STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

CORNERSTONE HOME — 0033837

Facility Name — I.D. Number

1009 SOUTH IRVING, MONTICELLO, ILLINOIS 61856
Address

Date of Survey: 03/04/2004

Annual Survey

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.1210b) Nursing services to provide immediate supervision of the health needs of each resident by a registered
350.3210o) professional nurse or a licensed practical nurse, or the equivalent.
350.3240a)
350.3240f) The facility shall also immediately notify the resident=s family, guardian, representative, conservator and any private or public agency financially responsible for the resident=s care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

RESIDENT AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A REPORT OF SUSPECTED ABUSE OF A RESIDENT INDICATES, BASED UPON CREDIBLE EVIDENCE, THAT ANOTHER RESIDENT OF THE LONG-TERM CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT RESIDENT=S CONDITION SHALL BE IMMEDIATELY EVALUATED TO DETERMINE THE MOST SUITABLE THERAPY AND PLACEMENT FOR THE RESIDENT, CONSIDERING THE SAFETY OF THAT RESIDENT AS WELL AS THE SAFETY OF OTHER RESIDENTS AND EMPLOYEES OF THE FACILITY. (Section 3-612 of the Act)

These Regulations were not met as evidenced by the following:

A) Based on interview, file verification and observation, the facility neglected to implement their policies regarding client protections, abuse and neglect in that; (a) individuals who are the recipient of other clients physical/psychological harm have not been identified; (b) there is no reproducible

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documentation that individuals who are the recipient of other client=s physical aggression are checked for injuries; (c) the facility neglected to prevent R3's continued physical/psychological harm towards other residents; in that the facility did not provide increased monitoring for R3, on a formal basis, until 2/9/04 (at the day training site) and until 2/26/04 (at the residential facility), with potential to affect 15 of 15 individuals (R#'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 , 11, 12, 13, 14 & 15).

1.) The facility neglected to identify the recipients of R3's, R2's and R1's physical/psychological harm toward other individuals of the facility.

Per review of a facility document entitled, "Illinois Department of Public Aid IOC Worksheet", presented on 2/24/04, there are 15 individuals who currently reside at this facility. Two (2) of the individuals function in the mild range of mental retardation; six (6) function in the moderate range of mental retardation; three (3) function in the severe range of mental retardation and four (4) function in the profound range of mental retardation. R4 (profound) and R15 (moderate) have an additional diagnoses of Legal Blindness. Per observation, R15 also utilizes a walker to assist in her ambulation, and per her current physician orders sheet has a diagnoses of Cerebral Palsy. R1 (mild) also has an additional diagnoses of blindness. Per a facility document presented on 2/26/04, the facility has identified R5 (severe) and R6 (profound) as non-verbal. This same document identified R#'s 4, 12, 7, 3 and 14 as verbal, but not interviewable. R#'s 8, 9, 10, 2, 11, 1, 3, 14 and 5 are on BSP's (Behavior Support Program) and require medications to assist in their behavior control.

In review of facility created "A-B-C- Data Collection Form" sheets, the following is documented:

8/9/03 - R2, "tried to drag another client off bike, hit/kicked the other client".

9/18/03 at 7:25-7:27 - R1 "punched & pushed another resident".

9/18/03 at 7:40-7:42 - R1, "punched & threatened another resident".

10/6/03 - R1, "striking resident on face".

7/21/03 - R3, "threw rocks, spit and chased a female resident waiting for her ride to work".

8/11/03 - R3, " .....spitting on residents...".

9/17/03 - R3, ..."physical altercation w/ another client...".

9/24/03 - R3, "...."pinched another client...".

1/30/03 - R3, "not letting other clients have their lunch boxes, smacking clients on the butt.....".

For R3, there are additional incidents of physical/psychological harm for the following dates: 10/9/03, 10/22/03, 11/3/03, 11/7/03, 11/1/03, 12/3/03, 1/20/04, 1/22/04, 1/26/04, 2/5/04, 2/10/04, 2/11/04 and 2/16/04.

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E2 (Residential Services Director/Qualified Mental Retardation Specialist {RSD/QMRP}) was interviewed at the facility on 2/26/04. E3 (Administrator) was also present for the interview. At this time, E2 confirmed that after the ABC sheet is completed, no reproducible documentation is further completed as to who was aggressed upon. E2 further stated that he had instituted the ABC sheets upon his employment at this residential facility (07/03). Per review of facility records there is no evidence of any other system for documenting resident behaviors which identifies residents who have been the recipients of aggression. E2 also confirmed that there is no reproducible evidence of guardian notification for the client to client maladaptive behaviors identified above. As E2 went through some of the ABC sheets with surveyor, E2 could identify by memory what resident aggressed on what resident, but confirmed he could not remember all of them.

E5 (Housekeeper/Habilitation Aide) was interviewed on 2/26/04 regarding an 11/3/03 incident when R3 hit two other residents. E5 could not recall who R3 hit.

E1 (Food Service Director/Medical Director{FSD/MD}),was interviewed on 2/26/04 regarding a 1/26/04 incident when R3, "hit other clients". E1 stated that she was "pretty sure" that R3 hit R13, but could not remember more, that it was too far back.

In an interview with E1 on 3/1/04 at the facility, E1 stated that prior to the implementation of the ABC sheets (07/03), individual's behaviors were recorded on a data collection sheet with a mark placed by the specific behavior. The marks could than be tallied, specific to each behavior. E1 (who per the health care worker background check has been an employee of the agency since 06/88) confirmed that this method of data collection did not identify the recipient of the maladaptive behaviors either. When the data sheets for April/May/June/03 for R3 were requested, E2 stated that the facility no longer had this data. He stated (on 3/2/04 at the facility), that once the data has been entered into the computer program, the data sheets are not saved.

Additionally there are instances on R3's ABC sheets where R3 has been hitting, pinching and biting, but it is not specific as to whether R3 aggressed upon staff or other residents. E1 and E5 were interviewed on 3/2/04 at the facility regarding ABC incidents documented on 2/17/04 and 2/23/04, that state that R3 was, "hitting, pinching & spitting"....."hit spit-pinch.....". (E1 and E5 were the staff on duty regarding the dates in question and had also initialed the ABC sheets for those dates). When asked, E1 and E5 were not sure, but thought that R's 13, 8 or 7 were "probably" the recipients of R3's described behaviors. E1 stated that R3 also pinches staff, and was not sure about the 2/17/04 and 2/23/04 dates. Additional dates on the ABC sheets for R3 where it is not documented as to whether R3 physically aggressed/spit on staff or residents are as follows: 7/14/03, 9/10/03, 9/25/03, 10/5/03, 10/22/03, 10/24/03, 11/4/03, 12/4/03, 12/9/03, 12/12/03, 12/17/03, 12/18/03, 12/19/03, 12/23/03, 12/28/03, 12/31/03, 1/13/04, 1/14/04, 1/20/04, 2/23/04, 2/24/04, and 2/26/04.

2. The facility neglected to provide a reproducible documentation system to ensure that individuals who are the recipients of physical aggression are checked for injuries, with potential to affect 15 of 15 individuals (R#'s 1-15).

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R's 1, 8 and 13 were interviewed individually on 2/26/04 at the facility in the presence of E3 (Administrator). (The above individuals were identified by the facility as being interviewable, per a document presented by the facility on 2/26/04, at surveyor request). R1 stated that when R3 hits him, he hits him, "in the arm" and "it's a hard hit". R13 stated that when R3 has hit her, its,"a hard one and it hurts like crazy". R8 stated that when R3 hit him, it, "hurts a lot".

In an interview with E2 in the presence of E3 on 2/26/04, E2 confirmed that there is no reproducible documentation that individuals have been checked for injuries after the ABC sheets have documented physical aggression from one client to another.

3. The facility neglected to prevent R3's continued physical/psychological harm towards other residents; in that, increased monitoring was not provided for R3, on a formal basis, at the day training site until 2/9/04 and at the facility until 2/26/04.

Per review of R3's current physician's order sheet, R3 is a 36-year-old male who functions in the severe range of mental retardation, with additional diagnoses of Depression and Psychosis NOS. R3's 9/22/03 Nutritional Evaluation states that R3 is 5' 8" tall and weighs 301 pounds. His 5/16/03 face sheet documents his admit to the facility on 11/18/88 and also documents guardianship by his mother.

A 5/7/96 psychological report for R3 documents a history of property destruction, physical aggression, elopement and depressive symptoms. The report further states that during his episodes of increased irritability, R3 frequently becomes easily agitated and strikes out at staff and peers. Additionally, the report states that R3 has a formal Behavior Management Plan to address his depressive episodes and elopement. A 10/15/03 psychological evaluation documents that R3 receives psycho tropic medication to assist in his mood and behavior, that he has a formal behavior support program to address spitting at others, physical aggression, property destruction and elopement. This report further documents that R3 tends to take out his frustration and disappointment on others by attempting to hit or otherwise harm others or property.

The ABC document states that staff attempted to redirect with no success and that the behaviors continued until R3 got on the work van. The time is listed as 6:00 a.m.- 8:00 a.m.

8/22/03 - "....hit walls and furniture, spit at staff & clients, used obscenities & obscene gestures repeatedly over the 2+ hour period (time listed as 6:00 a.m.- 8:00 a.m.).

9/17/03 - "...physical altercation w/ another client...". This entry also states that R3 hit walls, cursed, spit, made obscene gestures and that the behaviors began at 4:00 a.m., lasting until bus time.

10/9/03 - "...spitting on clients...".

10/22/03 - "...spit on another client off & on until bus time".

11/3/03 - "...hitting 2 residents...".

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11/10/03 - "...blocking resident from going out...".

12/30/03 - "not letting other clients have their lunch boxes, smacking clients on the butt.....".

1/22/04 - "hit another client in the head...".

From 7/6/03 to 2/26/04, R3's ABC sheets document numerous behavioral incidents for R3 with regards to pounding on walls and furniture, hitting windows, yelling, using obscene language and gestures, spitting at and on residents and staff, throwing rocks, throwing objects at residents, hitting residents and staff, and keeping his roommate up with his behaviors beginning as early as 4:00 a.m. in his room.

On 2/26/04, R1 was interviewed at the facility in the presence of E3. R1, (per the facility level of functioning documentation sheet) functions in the mild range of mental retardation. Upon surveyor request, the facility provided a list of individuals who the facility felt were interviewable, and R1's name was provided. Per observations made on 2/24/04, R1 is ambulatory and verbal, using complete sentences. His current physician's order sheet documents Blindness as an additional diagnoses for R1. During the interview, R1 confirmed that R3 hits him. R1 indicated by gesture and verbally that R3 hits him in the arm (gesturing to the area between his elbow and shoulder). R1 stated that R3 hit him,"a lot" and that, "it's a hard hit". R1 further stated that, "he (R3), goes around and beats on staff.....bangs on walls and doors...bathroom door.....when I'm in there". R1 also stated that, "He (R3) spits on me too and on the floor..". R1 stated that when it lands on him it sometimes lands on his forehead. R1 pointed to his forehead as he spoke about R3's spitting. R1 stated that it makes him feel, "not good" when R3 hits him.

On 2/26/04, R13 was interviewed at the facility in the presence of E3. R13 (also interviewable, per facility document) functions in the mild range of mental retardation (per facility level of functioning documentation). Per observations made on 2/24/04, R13 is verbal, using complete sentences. Additionally R13 has Cerebral Palsy (physician order sheet) and per observations ambulates with a limp. Per R13, she has been hit by R1 on the arm. She also identified R3 as having hit her. She stated that she thought she was hit on her back and that it was, "a hard one and hurt like crazy", referring to R3. R13 also confirmed that R3 has spit at her, that sometimes it gets on her face. She stated that she just wipes it off with her shirt sleeve.

On 2/26/04, R8 was interviewed at the facility in the presence of E3. R8 (interviewable per facility document) functions in the moderate range of mental retardation (per facility level of functioning documentation). Per observations made on 2/24/04, R8 is verbal and ambulatory. R8 stated that R3 has hit him and gestured to his shoulder area. He stated that it, "hurts a lot". He also stated that, "He spit me" and that the spit, "got on my clothes". He stated that he felt, "pretty upset".

Review of R3's BSP (Behavior Support Program) document programming as far back as 11/29/99. The maladaptive behaviors to be decreased were spitting, physical aggression, property destruction and elopement. R3's BSP has been revised on 2/10/00, 4/24/01, 7/31/03, 10/15/03, 11/17/03 and 2/25/04. A document entitled, "Client to Client Aggressive Behavior Timeline for (R3)" documents that R3's BSP was revised after

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7/21/03 to remove CPI (Crisis Prevention Intervention) and replaced with clearing others from the area when R3 engages in aggression. Concrete reinforcers have also been added at each interval of R3's star chart reinforcer programming. Psychiatric notes also document medication changes for R3 over this time period.

A special Interdisciplinary Team meeting (IDT) was held on 2/9/04. The document states that R3 has had several incidents of physical aggression in the last few weeks and states that his mood is unstable. The day training site began 1:1 support for R3 on this date. E2 and three-day training site staff signed off on this IDT for R3. Confirmed per interview with E2 on 3/2/04 at the facility.

Per interview with E2 on 3/2/04, E2 confirmed that an informal 1:1 was implemented for R3 on 2/17/04 for the a.m. times only at the facility. E2 explained that informal 1:1 meant that staff were to keep R3 within their visual contact at all times. E2 stated that he had shared this information with E1 and E5. E2 confirmed that there was no reproducible documentation for this informal 1:1 for R3. (ABC sheets for 2/17/04 and 2/23/04 document R3's hitting, pinching and spitting in the a.m. hours. In interviews with E1 and E5 on 3/2/04 at the facility, both staff could not identify who R3 aggressed on, but thought it was probably R's 8, 7 and 13).

A facility document (Medical Visit Synopsis/Consultation) form dated 2/19/04 validates that R3's routine psychiatric appointment has been, "moved up due to (up arrow) Bx (behaviors)". This form further states, "Incidents of physical aggression toward peers.....". A facility document (Interdisciplinary Team/Human Rights Committee Telephone Conference) dated 2/19/04 documents an increase in irritability and aggressive behavior for R3 over the last few weeks. A medication change was initiated on this date.

On 2/26/04, the facility implemented formal 1:1 behavior support beginning in the p.m. (after R3's return from the day training site), for R3 during all waking hours, after the surveyor expressed concern for R3's aggressive behaviors towards other clients of the facility. An emergency IDT was then held for R3 on 2/27/04.

Review of facility policies states under "Condition of Participation: Client Protections" that, "The facility must ensure the rights of all individuals. Therefore, the facility shall: Ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or punishment.....You shall be treated with consideration and respect and with full recognition of your dignity and individuality....You shall not be mentally or physically abused".

Under the policy entitled, "Abuse and Neglect Policy for Detection and Prevention" it states, "Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...It is the practice of this agency to implement strong policies and procedures to detect and prevent incidents of abuse and neglect.....".

The facility neglected to take action to prevent the continued reoccurrence of R3's client to client physical/psychological harm in a timely manner.

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