| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6005789 | A. BUILDING: _____ B. WING _____ | C 05/22/2025 |

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| Z 000 | COMMENTS<br><br>Facility Reported Incident of 02/04/2025/ IL188998. | Z 000 | | |
| Z9999 | FINDINGS<br><br>Statement of Licensure Violations:<br>350.620a)<br>350.1210b)<br>350.3240a)<br><br>Section 350.620 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.<br><br>Section 350.1210 Health Services<br><br>b) The facility shall provide all services necessary to maintain each resident in good physical health.<br><br>Section 350.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. (Section 2-107 of the Act) | Z9999 | | |

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| Z9999 | Continued From page 1<br><br>These Requirements were not met as evidenced by:<br><br>Based on observation, record review, and interview, the facility failed to prevent neglect for 1 of 1 resident in the sample (R3) who had a fall with a facial injury, that caused fractures of two teeth and surgical extraction. This failure affected 1 of 3 residents (R3) reviewed for falls.<br><br>Findings include:<br><br>R3's Individual Service Plan (ISP) dated 3/23/25 indicates R3 is a 27-year-old, male who functions in the Profound level of Intellectual Disability, and is deaf, non-verbal, and has Low vision.<br><br>The facility's final report investigation dated 04/17/25 includes "...Progress note indicated on 04/17/25 at / around 10:30am, report called to the bathroom next to Day Training (DT) classroom.' R3 to have endured a fall with cranial impact. Staff (E3) reported R3 to have fallen on the floor while changing. R3 reported to have landed 'face first.' Upon arrival, R3 observed to be sitting upright on 'changing station' with support of two staff. Blood observed to be pooling in his mouth. Lower lip observed to have some inflammation. R3 was repositioned with slight forward lean to prevent choking/aspiration. A gauze pad was used to absorb/remove pooling blood. Source of bleeding was difficult to identify but appeared to be originating from right-Upper Gumline. Gauze was placed between gums and lip, secured in place with light external pressure. Gauze was continually changed as needed due to saturation of blood/saliva. 911 called to order ambulance, due to inability to establish hemostasis (control bleeding)." | Z9999 | | |

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| Z9999 | Continued From page 2 | Z9999 | | |

R3's Dental Health Report dated 4/18/25 indicates -ecchymosis (bruising) of right lip with swelling, dental x-rays indicated apically displaced #6, #7 with lingually displaced #5 (did not assess occlusion) bruising of gingiva (gum)-slight purulence (pus) noted. Plan of care included, allow for swelling to decrease, Extract tooth #6, #7, and likely #5 in 1 week finish course of pain meds, soft diet for 2 weeks. R3's Dental Health Report dated 4/25/25 indicate -R3's tooth #6, #7 were extracted, Tooth #6 root was horizontally fractured due to fall, needing to be surgically extracted.

R3's Risk Assessment dated 01/20/2025 indicates that, R3 is dependent upon staff for all safety needs and awareness. R3 needs continuous monitoring to avoid injury from falls. R3 has incredibly limited vision currently and uneven gait. R3 is fully dependent on staff assistance and has been going blind for the last two years.

On May 19th, 2025, E5 Qualified intellectual Disability Professional (QIDP) stated that R3 requires 1:1 contact guard assistance at gait belt for transfers on and off the toilet during toileting. Staff should move R3's hands to cue R3 to hold onto grab bars for transfers during toileting, into/out of shower and off shower bench. E3 (DTI) failed to follow R3's plan of care. R3's plan of care was last updated 12/29/2020. R3 does not have an updated plan of care since the fall incident on 04/17/2025.

The facility's Inter Disciplinary Team (IDT) Change Form /Therapy Inservice Documentation dated 12/29/2020 indicates, R3 was reassessed by physical and occupational therapy due to

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| Z9999 | Continued From page 3 | Z9999 | | |

reports of visual and mobility changes.
Functional mobility: R3 requires 1:1 contact guard assistance and gait belt for all transfers and ambulation.
Dressing & Oral/Facial Hygiene: Provide 1:1 contact guard assistance at gait belt when R3 is standing at sink (e.g. for hand washing). Have R3 sit for activity of daily living (ADL's)'s when possible (e.g. for facial shaving, brushing teeth, and dressing).
Toileting: Provide 1:1 contact guard assistance at gait belt for transfers on/off the toilet.
Bathing: Provide 1:1 contact guard assistance at gait belt and move Tommy's hands to cue him to hold onto grab bars for transfers into/out of the shower and on/off shower bench.
Sensory aides for hearing impairment and low vision: Continue to ensure R3's environment is well lit during times R3 is ambulating and performing ADL's. Provide tactile cues whenever possible (e.g. place R3's hands on grab bars during transfers, place toothbrush in his hand, use hand-over-hand assistance when needed, etc.)

On May 19th, 2025, at 10:00 a.m. E3 Developmental Training Instructor (DTI) stated that she was changing R3 in the resident bathroom at Day Training (DT). R3 was in a standing position facing the bathroom wall while holding it for support. E3 turned around to gather more wipes when R3 lost his balance, fell forward, and landed face first on the bathroom floor. E3, did not have R3's 1:1 contact guard assistance at gait belt at the time R3 fell. E3 tried to grab R3 to prevent the fall but she was not fast enough.

On May 19th, 2025, at 9:45 am, observation was conducted at Day Training (DT) in the resident

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bathroom where R3's fall incident occurred. The bathroom contains three-bathroom stalls and three sinks. Upon entry to the bathroom, a changing table station was on the right side next to the bathroom stalls and a storage cabinet on the left side next to the bathroom sink. There were no grab bars on the walls in the stall that R3 was holding during incontinent care, next to the changing table station.

On May 16th, 2025, at 11:00 am, E1 (Administrator) stated that R3 fell in the bathroom at Day Training center during incontinent care. R3 was holding the bathroom wall when Staff turned to grab more wipes, R3 lost balance and fell. E3 Direct support person (DSP) did not follow R3's plan of care because that was how they changed R3 during incontinent care.

On May 19th, 2025, at 10:00 a.m., E7 (Day Training Director) stated that R3 requires 1:1 contact guard at the gait belt while toileting. R3 has always been changed in the bathroom while in a standing position while holding the bathroom wall or bathroom sink and should be monitored continuous during toileting.

On May 19th, 2025, at 10:15 am, E6 Direct Support Person (DSP) stated that R3 holds on the sink with 1:1 contact guard at the gait belt during incontinent care and monitored continuous. R3 should not be left unattended.

Facility policy dated April 2025 CHK. Page 5) indicates Neglect: An employee's, agencies, or facility's failure to provide adequate medical care, personal care, or maintenance, and that, as a consequence, causes an individual pain, injury, or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an

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| Z9999 | Continued From page 5<br>individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm or death. (B) | Z9999 | | |