Page 1 of 5

COLONIAL PLAZA	0039552
Facility Name	I.D. Number
618 WEST GOODNER, NASHVILLE, IL 62263	
Address	
	12/20/04
Reviewed By	Date of Survey
COMPLAINT 0445735	
Type of Survey	Surveyed By

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 <u>original signature</u>.

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):

350.620a)The facility shall have written policies and procedures governing all services provided by the350.1060e)h)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.

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.

There shall be available sufficient, appropriately qualified training 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.

Direct care personnel shall be trained in, but are not limited to, the following:

Basic skills required to meet the health needs and problems of the residents.

Page 2 of 5

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350.620a) 350.1060e)h) 350.1230b)2) 350.3240a)b)e)d)	AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDICATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (SECTION 3-610 of the Act) A FACILITY ADMINISTRATOR, EMPLOYEE, OR AGENT WHO BECOMES AWARE OF
	ABUSE OR NEGLECT OF A RESIDENT SHALL ALSO REPORT THE MATTER TO THE DEPARTMENT. (Section 3-610 of the Act) EMPLOYEE AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A
	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 THE LONG-TERM CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT EMPLOYEE SHALL IMMEDICATELY 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)
	These regulations were not met as evidenced by the following: 1) R1 is a 19 year old ambulatory male who functions in the profound range of mental retardation with an additional diagnosis of cerebral palsy, autism, and deafness in the left ear. R1 was admitted to the facility on 11/30/04. The facility is still in the process of completing assessments in order to develop a Individualized Service Plan (ISP).
	Review of R1's Initial Social Service Assessment completed on 11/30/04 was completed. R1's communication skills are poor. Speech is poor in terms of clarity and comprehension. R1 is deaf in the left ear and has poor attention span. Per documentation, R1 has repetitive motor movements such as waving arms, flapping hands and shaking his head from side to side. R1's behaviors include yelling, inappropriate verbal reactions, and at times, aggression and property destruction.

Page 3 of 5

COLONIAL PLAZA	0039552
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350.620a)

350.1060e)h)

350.1230b)2)

Per interview with E3 on 12/13/04 at approximately 10:30am by phone and at the facility at approximately 3:00pm also on 12/13/04, E3 stated that on 12/4/04 at 5:00pm, R1 was exhibiting behaviors of velling and coming out of his room naked. E3 indicated that she was trying to redirect him back to his room to put on his clothes. E3 stated that E4 had just returned to the facility from picking up 350.3240a)b)e)d) another individual from the hospital. E3 continue by saying that E4 came down the hallway and started yelling at R1. E3 stated; "They were not nice words', to get back into his room and put on his clothes. E3 also indicated that when E4 was at R1's door, E4 pushed R1 back into the room. E3 stated that the push was hard enough that R1 lost his balance. E3 did not indicate that R1 fell to the floor. When asked the mood of E4 the rest of the evening, E3 responded that E4 was very rude to everyone the rest of the evening.

> Per interview with E1 on 12/13/04 at approximately 2:30 in the kitchen, E1 stated that on 12/04/04, she received a phone call from the facility to come into work for a few hours due to the fact that the facility was short handed and E4 had to go to the hospital to pick up the client. E1 indicated by the time she arrived at the facility, it was around 5:00pm and E4 had return from the hospital. E1 stated she was in the dining room assisting a few individuals in setting the table. E1 said she heard E4 yelling at R1 ("using the f.... word a lot"). E3 came into the dining room and told E1 that E4 was yelling at R1 and also pushed R1.

> During interview with E1 and E3 they stated they had not reported this to the RSD that night due to the fact E2 was out of town that weekend. They also indicated that neither the administrator or the owner of the facility were not notified on 12/04/04. E3 did state that she wrote E2 a note and slipped it under her office door on 12/05/04. There is no evidence a note had been written.

Per review of E4's time sheet, E4 worked on 12/05/04 from 9:53am to 5:57pm.

Page 4 of 5

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350.620a)
350.1060e)h)
350.1230b)2)
350.3240a)b)e)d)
Per interview with E2 on 12/13/04 at approximately 9:30am, E2 was informed of the alleged abuse on 12/06/04 and the investigation was started immediately. E4 was placed on immediate suspension since E4's schedule days off were 12/6 and 12/7. E4's only suspended day was 12/8 and E4 returned to work on 12/9. E2 stated she verbally went over the policy of abuse/neglect when she return to the facility on 12/9/04. There is no evidence that E4 was retrain when she return to work. There was an mandatory staff meeting on 12/13/04 concerning the abuse/neglect policy.

Interview was held with E4 on 12/04/04 at approximately 1:00pm. E4 denies that on 12/4/04 that she yelled or pushed R1. E4 stated she became aware of the allegation on 12/6/04 when she was contacted by E2 and told there was an allegation against her concerning abuse and she was suspended until further notice. E4 also stated that when she returned back to the facility on 12/9/04, she was not retrained by E2.

2) The neglect/abuse policy was reviewed on 12/14/04. The policy states that the facility shall be responsible to insure that no resident is subjected to physical, verbal, sexual or psychological abuse or punishment.

a) Abuse refers to ill-treatment, violation, malignment or exploitation of an individual whether purposeful or due to carelessness, inattentiveness or omission of the perpetrator.

b) Verbal abuse includes any spoken, written or geatural language

Procedures for Completing an Abuse/Neglect Investigation:

1) A resident, staff member, or anyone suspecting or witnessing abuse, mistreatment, or neglect of residents should report the suspected incident immediately to the QMRP and

Adminstrator/Operations Manager. If they are not on duty at the time, they will be contacted at home to report the incident.

Page 5 of 5

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350.620a) 350.1060e)h) 350.1230b)2) 350.3240a)b)d)e)	2) The person being accused will be notified and placed on suspension without pay pending the completion of the investigation.
	3) When an allegation of mistreatment, neglect or abuse is received verbally or in writing, the agency will immediately begin a thorough investigation and gather as much information regarding the incident as possible.
	4) Once the interviews have been completed, the agency will carefully review the facts presented. If there is evidence that the allegation can be substantiated (i.e. one or more correborating reports of abuse) the employer will be terminated.
	5) Failure to report any alleged or suspected abuse will result in disciplinary action and possible

5) Failure to report any alleged or suspected abuse will result in disciplinary action and possible termination of employment

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Page of

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