. E1 states, "No." Review of an in-service conducted by E15 (Regional Nurse Trainer) given to E2 includes E2 attended a "session" of "review of policy 7.02 nursing services, thorough and timely nursing documentation and assessment post injury; review of policy 5.57 Physical injury and Illness/Individual Medical Emergencies." The date of the in-service is dated 9/26/18 (8 days after neglect was identified by the facility). E2 continued to provide nursing services to all residents living in the home when facility policy required suspension. Per telephone interview with E22 (Regional Trainer) on 10/30/18 at 10:01am, E22 was asked how was the decision made by the organization of the time period of when corrective actions, training or retraining will occur after an incident of negligence. E22 states, "I retrain when I am advised by the Administrator." Surveyor asked if the investigation for R3 was completed on 9/19/18 and the conclusion results were policy and procedure were not followed by staff, why did retraining or corrective action not occur until 9/26/18 (8 days later.) E22 states, "I trained on the date I was advised by the Administrator."	Z9999		

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Z9999	Continued From page 11 Per interview with E1 (Administrator) on 10/24/18 at 10:38am, E1 was asked when R3's guardian was notified of R3's fall on 9/11/18 and transport to emergency room on 9/13/18. E1 states the guardian was at the facility "first thing" Friday morning, 9/14/18. E1 states she will check if Z4 (former Qualified Intellectual Disability Professional) documented when she contacted the guardian, Information was not received by surveyor. Observations were made on 10/10/18 at 12:30pm of both bathrooms in the facility that all residents utilize for toileting, personal hygiene and shower use. The residents' bathroom located on the south west side of the facility is the bathroom identified by E2 where R3 fell on 9/11/18 and obtained rib fractures. The bathroom does not have a stand-alone shower but rather a shower horizontal over the bathtub which requires a two feet step over to access the shower. The shower mat was found to be worn, suction cups do not adhere to the base of bath tub and the mat slides. The entrance to the bathroom has a 4 inch by 2 inch metal strip which was found to be loose and impacts the step when the foot is not lifted completely to step over it. These observations were pointed out for corrections with E2, who was with the surveyor at findings. Observations were made again on 10/24/18 at 11:15am of the same bathroom on the south west side of the facility. The bathroom was found in the same condition. E2 confirmed this with the Surveyor at the time of finding. E21 (Maintenance) came to facility at 12:00 noon on the same day and secured metal strip to entrance to bathroom and the other corrections were made.	Z9999		

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Z9999	Continued From page 12 Per interview with E17 (Regional Trainer) on 10/24/18 at 12:00pm, E17 conducted the investigation regarding R3's fall and fractured ribs. E17 confirmed the above information listed. E17 states, "I don't think we addressed (the bathroom safety risks)." "I did a quick glance of the bathroom." "I don't know if the guardian was notified." "We usually do look at the GP-15 depending on what is happening in the GP-15. The GP-15 should have been part of the investigation; not sure how the GP-15 was left off." E17 was asked why failure of the staff to use fall precautions for R3 were not included in the investigation. E17 states, "Not sure." Per interview with E2 (RN) on 10/24/18 at 10:30am, E2 was asked if R3 should have showered unassisted or unsupervised with the use of a walker and unsteady gait. E2 states, "No, I asked E3 (DSP) about the unassisted shower and she said, 'No they don't assist him.'" 3. Per nurse's note dated 9/11/18 (not timed) written by E2 (Registered Nurse), "Upon coming out of another individuals room this writer was stopped by R3 who stated 'I slipped coming out of the shower.' While R3 was completely dressed when he reported his fall, when queried as to who helped him up, R3 stated 'I managed to get up myself.' Head to toe assessment performed; no visible injuries noted at this time. R3 complained of mild to moderate pain, pain management implemented, fall precaution implemented. Respiratory - easy non-labored; continues to ambulate with walker gait/balance impaired." The facility was not able to show evidence that fall precautions were implemented or that E2 gave pain medication or implemented pain	Z9999		

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Z9999	Continued From page 13 management for R3. Review of R3's record failed to include evidence that a nursing assessment was completed for R3, medical instructions were given to staff regarding monitoring R3, if pain medication were administered by E2 (RN), physician notification regarding R3's injury or that fall precautions were implemented. Per interview with E1 on 10/29/18 at 12:55pm, E1 was asked when she received notification that R3 had sustained an injury through a fall. E1 states she was notified by Z4 (QIDP) on 9/13/18 (2 days after incident occurred.) Z12 (Guardian for R3) stated per telephone interview with on 10/29/18 at 4:30pm, "I was not notified of R3's fall when it happened on 9/11/18. I wasn't notified until the evening on September 13th when he was already in the hospital. They didn't let me know." Per hospital note dated 9/14/18 written by Z9 (Physician) states R3, "presents to the emergency room after a mechanical fall. The fall happened 4 days ago while he was trying to shower by himself. He stated the fall was unwitnessed. He was having the shower unassisted as well. Patient states left side was endorsed with pain after the fall on the left side. Pain persists since the fall. Stated he has not taken any pain medication." "Patient endorsed a cough for about a week now. He states he has some sputum non-bloody. He stated the cough is making the pain worse." Per hospital emergency department notes dated 9/13/18 at 10:58am written by Z8 (Physician) includes x-ray ribs and chest x-ray, "Impression:	Z9999		

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1. Minimally angulated left posterolateral 6th through 9th rib fractures, possibly also involving the 10th rib." "Streaky opacities along the left lung base are nonspecific but favored to represent pulmonary contusion or subsegmental atlectasis."

Per hospital admission note dated 9/13/18 at 8:39pm written by Z1 (Hospital Physician) states, "multiple rib fracture from fall. Patient has lung contusion. Pain management."

Z4 (Hospital Physician) documents on 9/14/18 at 12:02am, "patient requires hospitalization for 2 nights or more."

Per interview with E3 (DSP) on 10/29/18 at 1:13pm, E3 was asked if E2 (RN) gave her instructions before E2 left the home after R3's fall. E3 states she was told to monitor for bruising and that was it; "maybe pain." E3 states E2 "told me to check on him throughout the night." E3 was asked if E2 gave E3 instructions on what specifically to check for throughout the night. E3 states, "No but I checked on him again and he said it hurts and he said it hurts when he coughs."

Per interview with E7 (Direct Support Person) on 10/24/18 at 9:52am, E7 worked 11:30pm to 9:00am (the night of R3's fall.) E7 was asked if she received fall precautions, instructions on monitoring R3 or pain management instructions from nursing. E7 states, "No fall precautions that I recalled. E3 (DSP) told me R3 took a fall. R3 told me he was sore and pointed to his side. I asked if he needed medicine and he said, 'no.'"

(B)