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

PINE LAWN MANOR	0045708
Facility Name	**I.D. Number**

200 POPLAR DRIVE, SUMNER, ILLINOIS 62466
Address

Date of Survey: 2/10/2004

Complaint Investigation

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.

"REPEAT A" VIOLATION(S):

Facility failed to follow the IPOC for the survey of July 30, 2003, by failing to ensure that "...Review of existing policies and procedures regarding physical aggressive residents to identify:

...Staff are informed of the level of supervision required for each resident.

...All allegations of physical assault will be thoroughly investigated.

...Protection of other residents from physical aggressive resident.

...Policies and procedures are followed.

350.620a) **The facility shall have written policies and procedures governing all services provided by the**
350.3240a) facility which shall be formulated with the involvement of the administrator. The policies shall
350.3240f) 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.

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 PERPERTRATOR OF ABUSE. WHEN AN INVESTIGATION OF A REPORT OF SUPECTED ABUSE OF A RESIDENT INDICATES, BASED UPON

CREDIBLE EVIDENCE, THAT ANOTHER RESIDENT OF THE LONG-TERM CARE FACILITY IS THE

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350.620a) PERPETRATOR OF THE ABUSE, THAT RESIDENT'S CONDITION SHALL BE
350.3240a) IMMEDIATELY EVALUATED TO DETERMINE THE MOST SUITABLE THERAPY AND
350.3240f) PLACEMENT FOR THE RESIDENT, CONSIDERING THE SAFETY OF THAT RESIDENT
(Cont'd.) AS WELL AS THE SAFETY OF OHER RESIDENTS AND EMPLOYEES OF THE FACILITY.

Based on observation, interview and file review, the facility has failed to implement their own
policies and procedures that ensures that clients of the facility are not mistreated, neglected or
abused, as evidenced by:

1) The facility has neglected to take necessary actions to protect clients of the facility from client to client abuse and neglected to prevent reoccurrence, by their failure to investigation allegations and incidents of client to client abuse, and by their failure to provide sufficient, competent trained staff to protect the health and safety of nine clients of the facility (R3, R11, R12, R13, R14, R17, R18, R24 and R31) and additional unidentified clients of the facility who have been subjected to psychological and or physical abuse from newly admitted clients to the facility (R1, R2, R4 R5 and R8), having the potential to impact all forty seven clients of the facility .

2) The facility has neglected to provide necessary monitoring and supervision to clients with known special needs as evidenced by their failure to provide sufficient staff monitoring to ensure that clients of the facility are free from injury due to self injurious behaviors for one client in the sample (R8) who has documented incidents of sticking foreign objects including papers and coat hangers in his ear, coupled with stealing lighters and smoking unsupervised; and for one client outside the sample (R16) who has history of disruptive behavior (resulting in injuries) of pulling sinks off of the bathroom walls, who has had three documented incidents of pulling a sink off of the bathroom wall since the modification of his behavior program on 12/24/03, with two of those incidents (01/21/04 and 01/25/04) resulting in injury.

3) The facility has neglected to develop an active treatment program and to ensure sufficient staff monitoring by competent trained staff for one client in the sample (R6) who was admitted to the facility on December 17th, 2003 with a diagnosis of Depressive Disorder - Pyromania. File review identified that prior to R6's admission to the facility, R6 had been court ordered to a secured forensic facility on 09/25/02 on felony charges of arson and aggravated arson. As of 01/23/04, no active treatment program had been developed to address R6's diagnosis of Depressive Disorder with Suicidal behaviors, nor had staff been trained in techniques to meet the mental health needs of R6 as with other clients with dual

diagnoses, having the potential to impact all clients of the facility.

E1 (Assistant Administrator), E2 (Administrator) and E3 (Vice President) were notified and an Immediate Jeopardy was called on 01/29/04 at 2:15 P.M. in regards to the facility's failure to prevent neglect by their failure to provide sufficient, competent trained staff to supervise clients with known special needs; and failure to protect clients from psychological harm by their failure to provide sufficient, competent trained staff to intervene to prevent clients from creating an environment of fear.

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Findings include:

1) Clients of the facility have been subjected to psychological and physical abuse from newly admitted clients to the facility and the facility has neglected to take necessary actions to protect clients of the facility and to prevent reoccurrence.

a) File review identified that clients of the facility have been subjected to psychological and physical abuse from R8.

Per review of the Pre Admission Evaluation dated 11/13/03, R8 is an 18 year old male who functions at a mild level of mental retardation and has diagnosis of Intermittent Explosive Disorder, Schizophrenia, Attention deficit hyperactivity disorder and Scoliosis.

Review of the Nurse's Notes for R8 identified that R8 arrived to the facility on 11/14/03 and was placed on 1:1 staff escort. No further documentation was noted until 11/26/03 at 5:00 P.M. when documentation reflected that ... "some behaviors have surfaced such as verbal and physical altercations with others. Mostly displays motions of Kleptomania and picks up every loose item he passes by.... Tonight he was pretending to hit another res. (resident) by swinging items at the head and stopping just a couple inches from their skulls. He would run up behind someone in the hall and act like he was going to hit them with his fist, again stopping an inch or so away and laughing all the while. He began to torment another (helpless) resident by grabbing his hat and other items from his w/c (wheelchair) and running away with them and preventing him from getting into his own rm (room). After a lot of redirections, he (R8) agreed to go to bed." Further review of the Behavior Record for R8 dated 11/26/03 identified "R8 paced constantly all P.M. at times rapping with dirty phrases and sometimes phrases about killing. He was making motions like he was going to hit R17 on the head with a toy keyboard, He would swing it down to R17's head and would stop about 2 inches from R17's head. Was doing this repeatedly and wouldn't stop until I (E8 Nurse) called for E19 (Direct Care) and he (R8) laughed all while he did this. He came up behind others in the hall and would aim his fist at

the backs of their heads again, stopping just inches away from contact. When asked to stop these things, he just goes on laughing. He began grabbing things off R13's w/c, his hat and other personal items, and was keeping R13 from getting into his rm. In general, just teasing and tormenting R13, who became very scared and was crying hard for almost an hour."

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On 11/27/03 Nurse's Notes identified that at 10 A.M. that R8 "got into a verbal argument with another client and told client to shut up or he was going to kick his a-s and then all of a sudden this client stood up and punched another client with closed fist in the back of his head..." Review of the Behavior Record and the Incident Report dated 11/27/03, identified that R8 had hit R18 in the back of his head with his fist with R18 requiring an ice pack to the back of head.

Further review of R8's Behavior Record dated 11/30/03 identified, "R8 has continually paced throughout the building, taking things from others and loose items. . . He deliberately antagonizes other residents. He refused to get out of his roommates bed until nurse intervention and when he got up, he was hiding a fork bent into a weapon shape and also had a large pronged hair pick..."

On 12/01/03, Nurse's Notes identified that at 8:20 A.M., "Z1 (Physician) notified of resident (R8) collecting broken pieces of plastics, poking them in his ear, taking pieces of hanger and making it into a weapon and bending forks into weapons. Threatening residents and staff..." Further documentation identified that R8 was admitted to a local psychiatric unit on 12/01/03. R8 remained in the psychiatric unit until he was discharged back to the facility on 12/29/03.

On 12/31/03, Nurse's Notes identified that at 7:10 P.M. "...A nurse walked into a resident's room bedroom to administer tube feedings to 2 diff. (different) residents and R8 was hiding between the wall and bed of one of the res. (resident) (the name of the resident not identified)..."

Review of the Nurse's Notes dated 01/02/04 identified "late entry for 01/01/04 - A DT (Developmental Trainer) came to this nurse with a cigarette lighter and stated she went to

res. (resident) room and res. was smoking, hid cigarette between sheets and she saw it smoldering... She took cigarettes and put it out and made sure sheets were not burning." No further documentation was found to identify that additional monitor was started after R8 was found in his room smoking.

On 01/02/04, Nurse's Notes identified that R8 had been wandering in and out of other resident's rooms. Additional documentation was noted that identified that as resident (R11) alleged that R8 had choked him in front of Room 45 that morning. Review of the Incident Report completed by the facility noted that the incident had been reported at approximately 7:15 A.M. on 01/02/04.

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Documentation of the Daily Schedule for 01/02/04 identified that R8 was not placed on 1:1 monitoring until the 3-11P.M. shift. No documentation was noted to reflect that R8's 1:1 staff monitoring was continued on third shift for 01/02/04 or for 01/03/04.

On 01/04/04 Nurses Notes identified that a at 10:20 A.M., resident (R11) told staff that R8 "kneed a female resident #276 (R12) in the groin and then hit her in the abd. (abdomen)...Resident (R8) first denied hitting female, then said he hugged her then changed story to she grabbed me so I kicked her with my knee..." At 12 P.M. documentation identified that resident (R8) has been seen today by staff agitating other residents. Also a late entry was made at 1:45 P.M. that stated that at 12P.M., that a DT (Developmental Trainer) reports that resident (R8) came up behind him and resident #276 (R12) with a metal bar in his hand.

Further review of R8's Behavior Record dated 01/04/04 identified "Another resident (R3) approached staff very upset, He showed staff his broken DVD. He (R3) stated that this resident (R8) had broken it. R3 became so upset that he attempted elopement. R8 denies accusation. However the previous day he was observed taking this same item 2-3x's (times)."

Documentation of the Daily Schedule for 01/04/04 identified that R8 was not placed on 1:1 monitoring until the midnight shift. R8 remained on 1:1 staff monitoring until the 3-11 shift on 01/05/04. R8 was placed back on 1:1 monitoring on 01/06/04 for the morning shift.

On 01/11/04 Nurse's Notes identified that at 8 A.M., "Res. (resident) pacing halls, this nurse took a lg. (large) stick from him (R8) and he started rapping you make me mad and I'm going to beat you face in, etc.". At 2:45 P.M. Nursing Notes identified that R8 had stood in front of defenseless residents (client's names not identified) with arms spread out and growling at them.. Documentation also stated that R8 had stolen a lighter and a cigarette out of a PT (Physical Therapy) girls purse while in PT room and lit it in the bathroom, his 1:1 caught him and brought the lighter back to the PT girl... Res. continues to be on 1 on 1."

At 10:15 P.M., Nurse's Notes identified "Hab Tech reported to Nurse found him taking a metal clothes hanger and sticking the end of it into his ear... Resident then returned to his room and went to bed. Continues to be on a 1-1 basis with staff member staying close to his door while he is sleeping."

Documentation of the Daily Schedule for 01/11/04 identified that that R8 was not placed on 1:1 staff monitoring due to his behaviors. Per interview with E5 (Staff Development Coordinator) on 01/22/04 at 2:20 P.M., E5 stated that R8 had been placed on 1:1 on the 3-11 P.M. shift with E11 (Developmental Trainer) and then was checked every 15 minutes while asleep on the third shift.

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Review of R8's Behavior Record dated 01/12/04 identified "This morning at 6:15 R8 was seen inappropriately touching two other residents in areas that are private. He was even told by one resident (R24) to leave her alone while walking down the hall and he kept on antagonizing her as well as other residents. E11 asked he to stop with the behavior told him it was inappropriate and he wasn't allowed to touch other residents in that type of manner. He began cussing and tried to push me... Continuing to behave inappropriately touching himself through the halls, pulling pants down, etc. Refused to stop or be redirected whatsoever."

**No documentation was noted on the Daily Schedule that identified that R8 was on 1:1 staff monitoring.
on 01/12/04.**

Documentation on the Daily Schedule for 01/13/04 identified that R8 was on 1:1 staff monitoring for the morning and evening shift. Review of the facility's policy for "One to

One (1:1)" staff monitoring identified "...The employee stays with resident close enough to intervene/prevent resident from making physical contact with others and or harming self related to inappropriate behavior/conduct..."

Review of R8's Behavior Record dated 01/13/04, documentation did not reflect that R8 was closely supervised by a one on one staff. Documentation identified, "R8 attempted to start a fight. He was also observed touching himself and others (residents and staff) inappropriately. He has been verbally and physically aggressive towards staff and residents. He stole another resident's necklace. He also antagonized a resident (resident not identified) and refused to comply with redirection."

Per interview with E13 (Developmental Trainer) on 01/29/04 at 1:00 P.M., E13 stated that he had worked at the facility for about 30 days and was not certified. E13 stated that he had worked with R8 before he was discharged from the facility on 01/14/04 and stated that he had "caught R8 a couple times sticking hangers in his ear and had also witnessed him taking things that didn't belong to him." During this interview, E13 confirmed that he had not received any training in crisis intervention prior to 01/22/04, nor had he been trained in techniques to deal with clients with diagnosis of mental illness since his employment with the facility

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Per interview with E19 (Developmental Trainer/DT- Evening Supervisor) on 01/28/04 at 12 P.M., E19 stated that R8 had been, "Very aggressive and cursed at the residents." E19 stated that when R8 had behaviors, "We'd try to talk with him and verbally redirect him, that's all we were supposed to or allowed to do." E19 also stated that when we (staff) have trouble with the new clients that are aggressive, "We physically escort them to their room and tell them that their behavior is inappropriate." E19 confirmed during this interview that staff of the facility had not been trained in crisis intervention techniques prior to 01/22/04, nor had staff been trained in techniques to handle clients with diagnosis of mental illness. E19 stated that he had been employed at the facility for over a year.

R8 was not discharged from the facility until 01/14/04.

b) Client and staff interviews confirmed that clients of the facility have been subjected to psychological and physical abuse from newly admitted clients of the facility, and the facility has failed to thoroughly investigate these incidents and allegations and take corrective action.

1) Per review of the facility's roster, R11 is a 55 year old male who functions intellectually at a mild level of mental retardation. Additional review of R11's Physicians's Order identified that R11 has diagnosis of Cerebral Palsy. During the survey dates, R11 was observed in his wheelchair and was observed to have limited use of hands. As observed, R11 would not be able to defend himself against aggressive clients of the facility, but would be capable of informing others that he had been abused.

Per interview with R11 on 01/23/04 12 P.M., R11 stated that he did not like R8. R11 stated that R8 had "grabbed my throat" (referring to the incident that had occurred on 01/02/04). When the surveyor asked R11 if he was afraid of R8? R11 said, "Yes." R11 also stated that he had told staff about R8 kicking R12 in the stomach (referring to the incident that had occurred on 01/04/04). R11 stated that he had told the QMRP (Qualified Mental Retardation Professional) who wears glasses (E6). When the surveyor asked if staff had done anything to protect him from R8? R11 said, "No."

Per interview with E6 (QMRP) on 01/28/04 at 11:15 A.M., E6 confirmed that R11 had come to him on 01/02/04 alleging that R8 had choked him. E6 stated that he had talked with administration and had told the nurse. E6 also stated, "R11 talks to me all the time. Generally I believe him, but he does say things to get people in trouble. Considering how R8 was, I had a belief that it may have happened and that R8 should have been monitored."

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Review of the facility's investigation regarding the incident of 01/02/04, documentation identified that the facility concluded, "Res. (resident) (R11) has programming for telling untruths and attention seeking. Resident #578 (R8) has been noted to have aggressive behaviors and being monitored R/T (related to) same per tx (treatment) plan - but it can not be clearly determine if incident occurred as no actual witness or injury noted/found." No documentation was noted to identify that additional staff monitoring was implemented to protect R11 at the time he informed staff of the allegation at 7:15 A.M.. R8 was not placed on one on one staff monitoring until the 3 - 11 P.M. shift.

Review of the facility's investigation regarding the incident of 01/04/04, documentation identified that R11 informed staff that R8 had kneed R12 in the crotch, then hit her in the stomach.

Per review of the facility's roster, R12 is a 44 year old female who functions at a profound level of mental retardation. R12 was observed on 01/28/04 and 01/29/04 ambulating down the halls of the facility aimless without consistent staff redirection to an activity. As observed and after attempted interview, R12 is non verbal and would not be capable of telling staff that she had been abused.

Further documentation of the facility's investigation for 01/04/04 noted the following staff statements:

"E14 (Developmental Trainer/DT) heard R11 yell R8 in front of R12 and R12's hand up in the air";

"E15 (Activity Aide) just seen him (R8) agitating other residents (resident's names not identified)";

"E16 (Developmental Trainer) just seen him aggravating R14"; and

"E17 (developmental Trainer) just seen him harassing other residents (resident's names not identified)".

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No documentation was noted within the investigation that identified that R8 had been interviewed.

Per review of the facility investigation, under the section marked, "Conclusion of possible causes related to internal/external factors and why you believe they have contributed to the incident/accident" documentation stated, "Resident (R8) is agitated - pacing hallways aggravating other residents."

Per telephone interview with E2 on 01/22/04 at 4:20 P.M., E2 confirmed that the facility

had, "concluded that the incident (of 01/04/04) didn't happen."

Review of the Nurse's Notes for 01/04/04 identified that at 10:20 A.M., R11 had told staff that R8 "kneed a female resident #276 (R12) in the groin and then hit her in the abd. (abdomen)... Resident (R8) first denied hitting female, then said he hugged her then changed story to she grabbed me so I kicked her with my knee...".

2) Per file review, R13 is a 31 year old male who functions intellectually at a moderate level of mental retardation and has diagnosis of Cerebral Palsy. During the survey dates, R13 was observed using his electric wheel chair for mobility. R13 was observed to have little to no use of his hands. As observed, R13 would not be able to physically defend himself against aggressive clients of the facility.

Per interview with R13 on 01/20/04 at 3:25 P.M., R13's speech was difficult to understand but R13 spoke in single word utterance and answered the surveyor's questions by shaking his head or answering, "Yes" or "No" to the surveyor's questions. When the surveyor asked R13 is he was afraid of anyone at the facility or who had lived at the facility? R13 stated, "Yes". R13 attempted to say the person's name, however the surveyor could not understand the name that R13 was saying. The surveyor then went down the names of the newly admitted clients to the facility individually. R13 stated, "No" to all the names mentioned by the surveyor until the surveyor called R8's name. R13 was observed to arch his upper body and state, "Yes". R13 then began to cry. When the surveyor informed R13 that R8 was no longer at the facility, R13 stated, "Glad... gone". During this interview, R13 also identified that R2 bothers him. R13 stated that R2 was "loud" and that he makes him "nervous" and "upset". R13 also stated that he would be "glad" if R2 left the facility.

350.620a) **Review of the Nurse's Notes for R8 for 11/26/03 at 5:00 P.M. reflected "...He began to torment**
350.3240a) **another (helpless) resident by grabbing his hat and other items from his w/c (wheelchair) and**
350.3240f) **running away with them and preventing him from getting into his own rm (room). After a lot of**
(Cont'd.) **redirections, he (R8) agreed to go to bed." Further review of the Behavior Record for R8**

dated 11/26/03 identified "R8 ... came up behind others in the hall and would aim his fist at the backs of their heads again, stopping just inches away from contact. When asked to stop these things, he just goes on laughing. He began grabbing things off R13's w/c, his hat and other personal items, and was keeping R13 from getting into his rm. In general, just teasing and tormenting R13, who became very scared and was crying hard for almost an hour."

Interview with E12 (Developmental Trainer) on 01/28/04 at E12 stated, "One day (couldn't recall date), R13 had been so upset. R8 was down the hall and would not let R13 go down the hall. I had told him to go down the hall because he had to go the bathroom. When I went into the hall, R13 was still sitting there. He was so scared that he almost "p-ssed" his pants. R8 was pacing back and forth down the hall. I asked R13 was he scared and he said yes. I asked him if he wanted me to go with him, and he said yes."

3) Per review of the facility's roster, R18 is an 18 year old male who functions at a mild level of mental retardation and was admitted to the facility on 07/09/03.

Per interview with R18 on 01/23/04 at 1:10 P.M., R18 stated that he had had some problems with other clients of the facility. R18 stated that he remembered R8 from high school. R18 stated, "He stole my stuff, DVD, games and cussed me out. He tried to fight me. Around Thanksgiving he punched me in my head and I had to have an ice pack. I tried to fight him,
but they wouldn't let me. R8 is at the hospital." When the surveyor asked R18 if he had observed R8 bothering or hitting any other clients of the facility? R18 stated, "R2 , R8 took his stuff. R8 also hit the others who couldn't talk. They screamed and upset R8. R8 didn't belong there... Staff were afraid of R8...". During this interview, R18 stated that he was afraid of R5 (who was admitted on 10/23/03) and R1 (who was admitted to the facility on 10/01/03). R18 stated, "R1 is bad. He bothers other residents, wants to go out, and pushes people and staff. Sometimes he bothers me and ask me for money. He (R1) curses all the time and all the time trying to get out of the door. He's kind of crazy...".

4) Per review of the Physician's Orders, R31 is a 33 year old female who functions at a moderate level of mental retardation and has diagnosis of paranoid schizophrenia, anxiety and seizure disorder.

350.620a) **Per interview with R31 on 01/23/04 at 12:25 P.M., R31 informed the surveyor that she was**

350.3240a) **scared of the "black boy without glasses, I broke them." R31 described this person as "short",**

350.3240f) **then stated his name (R1). R31 stated, "He hit me.. talking junk... I can't hit him, they won't let**

(Cont'd.) **me." R31 also stated, "A new girl tried to beat me up with fist." R31 described this person as a "black girl with black hair like mine" and that this person wears her hair in "pony tails...". (Subsequent interview with E1 (Assistant Administrator) on 01/23/04 at approximately 3:30 P.M., E1 identified this person as R5 who was admitted to the facility on 10/23/03.) During the interview with R31, R31 told the surveyor that had told a man at the facility about clients bothering her. R31 described which person she had told and stated that he wore glasses and was the the QMRP (Qualified Mental Retardation Professional) (described E6 QMRP). R31 stated, "Sometimes" when asked by the surveyor if E6 did anything about her complaints. R31 then stated, "When they fight, they do something."**

Review of the Incident Tracking Log confirmed that on 01/12/04, R31 had hit R1 and broke his eye glasses. However, further review of the Incident Tracking Log for the past three and a half months identified that R31 had five documented incidents of being hit by three of the newly admitted clients. Documentation identified:

12/29/03 R31 was hit be a female resident (R4) and resident hit back;
12/19/03 R31 was hit by a male resident (R1);
12/08/03 R31 grabbed by male resident (resident's name not identified);.
11/10/03 R31 hit on cheek by R5; and
11/15/03 R31 hit by female resident (resident's name not identified).

5) Per review of the facility's roster, R14 is a 53 year old female that functions at a severe level of mental retardation. During the survey dates, R14 was observed to be non-mobile with her wheel chair and required staff assistance for mobility. As observed, R14 would not be able to defend herself against aggressive client of the facility. When the surveyor approached R14 on 01/28/04 at 10:30 A.M. and commented on her bracelet watch, R14 jerked her hands back quickly and said, "Mine, go away!"

Per interview with E12 (Developmental Trainer) on 01/28/04 at approximately 1 P.M., the surveyor asked E12 about R14 and informed him of how R14 had reacted to the surveyor earlier in the day. E12 stated, "Don't take offense, but R14 is afraid of black people because the new clients bother her and take her stuff. R14 is very afraid of R2...".

350.620a) **Per interview with R14 on 01/29/04 at 11:15 A.M. with E20 (Social Services Designee) present**

350.3240a) **during the interview, R14 stated that she had been bothered by a, "man" then stated, "boy."**

350.3240f) **When R14 was asked if this person was tall or short? R14 did not respond. When the surveyor**

(Cont'd.) **asked R14 if the person was black or white? R14 stated "black." The interview was ended when R14 began talking about other things and would not direct back to the conversation with the surveyor.**

6) Per review of the facility's incidents and the Incident Tracking Log from October 1st, 2003 to January 18th, 2004, the facility has had twenty five documented incidents of client to client aggression, with the twenty four of these incidents involving newly admitted clients to the facility. Examples included:

11/15/03 Incident of client to client aggression involving R2 (admitted on 10/01/03 and R25 (admitted on 06/26/03), requiring notification of the local police;

11/24/03 Incident of client to client aggression involving R1 (admitted 10/01/03), R5 (admitted 10/23/03) and (who was admitted 06/26/03), requiring stat medication for R1 and R5;

12/29/03 Incident of client to client aggression involving R3 (admitted 12/09/03) and R5 (admitted 10/23/03). Documentation identified that R3 had attacked a female resident and put his hands around her throat. R5 sustained a laceration to her lip during this incident. R3 was sent to the emergency room for psychiatric evaluation; and

01/19/04 Incident of client to client aggression involving R25 (admitted 06/26/03) and R3 (admitted 12/09/03). R3 received a small cut to his upper lip and a bump to his head. R3 complained of left knee discomfort and was sent to the Emergency Room. R3 returned back to the facility with a knee immobilizer.

Per interview with E2 (Administrator) on 01/21/04 at 10:50 A.M., E2 confirmed during this interview that the facility has admitted clients that are dual diagnosed and the facility had not provided staff with necessary training to meet the mental health needs of these clients. E2 also confirmed that the facility had not provided staff with necessary crisis intervention training to assist staff in dealing with physically aggressive clients.

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2) The facility has neglected to provide necessary monitoring and supervision to clients with known special needs.

a) Per review of the facility's Roster, R16 is a 29 year old male that functions at a severe level of mental retardation. Review of the Physician's Order sheet identified additional diagnosis of Blindness, Epilepsy, Hearing Impairment, and Severe Congenital Heart Disease.

Per review of R16's Individual Program Plan, R16 has a behavior treatment program in place for disruptive behavior which includes pulling on basin until point of breaking with an implementation date of 07/03 - 08/03. Review of the programs methodology did not identify the level of staff supervision required to provide necessary intervention to reduce R16's behavior. Methods identified within the behavior treatment program for disruptive behavior included:

1. When R16 displays disruptive behavior (jumping up and down, yelling and/or banging on furniture), if he is displaying this behavior at the sink, offer to let him wash his hands;.
2. Inform R16 that this behavior is not appropriate and redirect him to an area of activity;.
3. Provide activities of preference for R16, such as listening to music, going for a walk, offer a snack; and
4. If behavior escalates, follow physical aggression program.

Review of the facility's Incident Tracking Report identified that R16 had had one incident in December, 2003 (12/08) of breaking a sink and two incidents in January of 2004 (01/21 and 01/25) of breaking a sink, with all of these incidents resulting in injury. Review of R16's Behavior Record identified an undocumented incident that occurred on 01/23/04 where R16 again broke the sink off of the wall, but did not sustain injury.

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Review of R16's Nurse's Notes identified that on 12/08/03, "Res. (resident) pulled a sink off of the wall in another res. bathroom. A DT (Developmental Trainer) went into the bathroom and res. was standing there covered with blood from head to toe. He was immediately assessed and cleaned up to find source of blood loss. He has superficial cuts and abrasions on both hands. Source of blood loss was a 1" cut/gash on L (left) hand. It was cleaned and a pressure drsng (dressing) was applied. R16 tore off dressing and skin flap to wound. Another dressing was applied and he was taken to ER (Emergency Room)..." Further documentation of R16's Nurse's Notes identified that R16 received 5 sutures to his left hand as a result of pulling the bathroom sink off the wall. Documentation from 12/09 to 12/10/03 identified that R16 removed his dressing from his hand and by 12/10/03, R16 had removed one of the sutures from his hand. By 12/12/03, Nurse's Notes identified that R16's suture line had "increased redness yellow/white drainage and warm to touch..." R16 was started on antibiotics twice daily for 10 days due to "infected laceration". Nursing documentation from 12/13 to 12/17/03 identified that R16 continued to removed his dressing from his left hand. Review of the Nurse's Notes from 12/08 to 12/17/03 did not identify the level of staff supervision provided to R16 after he pulled the sink off the wall and continued to remove his dressing and pick at his hand. No documentation was noted on the Daily Schedule from 12/08/03 to 12/17/03 to identify that R16 had been placed on one on one staff monitoring to prevent further self injurious behaviors.

Review of the Behavior Management/Human Rights/ Interdisciplinary Team Committee report dated 12/12/03, recommendations were made for R16 to "see doctor, re-inservicing staff, new programming."

Review of the Nurse's Notes dated 12/12/03 identified that a referral was made to determine if R16's behavior could be seizure related. On 12/15/03, documentation in the Nurse's Notes identified that "Z4

(Neurologist) didn't think behaviors are seizure related, wants to increase Depakote to 1000 mg (milligram) TID (three times a day) and needs to see psychiatrist..." Further nursing documentation identified that an appointment was made with the psychiatrist for February 23rd, 2004.

Additionally, a new behavior program was provided to the surveyor that identified modifications had been made on 12/24/03 of the behavior program dated 07/03 - 08/03. Review of the modified behavior treatment plan did not identify the necessary staff supervision required to prevent R16 from pulling the bathroom sink off of the wall. Methods identified within the modified program included:

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(Cont'd.)

1. Staff to sign stop by staff placing 1st and 2 fingers in the palm of R16 hand and verbally inform him to stop. Tell R16 that this behavior is inappropriate. Staff may repeat this if behavior continues;
2. Redirect to area of activity by orientating him to his immediate area. Guide R16 to the nearest handrail.. Remain with R16 until area of activity. Attempt to involve him in the activity, then proceed with previous duties;
3. Provide activities of preference for R16, such as listening to music, going for a walk, offer a snack; and
4. If behavior escalates, follow physical aggression program.

Per review of the inservice reports provided to the surveyor by facility staff, no further staff inservicing had occurred as recommended by the Behavior Management/Human Rights/ Interdisciplinary Team Committee on 12/12/03, even though R16's behavior treatment plan had been revised on 12/24/03.

Review of the Nurse's Notes and R16's Behavior Record identified that R16 had three incidents of pulling the sink off of the wall after his behavior treatment plan was modified on 12/24/03.

Nurse's Notes dated 01/21/04 identified that at 4:45 A.M., "Res. (resident) in bathroom with broken sink on floor has 2 small lacerations on L (left) hand, one on thumb and one on area between thumb and index finger, both less than 0-3 cm (centimeters) and 1 small laceration on R (right)..."

Review of the Behavior Record sheet dated 01/23/04 identified "Reported by DT (Developmental Trainer) resident was found in BR (bathroom) in Rm (room) 31 with sink on floor and water running in tube and on floor. Resident was changed and redirected. No time was documented on the behavior sheet. Review of R16's Nurse's Notes for 01/23/04 did not reflect that any behavior occurred. On 01/24/03 documentation was noted for 01/23/04 at 8 P.M. "Reported by DT. Resident pulled sink off wall in Rm 31. No injuries. Monitoring behavior q (every) 15 min. (minutes) checks." Telephone interview with E1 (Assistant Administrator) on 02/04/04 at 11:45 A.M. confirmed that R16's bedroom is not located near Room 31 but is down the hall and to the left of this room.

350.620a) **Nurse's Notes dated 01/25/04 identified "3rd Shift nurse reported this res. (resident) pulled a sink**
350.3240a) **off the wall and broke the corner off. There is a small 2 cm (centimeter) laceration on top of L**
350.3240f) **(left) foot by big toe, approx (approximately) 1-2 mm (millimeter) deep and small abrasion on**
(Cont'd.) **top by big little toe..."**
Further documentation identified that R16 remains on one on one monitoring. Review of the Daily Schedule dated 01/25/04 did not identify that R1 was monitored one on one.

Review of the facility's 15 Minute Check sheet for January of 2004, R16 was monitored every 15 minutes per the facility's check sheet. Review of the dates of the incidents for 01/21, 01/23 and 01/24 and 01/25/04 did not identify that R16 had been found in the bathroom during the times of the incident on the check sheet. For example:

For the Incident of 01/21/04 that identified that R16 had broken the sink at 4:45 A.M., documentation on the 15 minute check sheet noted that R16 was in the main dining room (MDR) at 4:45 A.M.; and

For the Incident of 01/23/04 that identified that R16 broke the sink at 8:00 P.M., documentation on the 15 minute check sheet noted that R16 was in the main dining room at 8:00 P.M..

On 01/28/03 at 11:55 A.M., R16 was not observed in the main dining room prior to the lunch. When the surveyor asked E13 (Developmental Trainer) where R16 was? E13 looked around the dining room and then stated that R16 was in his bedroom. Observation of R16's bedroom identified that R16's bedroom is down the hall and away from the main dining room. When the surveyor entered the hall leading to R16's bedroom, the surveyor could not see R16 from the hall, and had to enter his bedroom to the right side of the hall to see R16 in his bedroom. During this time, the surveyor did not observe that R16 was being closely monitored by staff to prevent behaviors potentially leading to injury.

Interview with E13 (Developmental Trainer) on 01/29/04 at 1:00 P.M., E13 stated, "We check up on him (R16) as much as we can and try to do this every 15 minutes, but that doesn't always happen."

Interview with E12 (Developmental Trainer) on 01/29/04 at approximately 12:00 P.M., E12 stated that all clients are to be checked every 15 minutes. E12 stated that the clients are divided into three groups and they generally have two staff per group with one activity person. E12 then stated, "If one staff member toilets and changes the clients while the other client watches the group room, staff can't check on clients that are not in the area every 15

minutes. E12 stated "We can't always check every 15 minutes and you would need another staff person to make sure that 15 minute checks are done."

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b) Per review of the Pre Admission Evaluation dated 11/13/03, R8 is an 18 year old male who functions at a mild level of mental retardation and has diagnosis of Intermittent Explosive Disorder, Schizophrenia, Attention deficit hyperactivity disorder and Scoliosis.

Per review of the Nurse's Notes, R8 was admitted to a local psychiatric unit on 12/01/03 due to collecting broken pieces of plastics, poking them in his ear, taking pieces of hanger and making it into a weapon and bending forks into weapons. Threatening residents and staff...". R8 remained in the psychiatric unit until he was discharged back to the facility on 12/29/03.

Five days after returning back to the facility, Nurse's Notes for 01/02/04 identified "late entry for 1/1/04 - A DT (Developmental Trainer) came to this nurse with a cigarette lighter and stated she went to res. (resident) room and res. was smoking, hid cigarette between sheets and she saw it smoldering, he would not tell her where he got the lighter. She took cigarettes and put it out and made sure sheets were not burning." No further documentation was found to identify that additional monitoring was started after R8 was found in his room smoking.

On 01/10/04 at 9:15 A.M. a late entry was made for 01/08/04 that identified, "... Resident has been refusing doses of his Zyprexa, he will hide the pills then put them in a cup in his room. The cup was found and it had 3 doses of Zyprexa in it. Res. (resident) was hiding pills in his pockets, nurse found and put them in a cup. Res. will cont (continue) to be monitored...".

Additional documentation was noted in the Nurse's Notes for 01/10/04 that attempts were made to admit R8 to the psychiatric unit. Further documentation identified that R8 was to, "remain on 1 on 1 monitoring."

Review of the facility's policy for "One to One (1:1)" staff monitoring identified, "...The employee stays with resident close enough to intervene/prevent resident from making physical contact with others and or harming self related to inappropriate behavior/conduct..."

On 01/11/04 Nurse's Notes identified that at 8 A.M., "Res. (resident) pacing halls, this nurse took a lg. (large) stick from him (R8) and he started rapping you make me mad and I'm going to beat you face in, etc.". At 2:45 P.M. Nurse's Notes identified that R8 had stood in front of defenseless residents (client's names not identified) with arms spread out and growling at them.. Documentation also stated that R8 had stolen a lighter and a cigarette out of a PT (Physical Therapy) girl's purse while in PT room and lit it in the bathroom, his 1:1 caught him and brought the lighter back to the PT girl... Res. continues to be on 1 on 1."

350.620a) **At 10:15 P.M., Nurse's Notes identified "Hab Tech reported to Nurse found him taking a metal**
350.3240a) **clothes hanger and sticking the end of it into his ear then wanting a Dr. (doctor) called to get a**
350.3240f) **piece of paper out of his ear. Checked ear- wiped a sm. (small) amt. (amount) br. (bright) red**
(Cont'd.) **blood out of the out pt. (part) of his ear - found 0 sm. pieces of paper. Resident then returned to his room and went to bed. Continues to be on a 1-1 basis with staff member staying close to his door while he is sleeping."**

Documentation of the Daily Schedule for 01/11/04 did not identify that that R8 was placed on one on one staff monitoring due to his behaviors. Per interview with E5 (Staff Development Coordinator) on 01/22/04 at 2:20 P.M., E5 stated that R8 had been placed on 1:1 on the 3-11 P.M. shift with E11 (Developmental Trainer) and then was checked every 15 minutes while asleep on the third shift. Additionally, no documentation was found to reflect that the facility had investigated the incidents of 01/11/04 to ensure that sufficient staff was provided to R8 to prevent injury to himself and others and to ensure that R8 received appropriate nursing services.
Per interview with E2 (administrator) on 01/28/04 at 4:00 P.M., E2 stated that she had interviewed E22 (Developmental Trainer) on 01/27/04 (sixteen days after the incident of 01/11/04). E2 then provided the surveyor with a written statement that had been written by E22. Review of E22's statement confirmed that R8 had not been on one on one staff monitoring during the 3 - 11 shift on 01/11/04. Review of E22's statement identified:

"I worked evening shift on 01/11/04 and res. (resident) R2 reported to me and E23 that R8 had stuck a hanger in his ear. I went to check on R8 and E22 went to report it to the nurse. When I looked at R8's right ear I could see a small spot of blood (similar to what would be present if you stuck your finger with a pin) in the outer ear just outside the ear canal. Myself and E24 went to remove hangers from room. Res. (R8) said he had a piece of paper

in his ear, that he was supposed to have surgery to remove and that was why he was attempting to put hanger in his ear was because it was bothering him. Res. then went to bed without any further problems."
Review of the Nurse's Notes for 01/14/04 identified that R8 "remains to be monitored per protocol - QMRP making contact calls in attempt to get res. transfer to facility to better meet needs of res. (resident) and for safety of all others at this time." R8 was transferred from the facility on 01/14/04.

3) The facility has neglected to develop an active treatment program and to ensure sufficient staff monitoring by competent trained staff to meet the client's needs for one client in the sample (R6) who was admitted to the facility on December 17th, 2003 with a diagnosis of "Pyromania" and Depressive Disorder.

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Per review of the Pre Admission Evaluation, R6 is a 26 year old female that functions at a mild level of mental retardation and has diagnosis of Impulse Control Disorder - Pyromania and Depressive Disorder,

Per review of the Psychological Assessment dated 10/25/03, R6 was admitted to a mental health forensic unit on 09/25/02 after being found unfit to stand trial on a felony charge of arson and aggravated arson.

Additional documentation was noted within the assessment to identify that R6 had "exhibited occasional incidents of immature behavior related to interpersonal relationships, poor judgement, impulsive behavior, suicidal behavior and self injurious behaviors...". Recommendations within the assessment identified:

"R6 will need a community group home setting than can provide support and should be highly supervised and highly structured; and

She (R6) needs to continue to learn effective coping skills to find socially appropriate ways to manage her depression, anger and frustration."

a) The facility has failed to develop an active treatment program for R6, who was admitted to the facility on December 17th, 2003 with a diagnosis of Depressive Disorder and has history of suicidal behaviors.

Six days after R6's admission to the facility, per the QMRP Notes of 12/23/03, R6 brought to E1's (Assistant Administrator) attention that she was having feelings for a staff member. On 12/24/03, QMRP Notes identified, "R6 told me (E2) today that her feeling were getting worse...". No further documentation was found to reflect that the facility had placed R6 on one on one or closer staff monitoring due to her history. A later entry was made for 12/24/03 that identified "R6 walked into the nurse's station and stated that she wanted to kill herself. This was at 5-5:30 P. (P.M.) I (E9/QMRP) asked R6 questions, she stated that she felt depressed and wanted to kill herself. R6 was placed on 1:1 with staff. Transported R6 to ER (Emergency Room for psych (psychiatric) val (evaluation)/admission."

Emergency Room documentation titled "Crisis Services Report" with a date of 12/24/03 identified, ".... Client (R6) reports feeling depressed for the last couple of days as well as suicidal thoughts. Client commented that she feels "down in the dumps" and attempted to hang self early this evening prior to arriving at ER ...".

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R6 was admitted to a local psychiatric unit on 12/24/03 and did not return back to the facility until 12/29/03.

Per review of R6's Behavior Treatment Program for SIB (Self Injurious Behaviors) target behaviors are for "wraps sheet around her neck, pokes self with objects, attempts to cut wrist, attempts to set fire to clothing". Interventions identifed within the program included:

When antecedents are present (depression, isolation, breaking up with partner), approach R6 in a supportive tone of voice and attempt to find out what is bothering her. Notify a QMRP or a nurse immediately.

If SIB is present, attempts to redirect to an alternative task by asking R6 to completes simple puzzles or having her listen to music (these are often effective redirective strategies). Notify a QMRP or a nurse immediately.

If SIB behavior continues or is at a stage that steps two is irrelevant, staff will give the verbal prompt of "stop," if R6 does not stop the behavior after 2 verbal prompts have been given staff should intervene using least restrictive CPI hands on techniques to stop/block the behavior.

Once the SIB behavior stops, engage in a 1:1 activity with R6 for a brief period of time (1 minute) to ensure it does not start again and then exit. Notify a QMRP or a nurse

immediately.

No methods are identified within the program that specifies what staff are to do when R6 "threatens to kill herself". Additionally, no environmental modifications are included within the program to identify any type of articles staff are to remove from R6's possession when she threatens to harm herself.

Per interview with E19 (Developmental Trainer/DT- Evening Supervisor) on 01/28/04 at 12 P.M., E19 confirmed during this interview that staff of the facility had not been trained in crisis intervention techniques prior to 01/22/04, nor had staff been trained in techniques to handle clients with diagnosis of mental illness. E19 stated that he had been employed at the facility for over a year.

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Per interview with E2 (Administrator) on 01/21/04 at 10:50 A.M., E2 confirmed during this interview that the facility has admitted clients that are dual diagnosed and the facility had not provided staff with necessary training to meet the mental health needs of these clients.

b) Facility has failed to ensure sufficient staff monitoring by competent trained staff for R6 who was admitted to the facility on December 17th, 2003 with a diagnosis of "Pyromania" and Depressive Disorder with Suicidal behaviors.

Review of the Admission Policy and Procedure identified, "Prior to admission, the Interdisciplinary Team would review and develop a plan... Every admission to the facility will be assigned 1:1 supervision (extra from scheduled staff). 1:1 supervision will be maintained until such time as the resident's behavioral needs can be evaluated. 1:1 will continue until such time that resident no longer displays noted behavior(s) and/or plan is developed."

Per interview with E5 (Staff Development Coordinator) on 01/21/04 at 11:50 A.M., E5 stated that clients are placed on one on one at the time of admission. If no behaviors are

shown during the first twenty four hours, the one on one supervision is not continued.

When E1 (Assistant Administrator) was questioned by the surveyor on 01/23/04 at 2:30 P.M., regarding how R6 and other newly admitted clients of the facility were monitored? E1 stated that clients are placed on one on one initially on admission, evaluated the following day, and if no behaviors have occurred, the one on one is dropped. E1 stated that after admission , clients are placed on fifteen minute checks.

During an interview with E12 (Developmental Trainer) on 01/29/04 at approximately 12:00 P.M., E12 stated, "We can't always check on the clients every 15 minutes... you would need another staff person to make sure that 15 minute checks are done."

Per interview with E2 (Administrator) on 01/21/04 at 10:50 A.M., E2 confirmed during this interview that the facility has admitted clients that are dual diagnosed and the facility had not provided staff with necessary training to meet the mental health needs of these clients.

350.620a) **R16 was placed 1:1 with staff on 01/29/04 when awake and fifteen monitoring when asleep with**
350.3240a) **an alarm on the door to his room to alert staff when resident exits room. Behavior**
350.3240f) **Management/Human Rights Committee to review on 02/04/04 . As of 02/04/04 stainless steel**
(Cont'd.) **basins were installed in bathroom. E1 (Assistant Amdinistrator) to monitor for compliance.**

The Admission Policy and Procedure was modified on 01/29/04 to reflect that if the psychologist and or Mental Health Professional was not available to participate in the admission review, the admission packet would be faxed for review and returned with input per fax.

Staff to be inserviced on an ongoing basis and prior to admission of dually diagnosed clients as based on the individual client's needs. Mental Illness inservice completed on 01/29/04. Crisis intervention training was provided to direct care staff on 01/22/04 and 01/24/04 and will be adapted into routine training for direct care staff. Staff Development Coordinator, Assistant Administrator or designee will monitor for compliance.

The facility will secure a psychiatric consultant to provide periodic review of medication regime, overall functioning of residents with dual diagnosis and to provide staff inservicing.

The facility has developed PODs (designated living area for residents of similar level of mental, physical, cognitive functioning) to assist staff to be able to implement, perform and or assist residents with programs and active treatment. POD 3 is for cleints with lesser degrees of mental retardation and may be dually diagnosed. Daily routines are being established and are in the introductory stage as of 02/03/04. Direct Care staff will be inserviced daily related to group daily routines until fully functioning. General inservicing will be done for all staff by 02/09/04. Review/reassessment and modifications wll be on an on going basis. Monitoring to be done by the Assistant Administrator.

The facility will maintain a QMRP on duty between the hours of 6:00 A.M. to 9:00 P.M.. A QMRP will be on call between 9:00 P.M. and 6:00 A.M. daily if needed to assist with behavioral issues. There also will be a member of management on call for 1:1 implementation if QMRP or Charge Nurse deem a resident to be in need of 1:1 staffing and will be on call and available to perform the duty of 1:1 staffing if needed.

Resident Council meetings will be held on an on going basis to reflect view points of the facility residents. Process is ongoing and if any client expresses any psychological stress or concerns in the meeting or at any other time, the facility administration will intervene immediately.

350.620a) 350.3240a) 350.3240f) (Cont'd.

Although the Immediate Jeopardy was abated on 02/06/04 at 4:30 P.M., Non Compliance continued at the time of the Exit Conference since the facility's monitoring of R16's behavior will be on an ongoing basis, staff training will be on an ongoing basis, admission decisions to be made as clients are admitted to the facility, the facility has not yet contracted with a psychiatric consultant to assist in meeting the mental health needs of the dual diagnosed clients of the facility, the designated living area of the facility for residents with similar levels of mental physical, cognitive functioning (PODS) daily routines have not been fully established and staff have not be fully trained on the new routines, and per the facility's need to monitor the implementation of their policy and procedures on a on going basis.

(A)

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