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



MOULTRIE CO. COMMUNITY CENTER
Facility Name

0026112
I.D. Number

240 EAST STATE, P O BOX 229, LOVINGTON, ILLINOIS 61937
Address

11/10/2004
Date of Survey

COMPLAINT INVESTIGATION
Type of 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 of 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):

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| 350.620a) | The facility shall have written policies and procedures governing all services provided by the 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. |
| 350.700a) | The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department |
| 350.1060e)h) | An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. |
| 350.1210b) | There shall be available sufficient, appropriately qualified nursing staff and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. |
| 350.3240a)c)d)e) | Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse of a licensed practical nurse, or the equivalent. |

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

A FACILITY ADMINISTRATOR WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER BY TELEPHONE AND IN WRITING TO THE RESIDENT'S REPRESENTATIVE. (Section 3-610 of the Act)

EMPLOYEE AS PERPETRATOR OF ABUSE - WHEN AN INVESTIGATION OF A REPORT OF SUSPECTED ABUSE OF A RESIDENT INDICATES, BASED UPON CREDIBLE EVIDENCE, THAT AN EMPLOYEE OF A LONG-TERM CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT EMPLOYEE SHALL IMMEDIATELY BE BARRED FROM ANY FURTHER CONTACT WITH RESIDENTS OF THE FACILITY, PENDING THE OUTCOME OF ANY FURTHER INVESTIGATION, PROSECUTION OR DISCIPLINARY ACTION AGAINST THE EMPLOYEE. (Section 3-611 of the Act)

Based on observation, interview, file verification and review of facility policies, the facility neglected to implement policies and procedures based on allegations of staff to client and client-to-client abuse for eight of 16 clients in the facility (R#'s 2, 3, 4, 6, 8, 9, 14, and 15) with the potential to impact all clients in the facility (R#'s 1, 5, 7, 10, 11, 12, 13, and 16) when the facility neglected to: (a) Thoroughly investigate allegations of staff to client abuse and incidents of client-to-client abuse; (b) Remove staff being investigated for abuse from contact with residents during the investigation; (c) Notify the guardians of allegations of abuse from client/staff; (d) Notify the nurse for an assessment of injuries regarding the allegations of abuse; (e) Provide training/retraining in abuse/neglect policies as a result of these allegations; (f) Notify the Department of the allegations of abuse; and (g) Revise clients behavior management programs, for those individuals identified with aggressive or inappropriate sexual behaviors.

1. The facility failed to protect individuals from neglect regarding allegations of staff-to-client abuse.

A. Per observations made on 10/27/04, R2 is ambulatory female with verbal skills. Per review of the current Physician's Order Sheet dated 10/8/04, R2's diagnoses include: severe mental retardation, Dementia with agitation and Down's Syndrome.

Per interview with E1 (Administrator) on 10/26/04, E1 stated she was unaware of any allegations of abuse/neglect being reported or investigated in July of 2003. When E1 was provided time to check her files, E1 stated that she had not had allegations of abuse to investigate in 2003. At this time E1 was informed of an alleged incident in July 2003 involving R2 and E4. She stated "I did not know about it." When E1 was asked what she was going to do since she was informed of this incident. She stated she would "do what the policy says..." When E1 was asked what steps she would take to protect the clients during the investigation, E1 stated she would suspend E4 until the investigation was complete.

Upon entry into the facility on 10/27/04, the surveyor asked E1 who worked through the night last night. E1 stated that E4 had worked on the night shift alone. E1 stated that she attempted to call E4 on several occasions however, she was unable to reach E4. E1 stated she fell asleep when she returned home and did not get a hold of E4 prior to the onset of the midnight shift on 10/26/04. E4 worked the midnight shift unsupervised after the Department informed the Administrator that this was the individual with an allegation of abuse/neglect unresolved.

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A report from the workshop states, "The facility got a call from workshop Monday, 07/07/03 asking if the facility knew anything about this incident with R2 that they heard from the residents when they arrived at the workshop...The Administrative Assistant started investigation the same day from residents and staff as well. According to the residents that were interviewed, they witnessed E4 yelling at R2 to put her underwear on and R2 refused. She (E4) then walked over and grabbed R2 by the wrist and started telling R2 "you are going to put f-----g underwear on...R2 then hit E4 and E4 grabbed (R2) her other arm and crossed both arms in front of her and pinned her to the wall. After that, E4 did not release her but dragged her and shoved her into a chair."

Per review of a Misconduct Notice for E4 (direct care staff) located in E4's personnel file, dated 07/08/03 it states, "On Tuesday July 1, 2003, E4 wrote a letter saying that she had a battle with R2 trying to get her to wear underwear underneath her knit shorts. She also called that afternoon and told the administrator and mentioned she accidentally scratched her when she grabbed her by the wrists to try to get R2 to stop hitting her."

Under the "Determination" section of this Misconduct Notice it states, "E4 has displayed an unacceptable and serious conduct by abusing a resident physically and verbally. E4 has displayed verbal abuse several times and was confronted about it. This is E4's final warning and another incident of verbal and physical abuse, calling names, raising voice, picking on a certain resident, commanding instead of requesting a resident to do something, talking bad about a resident or staff in front of residents, cussing in front of residents will lead to immediate termination. This document is dated as signed on 07/09/03 by Z2 (former Resident Services Director), E1 (Administrator) and E4 (direct care staff).

Per interview with E1 on 10/27/04 regarding the signed Misconduct Notice for E4, E1 stated that she just signs whatever papers are put out for her to sign. E1 stated she does not remember whether she was informed of this incident in July of 2003 by facility staff. Per interview with E1 (Administrator) on 10/26/04, E1 stated she was unaware of any allegations of abuse/neglect being reported or investigated in July of 2003, however on 10/27/04 the surveyor became aware of written statements provided by witnesses to the incident which were presented to the surveyor upon request.

Per interview with E2 (Administrative Assistant) on 10/27/04, E2 stated that she had been on vacation at the time of the 07/03/03 incident and that upon her return, she was informed of this incident by facility staff. E2 stated at that time she initiated an investigation including statements of staff who were present during the incidents. E2 presented the surveyor with a copy of her written report. The investigation does not include input from the Administrator, nor does it include evidence that the guardian was notified or the Department.

Per review of the written statement given by E8 (direct care staff on duty on 07/03/03 at the time of the incident) stated, "at about 7:40 AM, I was in the kitchen when I heard yelling et came out to see E4 with R2's arms crossed in front of R2 et pushing R2 backwards across room et shove her into the chair by the kitchen door. R2 was rolling her head from side to side et crying et saying "Stop, please. Leave me alone. Please. Please stop." E4 kept her grip on R2 et said " you aren't going to hit me." "Put some f-----g underwear on. It's disgusting not to wear any." E6 also came over and E4 let go of R2. R2 got up et started to her room et E4 yelled at her to "get some f-----g underwear on." She also told her she couldn't go to workshop without it. R2 told E4 to "shut up, you b---h." Some residents were still in the room: R9, R8, R6, R13, R10...I noticed on her left arm were marks that looked like fingernails had dug into her arm, she kept saying the same thing...that she was going to take her underwear off in the women's bathroom at workshop, put in the bag she had et hide it in the trash...I went back up to the porch et E4 told me she had scratched R2...skin on her arm was not completely broken et did not bleed."

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Per review of a written statement given by E6 (direct care staff on duty on 07/03/03 at the time of the incident), this statement says, "...R2 had refused to put underwear on all morning. E4 was yelling at R2 "you need to put some f-----g underwear on or you won't go to workshop" R2 was very upset and wanted to talk to E8 (direct care staff) who was working kitchen duty...E4 walked over to R2 who was now standing by kitchen door, grabbed R2 by the left arm and told her "you are going to put f-----g underwear on." R2 then hit E4 on the shoulder. E4 then grabbed R2's other arm, crossed both in front of R2 and pinned her to the wall. I came over to where they (R2 and E4) were and tried to talked R2 into settling down to come with me to her room. E4 did not release R2 instead she told me to move, I did thinking she (E4) was going to release R2 instead she drug her to a dining room chair and shoved her down onto chair continuing to hold her down. E8 came out of the kitchen to see what commotion was about, I again asked R2 to come with me to her room. E4 finally released R2 who then came to her room with me..." E1 informed the surveyor that she had just obtained these copies from E6 and E8 and that she had never read these statements prior to this date (10/27/04).

A confidential interview (#1) stated, that Z2 (former Resident Services Director) was notified of this incident upon his/her arrival at the facility on 07/03/04 and that E1 had also been notified. It was stated that there was no investigation initiated until E2 (Administrative Assistant) returned from vacation. Confidential interview with (#2) stated, that when he/she became aware of the incident occurring, that he/she spoke with E2 at this time due to lack of investigation having been initiated and an investigation was then initiated by E2. Per confidential interview (#3), stated nothing had been done about this abuse prior to E2 initiating an investigation. Per confidential interview (#1) he/she stated that E1 had been notified of this incident, but written statements had been obtained by E2, prior to E1's signing of the Misconduct Notice for E4 on 07/09/03.

Per review of a report presented to the surveyor by E2 (Administrative Assistant) dated 07/04/03, this report states the following residents were interviewed regarding this incident and the responses were:

a. R9- E4 pushed R2 down to a chair, "She cussed my friend out."
b. R11- E4 pushed R2 against the wall and cuss her out.
c. R7 - she heard E4 yelling and cussing at R2 to put her underwear on.
d. R4 - Stated that E4 was yelling at R2 and pushed her against a wall.

Per review of the nursing progress notes, there is no evidence to support that R2 was assessed by nursing staff for injuries after the 07/03/03 incident. Per interview with E3 (RN Consultant) on 10/27/04, E3 stated that she had not been aware of 07/03/03 incident with R2 until this date. E3 stated that she would have checked R2 for injuries if she had been notified.

Per interview with Z3 (guardian of R2) on 11/08/04, Z3 stated that he had been notified of an incident with one client there who has hit and bit R2 on some occasions and stated he doesn't remember any other allegations of abuse which involved R2. Z3 stated that he would be alarmed if there were any allegations of abuse involving staff.

B. Per review of current physician's orders, R8 is a 44-year-old female with a diagnosis of severe mental retardation, Schizo-Affective Disorder. A preliminary report submitted by E2 states, R8 informed staff in the morning on 05/24/04 that E4 had slapped her in the face just like she does every morning. Per review of the facility incident investigation, this investigation does not include evidence that the Administrator was notified or that the guardian was notified. Nor is there any evidence of staff or resident interviews.

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Confirmed per interview with E3 (RN Consultant) on 11/04/04, she stated that she was not notified of this incident, so she could assess R8 for injuries. Per interview with E2 on 10/27/04, E2 stated that she notified E1 of this incident. E2 confirmed that this report was not submitted to the Department, nor was a thorough investigation completed on this allegation of abuse. E2 stated that her position is to initiate the incident forms.

C. Per review of a report submitted to the Department dated 09/01/04 it states, "On 8/26/04, a staff reported that E8 had smacked the hand of a male resident R3. A document dated 09/01/04 states, upon completion of my investigation (completed by E2)...R3 denied the incident happen (typed as written), even after repeated questioning numerous times...This employee has been employed by the facility since October of 2001...never been an incident reported from staff or clients...due to this employee never having an incident happening...disciplinary action will be...placed on a 6-week probationary status... not allowed one on one outings with clients...not be allowed to bathe clients one-on-one...will be evaluated weekly...if any problems arise...employment will be terminated..."

A written statement submitted by E7 (direct care staff) states, "...R3 was standing behind the couch with both hands resting on top of it..." R3 was observed to be repeatedly asking another client about where his glasses were. "...E8 walked downstairs to start the med pass. Out of nowhere she walked down the stairs to the living room, smacked R3's hand and told him to shut up + sit down & wait for his meds..."

An additional statement was written by E10 (direct care staff) dated 8/27/04 which states, "...E8 came from med room, picked up one of R3's hands and smacked it & told him to keep his hands to himself." A written statement by E9 states, "...heard E8 yell @ R3 and heard a smack..."

Per review of the facility staff schedules, E8 continued to work during the investigation and was not placed on suspension as identified in the facility policy. The investigation consisted of a summary of the interview with R3 (had been informed by E2 at the onset of this survey that R3 was not an interviewable client who was reliable). There is no evidence of staff retraining and no mention of how E1 would monitor E8's behavior.

D. Per review of the facility roster, R15 is a 51-year-old male with a diagnosis of moderate mental retardation and Brief Reactive Psychosis. R15 was observed on 10/27/04 as ambulatory and verbal with a well-established vocabulary. Per interview with R15 on 10/27/04 he stated that E9 was not always nice to them and R15 stated that she was "snotty" towards him. Upon notification to the Administrator on 10/27/04 of these statements, E1 stated that she was not aware that R15 had any concerns with E9.

A Preliminary Investigative Report was initiated on 10/21/04 by E2 after R15 voiced concerns during the IDT meeting. Per review of the IDT report for this date, E1 was in attendance for this meeting, however did not initiate an investigation until it was brought to her attention on 10/27/04.

The Preliminary report dated 10/21/04 states during R15's Interdisciplinary Team Meeting R15 told the team that there is one staff that he is worried about, with E9 identified. Per review of the incomplete investigation provided to the surveyor, this report includes a written statement from E9 dated 10/24/04 and from E8 dated 10/22/04. The written report from E8 states, R15 informed her on October 17th, 2004 that he had "...received a CD of hymns for his birthday from the Sunday School teacher. He told me he needed to save his money so he could buy a radio...I told him he could use the stereo at (name of this facility) because it was for everyone...he told me he had tried to listen to a Bible cassette one day and E9

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turned it down so low he couldn't hear it so he took it out et went to his room...later that day I told R15 he could go outside and smoke. He said he didn't think he should...said I would go outside with him...as I come back I could hear E9 telling him he couldn't go outside alone...He tried to tell her I was going out also but she kept telling him to come back...he said E9 was always telling him what to do and said she was "snotty" to him...et grouchy..."

Per review of a written statement submitted by E7 (direct care staff) dated 10/24/04, it states, "On numerous occasions I have seen E9 treat R15 differently than other residents. She acts like anything R15 says or does is a personal attack against her...R15 can do no right by E9. Often she is just plain rude to him...E9 does raise her voice to R15 when he tries to rationalize why he needs his cigarette now...E9 is constantly irritated by R15 and becomes increasingly aggressive (ex: raising her voice, telling him to wait, threatening him that he will not get his cigarette)...E9 has similar problems with...R9."

Per interview with R9 on 10/27/04, when asked how to the staff at the facility treat you, R9's initial response was that "E9 is kind of mean". R9 would not provide the surveyor with any additional information regarding this statement.

A final investigative report was faxed to the Department on 10/28/04 and written and signed by E2 (Administrative Assistant) which states, "Statements received from staff support allegations by R15 and R9. E9 will receive a write up for her tone of voice and inappropriate use of words around clients. E9 will be retrained on active treatment regarding her tone of voice and courtesy around clients...." There is no mention of how E1 will follow up to monitor E9's behavior.

2. The facility neglected to protect individual from client to client abuse.

A. Per review of the annual Individual Program Plan dated 07/22/04, R3 is a 57-year-old male with a diagnosis of severe mental retardation and Bipolar Disorder. R3 was observed on 10/26/04 as ambulatory and verbal. Per review of an incident report dated 06/08/04 at 8:00 AM, it states "...could hear R3 yelling at R6 (nonverbal roommate)...R3 was grabbing R6's blanket trying to pull it off...and R6 was trying to hang onto his blanket... R3 was told he needed to stop...and R3 immediately started saying R6 tried to play with my toy, toy..."

Per confidential interview with (#2), he/she stated that R3 had an incident in 05/24/04 in which R3 was observed "yanking" on R6's penis. This individual further stated that E1 was made aware of this incident at the time. Per review of R3's behavioral data sheet for this date, there is an entry of inappropriate behavior documented, however there is no description of what occurred at this time. Individual further stated that R3 was moved out of R6's room when facility staff asked E1 what she planned to do about R3's sexual behaviors. At that time E1 separated R3 and R6.

Per review of facility incident reports, there are incidents of R3 grabbing staff's private areas, or making suggestive remarks. Per review of an incident report dated 09/10/04, R3 was observed at 3:00 AM standing over R14's (new roommate's) bed, asking R14 to play with his "Toy, Toy". R3 was observed to be completely naked.

Per review of the facility records, there is no evidence of an investigation, nor does R3's behavior management plan include training regarding sexuality. R3's behavior management program does not include revision or criteria related to specific inappropriate sexual interventions. R3's file does not include any special team meetings held after the annual Interdisciplinary Team Meeting to address

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programming issues relating to R3's sexually inappropriate behaviors. Per review of R3's behavior management program, the initial intervention states R3 to be escorted to a time out area for five minutes. There is no evidence of a less restrictive first step. In addition, it does not include any interventions regarding R3's ongoing inappropriate sexual behavior.

A Behavior Management meeting was held on 09/10/04 to discuss a resolution to R3's behavior problems. This document states that R3 will be on 15-minute checks, will be supervised during bathing and bathroom use, and R3 will not be allowed upstairs without staff supervision. During a special team meeting held on 09/20/04, the meeting notes state R3 would be sleeping on the sofa. These Behavior management meetings do not include any review of R3's behavior management programming or revision to his behavior management program.

Per interview with E3 on 11/04/04 regarding the facility administration and notification to the nurse of injuries or allegations of sexual abuse, E3 stated that she had not been notified of specific incidents regarding R6, only heard later through the rumor mill. E3 stated that after the incident regarding R3 and R14 on 09/10/04, E1 had stated to E3 that "I don't know what to do with him." E1 informed E3 that she was going to put him on the couch for now.

B. Per review of current physician's orders, R1 is a 37-year-old female with a diagnosis of severe mental retardation and Schizo-Affective Disorder. Per observations made on 10/26/04, R1 was observed to be ambulatory and verbal.

Per review of facility incident reports, there are documented incidents of R1 hitting and/or biting R2 on:

05/11/04 - struck on the right forearm by flying dishes thrown by R1
06/16/04 - crying in the dining room after struck on the back by R1 - states hit on the back several times by the way the hand marks were seen on her back.
09/09/04 - was struck on the left shoulder and - no injury noted.
09/11/04 - slapped in the face - face reddened for 15 minutes
09/15/04 - struck on right shoulder while on the bus -no injury noted
09/18/04 - struck this client "many times" and then R1 bit R2
09/18/04 - hitting R2 and then R1 bit R2's arm.

On 09/13/04 an incident report states at 5:45 PM, R1 began having a behavior. R1 was described to break dishes and R3 received a small laceration to his right elbow. An incident report dated 06/28/04 states R12 was grabbed by R1 on the right upper arm with a resultant bruise approximately 1 1/2 cm (centimeter) by 1/2 cm.

Per interview with R2 on 10/27/04, R2 was asked if everyone at the facility was nice to her, R2 stated R1 "hit me." Per interview with R15 on 10/27/04, he stated that R1 is mean to everyone, she hits people and throws dishes. Per interview with R11 on 10/27/04, R11 stated that "R1 was mean, but they got rid of her today." (R1 was taken to an out of town Dr. visit).

Per review of R1's Individual Program Plan dated 10/21/04, R1's behavior management plan does not include review and revision of specific interventions, based upon the incidents of client to client aggression prior to 10/21/04.

C. Per review of the current Individual Program Plan dated 02/14/04, R4 is a 65-year-old female with a diagnosis of severe mental retardation, Hypertension, history of Seizure Disorder and Huntington's Disease. Per observations made on 10/26/04, R4 is ambulatory and verbal.

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Per review of an incident report dated 06/14/04, R4 was struck by R1 on the right forearm and on her back during a behavioral incident. The incident report states there were visible red marks noted on R4's back. An incident report dated 09/11/04 states R4 was yelling in the bathroom. Staff found R4 with blood on her mouth and chin and stated that her roommate had hit her (R1).

Per interview with R4 on 10/27/04, when R4 was asked how everyone treated her, she stated, "my roommate mean." A confidential interview stated that from 10/22/04 to 10/24/04 R4 had requested to sleep on the sofa due to fear of her roommate. It was stated that E1 had been notified of R4's concern in staying in her bedroom and gave permission for R4 to sleep on the sofa. E1 was asked by the surveyor if R4 had been sleeping on the sofa due to fear of her roommate, and she responded that she was only aware of this occurring one night. Per review of R1's record, there were no interventions put in place to protect R4 from R1 at the time the incidents of aggression occurred to R4. In addition there is no evidence that E1 followed up and addressed R4's continued fear of R1.

Per interview with E3 (RN Consultant) on 10/27/04, whether she had been notified of the 07/03/03 incident and if an assessment had been completed for R4 to ensure there were no physical injuries, E3 stated she had not been informed of any incident occurring at this time until this date.

When E3 was asked if she was having any difficulty obtaining information or being notified of specific incidents, E3 responded that E1 has a long history of asking staff what she should do about something and when she is given advice, she doesn't follow it. "...This has happened thousands of times..." E3 further stated that E1 doesn't tell her anything. She stated that she hears most information through the rumor mill. E3 further stated that notification is "inconsistent at best." There seems to be "the philosophy of hide and seek...I hope this does some good. I hope there can be a change."

Per review of the facility's policy on Resident Protection: Abuse and Neglect Policy, this policy states, "A resident, employee or family member who has reason to suspect that any resident of this facility is or has been subjected to physical, verbal, sexual or psychological abuse or punishment is required to immediately (word underlined) report the information to the facility Administrator... If the accused individual is an employee, he/she will be immediately suspended pending the outcome of the investigation in order to provide for resident safety. If the accused is a resident of the same facility, staff shall ensure supervision of the alleged perpetrator at all times to provide for resident safety...The facility investigator will notify Illinois Department of Public Health and the individual's guardian of all allegations of abuse as well as the findings of the investigation and measures that will be taken to prevent repeat occurrences. All incident reports will be reviewed by the Administrator, RSD (Resident Services Director) and RN (Registered Nurse) for patterns that might suggest abuse, neglect or mistreatment. If abuse, neglect or mistreatment is suspected, the Administrator will initiate an investigation as above." The facility policy regarding abuse and neglect does not include investigation of incidents of unknown origin.

**(A)**