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TAYLORVILLE TERRACE	921 EAST MARKET STREET TAYLORVILLE, IL 62568

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W 382	Continued From page 71 E2 confirmed that R1 keeps her physician prescribed medications in a lock box in her room. When asked (on 8/21/07 at 2:45 p.m.), E2 stated that facility policy requires all medications to be locked when not being administered. In a phone interview with E2 on 8/21/07 at 5:20 p.m., E2 stated that individuals of the facility are up and about the facility at approximately 6:30 a.m., having breakfast between 7:00-7:30 a.m. and do not leave the facility until 7:45-8:15 a.m.	W 382		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060b)1)2) 350.1060c)1)2) 350.1060d) 350.1060e) 350.1060f) 350.1060h) 350.1230b)3) 350.1230d)1)2)3) 350.1230e) 350.1230f) 350.3240a) 350.3240b) 350.3240c) 350.3240f) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the	W9999		

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public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1060 Training and Habilitation Services
a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.
b) Each resident shall have individual evaluations which shall:
1) Be based upon the use of empirically reliable and valid instruments whenever such tools are available.
2) Provide the basis for prescribing an appropriate program of training experiences for the resident.
c) There shall be written training and habilitation objectives for each resident that are:
1) Based upon complete and relevant diagnostic and prognostic data.
2) Stated in specific behavioral terms that permit the progress of the individual to be assessed.
d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.
e) 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.
f) There shall be a functional training and habilitation record for each resident, maintained by and available to the training and habilitation staff.
h) There shall be available sufficient,

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W9999	Continued From page 73 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. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.	W9999		

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W9999	Continued From page 74 c) 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. f) Resident as perpetrator of abuse. When an investigation of a report of suspectedabuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. These REGULATIONS were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement their system to prevent neglect for R's 1-15 when: 1) The facility failed to implement their own protocol related to injury assessment and failed to implement their own policy for neglect for R2. Facility staff failed to assess R2's lip injury and failed to assess R2 for further injuries when R2's roommate (R1) has a documented history of physical aggression to R2 and other individuals of the facility. 2) The facility failed to implement their own policy for resident room assignments. There is documented history of R1's general physical aggression, documented physical aggression to R2 (roommate), and continued placement of R1 and R2 as roommates for R2's entire stay at this facility.	W9999		

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3) The facility failed to implement their own policy for neglect and failed to ensure physical safety of residents of this facility (R's 2-15) when R1's aggressive behaviors were documented as having increased and R1's behavior management program was not revised, and R1's behavior management program did not provide further interventions for staff if verbal prompts were not effective in controlling R1's aggression.

4) The facility failed to implement their own policy for neglect and failed to provide for R1's physical safety needs when the facility failed to implement a level of supervision for R1's community access, and R1's assessments document her high-risk sexual behaviors.

These failures have the potential to affect 14 of 14 individuals who live in the facility (R's 1 & 3-15 and R2 who was discharged on 8/4/07).

Findings include:

In review of a facility document that validates level of functioning, at surveyor entry to this facility on 8/16/07, there are 14 (fourteen) individuals who reside here, with the following functioning levels: 3 who function in the mild range of mental retardation; 1 who functions in the moderate range of mental retardation; 4 who function in the severe range of mental retardation; and 6 who function in the profound range of mental retardation.

In review of a guardian list provided by the facility, 13 of 14 individuals of this facility have a guardian (R's 1-14).

There are 6 individuals of the facility (R's 4, 5, 6,

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7, 10 & 11), who are non-verbal, (list of names presented by E2, RSD/QMRP). When asked for a list of individuals who are interviewable, E2 stated, on 8/17/07 at 10:40 a.m., that there are 3 interviewable individuals in this facility (R's 1, 8 & 14).

Per observations made at the facility on 08/16/07 at 4:15 p.m., 13 of the individuals of this facility are ambulatory (R's 1, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14 & 15). R8, was observed in a wheelchair at this observation. When interviewed on 8/17/07 at 10:40 a.m., E2 stated that R8 usually utilizes a walker for assistance in ambulation. R8 has had some recent cardiac problems and utilizes the wheelchair for now.

At survey entrance to this facility (8/16/07), surveyor requested a list of roommates. The 8/16/07 list presented by E2 documents that R1 does not have a roommate. In an interview with E2 on 8/17/07 at 12:00 p.m., E2 stated that R1's roommate was R2, who was discharged on 8/4/07.

1. In review of a 1/4/07 Individual Program Plan (IPP) for R2, it validates that R2 was admitted to this facility on 12/5/06. At admit R2 weighed 236 pounds, standing 5 foot, 5 inches tall. Her Stanford Binet 5 of 8/15/06 places her intelligence quotient at 58, and her 12/29/06 Inventory for (ICAP) documents her overall adaptive level of functioning at 9 years and 8 months. At this IPP meeting the interdisciplinary team agreed on the need for guardianship, and it was agreed that one of the parents would pursue guardianship of R2.

Her 1/9/07 speech/language assessment documents that R2 is verbal, and able to engage

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in conversation.

R2's 8/1/07 physician's orders document that R2 functions at the mild level of mental retardation, with additional diagnoses of Developmental Disorder and Stage IV Breast Cancer with Metastasis to the Bone. Nursing notes for R2 dated 7/16/07 state that R2's father called and that R2 does have bone involvement with her spine and her jaw.

Nurse's notes for R2 dated 7/19/07 document that R2 was to start radiation treatments to her breast and continue this treatment through 8/3/07. Nurse's notes for 8/3/07 state that R2's treatment nurse stated that R2's breast area has become infected.

In review of R2's personal chart there is a discharge staffing dated 8/4/07 that validates R2's discharge to the home of her father and step-mother with a recommendation for referral to hospice and that her father is now her guardian.

An 8/9/07 physician's report for R2 documents extensive metastasis all over the body.

An 8/11/07 nursing note states that R2's father called the facility to let the facility know that R2 had been admitted to the hospital for intravenous antibiotics due to the infection at the radiation site.

In review of R1's current physician's orders dated 8/1/07, R1 was admitted to this facility on 2/10/03, and functions in the mild range of mental retardation. At admit R1 was 23 years old, standing 5 foot, 4 inches tall and weighing 239 pounds. Her 1/25/07 IPP documents an additional

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diagnosis of ADHD and validates that R1 has a legal guardian. Her 12/5/2000 Wechsler Adult Intelligence Scale (WAIS) documents an intelligence score of 63. Her ICAP of 1/10/07 documents an overall adaptive level of functioning of 10 years/9 months.

Further this 1/25/07 IPP states, "During today's IDT (Interdisciplinary Team) meeting it was explained to (R1) again that her behavioral concerns prevent her from being able to move to a less restrictive environment and further jeopardize her placement at (facility name)." At the closing summary of this IPP, it states that both R1 and her guardian understand that individuals who are dangerous to others are prohibited by regulation from residing in facilities such as (facility name). "Therefore, if (R1's) physical aggression continues, her placement could be in jeopardy."

A 1/25/07 social service annual update states, "She (R1) continues to have episodes of PA (physical aggression) toward her roommate (R2) and peers." This update also states that R1 hits R2, takes her things and has taken money from her.

An 8/16/07 psychiatric evaluation states, "antisocial personality disorder with impulse control problems. Lack of remorse becoming increasingly danger to others...All the other behavior modification modalities have failed at this time and dangerousness still continues to exist...She obviously being a threat to others as she lives in a facility for moderate to profound retarded who are unable to guard from harm that (R1) is inflicting on them."

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Her 8/16/07 IPP (in discussion of her 7/25/07 ICAP), documents, "a significant decrease from last years score in generalized behavior. This may be contributed to (R1's) increase in maladaptive behaviors. The ICAP also showed a decrease in service score/level from a 5 to a 4, extensive personal care and/or constant supervision."

Per observations made at the facility on 8/16/07 at 10:00 a.m., R1 was observed to be ambulatory and verbal.

A file review of R1's personal chart conducted on 8/17/07 documents that R1 has a behavior management program, with the most current revision on 10/12/06. This program documents one of R1's maladaptive behaviors as aggression - further defined as yelling, swearing, threatening others; hitting or attempting to hit others, dragging or pulling others.

When R1 exhibits aggressive behavior staff are to immediately verbally prompt R1 to stop. If necessary, repeat the prompt immediately. Staff are to further minimize attention for, or reaction to, the aggressive behavior, and attend to the target of her aggressive behavior to provide reassurance and safety while discontinuing direct interaction with R1. In lieu of direct interaction, staff shall provide 10 minutes of protective observation. In review of this program, there are no further interventions for staff to implement should R1's aggression escalate and verbal prompts are not successful in managing R1's aggression.

In an interview with E2 on 8/17/07 at 10:40 a.m., with E1 (Administrator) present, E2 confirmed

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that R1's 10/12/06 behavior management program does not provide interventions for staff if verbal prompting is not successful in managing R1's aggressive behaviors.

In a review of R1's behaviors documented by direct care staff on universal notes, the following acts of aggression are noted for R1 (after the last revision of her 10/12/06 behavior management program):

11/8/06 - R3 was kicked in the groin by R1 - area swollen and confirmed with E3 (LPN), on 8/17/07 at 1:00 p.m. that R3 was taken to the emergency room for evaluation. In this interview E3 stated that R3's scrotum was swollen.

12/21/06 - throwing movies and chair across the room

1/14/07 - yanked and pulled television remote from R3 - R3 observed holding his wrist after this incident

1/24/07 - threw the room partition down the hall

2/7/07 - flinging arms at R3 - R3 complained of leg and thigh hurting/flinging arms close to R3's face and body while he was in rocking chair

3/3/07 - scratch on R2's lower right side of face - Z1 (in a phone call to the facility, per the facility universal note), stated that initially R2 would not say how or when it happened, but finally stated R1 had scratched her

3/15/07 - pushed another non-verbal individual (R11).

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5/18/07 - shoved R3 back into a chair, causing him to fall to the floor

7/15/07 - using R2's cell phone to make a phone call

another undated phone incident of taking facility phone away from R2 (R2's phone call from relative)

In a phone interview with Z2 on 8/17/07 at 9:00 a.m., there is an undated incident of physical aggression by R1 to R2. Z2 stated that R2 told Z2 that R1 had pushed her down to the floor and kicked her.

8/3 or 8/4/07 - physical aggression to R2 - resulting in a swollen lip, a cut inside R2's mouth, two hematomas (left side of forehead and top of forehead), bruising on chin, lower back and upper left shoulder).

In review of the facility's accident/incident report dated 8/4/07 at 8:45 a.m., it states that E2 walked into the kitchen this morning and E5 (DSP) asked R2 what happened to her lip, as it was swollen. Per this report R2 stated that she had it when she got up. E5 asked her if she bit it or had been hit and R2 stated no.

Below this description there are spaces for documenting the following: temperature, pulse, respirations, blood pressure and pain. These areas are blank. There is no reproducible documentation that R2's injury was assessed. The report is signed by E5 and E2.

In an interview with E5 on 8/21/07 at 10:06 a.m., E5 stated that she documented R2's swollen lip

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on the incident/accident report, but did not complete any further assessment of R2 (i.e., vitals or any assessment for other injuries that R2 might have). E2 stated, "I guess I should have," and confirmed that vitals should have been completed, as well as assessed for pain. E5 stated that she tried to contact E3 (LPN), but by the time E3 returned the call R2 had already left the facility with her father (discharged from facility). There is no reproducible documentation on this report to validate that staff tried to contact nursing or that further assessment was completed.

There is a typewritten note signed by E2 stating that on 8/7/07, R2's father had called. He stated that R2 had a fat lip and lump on the side of her head. He stated that R2 had told him, after days of trying to figure out what happened, that R1 had, "beat her up." This note further documents that E2 talked with R1 when she arrived home from the day training site. R1 told E2 that she had hit R2 in the back and side of the head several times with a can of air freshener after she had asked R2 to help her with room care. R1 stated that R2 had also been grinding her teeth and she had asked R2 to stop. When R2 did not stop, R1 stated that she punched R2 in the mouth. In the facility's investigation of this incident, there is a hand written note signed by R1 stating that she did hit R2 in the head with a can of air freshener.

In an interview with R1 on 8/21/07 at the facility at 9:10 a.m., R1 stated that she hit R2 on her head, "with whatever was in her hand," as she no longer remembers what was in her hand, stating, it, "was a metal thing."

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W9999	Continued From page 83 In an interview with E7 (Advanced Direct Service Provider - ADSP) on 8/21/07 at 10:15 a.m., E7 confirmed that she was on duty the morning of 8/4/07 when R2's lip injury was observed. E7 stated that E5 alerted her to R2's injury. E7 stated that R2's bottom lip was swollen and red, and that the swelling was, "half-dollar size". She stated that it was, "pretty noticeable", and that it looked like someone had hit her. In a phone interview with Z1 (father/guardian), on 8/17/07 at 8:30 a.m., Z1 stated that he came to the facility on the morning of 8/4/07 to pick up R2, as she was being discharged on this day due to her stage IV breast cancer. Z1 stated that staff (could not remember which staff), notified him of R2's lip injury when he arrived and that there was no other indication from staff of any other injuries. Z1 stated that after his arrival home with R2, that at approximately 1:30 p.m., he observed other injuries on R2. Upon closer inspection, Z1 noted a small cut inside R2's mouth. Z1 stated that he noted a goose egg size lump on R2's left side of her forehead. Z1 stated that about 2 days later he noted a large lump on top of R2's head, describing it as approximately 4-5 inches long and 3-4 inches wide. Z1 stated that the lumps on R2's head are still there as of this date (8/17/07). Z1 further stated that R2, with great reluctance and many attempts at trying to find out what had happened, finally stated that R1 had hit her with a hairspray can. In another phone interview with Z1 on 8/17/07 at 11:55 a.m., Z1 stated that R2 does not report pain and that it is very unusual for her to accept pain medication. However, R2 did accept Vicodin on 8/4/07, after Z1 brought her home.	W9999		

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TAYLORVILLE TERRACE	921 EAST MARKET STREET TAYLORVILLE, IL 62568

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In a phone interview with Z2 (mother), on 8/17/07 at 9:00 a.m., Z2 stated she first saw R2 (after the 8/4/07 facility discharge), on 8/8/07 at Z2's home. Z2 stated that there was bruising on R2's chin area (R2's bone cancer documented above as affecting jaw area). Z2 stated that there was a "very large goose egg" above R2's left temple and a large lump on top of R2's head (described as the width of my (Z2's) hand, finger to palm.) Z2 stated when she tried to brush R2's hair, that she would flinch. When Z2 parted R2's hair to look at the top of her head, "it was black." Z2 further stated that R2's bottom lip was in a healing mode, scabbed over on the outside; that when Z2 looked into R2's mouth, the split was from inside the mouth to the lower outer lip.

Z2 stated that the next morning (8/9/07), Z2 helped R2 with her bath. At this time she observed three lines of bruising on R2's lower back, extending almost all the way across her back. These were purple and also fading in color. Additionally, there was a bruise on R2's left shoulder approximately the size of a hand print. This bruise was described as a, "deeper purple" in color. Z2 stated that R2 "flinched" when the bruises were touched. Z2 stated that R2 was, "reluctant" to talk about her injuries and would not discuss them until Z2 promised R2 that she was not going back to the facility. R2 told Z2 that R1 had hit her over the head many times with a hairspray can and had smacked her in the mouth. Z2 stated that she last saw R2 on 8/13/07 and that at that time, both hematomas were still present and R2's lip was still healing. Z2 stated that the back bruising was still visible but healing.

There is an 8/9/07 diagnostic imaging report

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further documenting , "Hematoma in the left supraorbital area and mid parietal area." Under IMPRESSION, it states, "No definite acute fracture is noted."

In a phone interview with Z4 (physician) on 8/23/07 at 10:30 a.m., Z4 stated that at his 8/9/07 exam of R2, the hematoma on R2's left supra orbital area was approximately 2.5 x 2.5 centimeters in size and the area on the top of her head was, "slightly larger."

In review of a facility protocol entitled, When should I call the RN Trainer?". Under the section entitled, "Call me for the following:, number 8. states, "Anytime there is an incident with injury - cut, skin tear, bruise, swelling, etc."

In review of the facility's policy entitled, ABUSE AND NEGLECT, it defines neglect as, "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." It further states, "It is the policy of this facility that all residents have the right to be free from...neglect...including, but not limited to, ...facility staff...other residents...."

2. R2, (as per example #1), was admitted to the facility on 12/5/06.

There is a 11/06 monthly QMRP summary and program progress note for R1 (as per example #1) that states the following: "Issues: This administrator spoke with (R1) firmly 11/17/06, regarding her "demand" to get rid of her roommate (here on a pre-placement visit). I discussed (R1's) aggressiveness to peers and explained that it is not acceptable."

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In an interview with E2 on 8/17/07 at 12:00 p.m., E2 stated that the administrator referred to in the above note is E8, who was also the RSD/QMRP, and is no longer employed at this facility.

In this same interview, E2 stated that R1 never wanted a roommate, but that R1 and R2 have been roommates since R2's admit 12/5/06, until her discharge on 8/4/07. When asked how the facility determines who becomes roommates, E2 stated that non-verbal individuals are placed together, that it also depends on where a bed is open, and that residents are also asked what they want.

In a phone interview with Z1 on 8/17/07 at 8:30 a.m., Z1 stated that E8 (former Administrator and RSD/QMRP), stated to Z1 that R1 and R2 were maintained as roommates because R2 could protect herself and could report it (aggression from R1), as R2 was verbal.

In a phone interview with Z2 on 8/17/07 at 9:00 a.m., Z2 stated that at R2's admission meeting (could not recall exact date), facility staff expressed concerns that R1 would "bully" R2. Z2 recalled that E8, E3 and another staff were at this meeting. Z2 further stated that some time later (exact date not recalled), E8 (former Administrator/RSD) told her they would change roommates. In a phone interview with E2 (current RSD/QMRP) on 8/28/07 at 9:05 a.m., E2 stated that E8 was employed by the facility as Administrator/RSD until 07/15/07, when E2 became the RSD/QMRP.

A 1/4/07 social history/psychosocial assessment for R2 documents that R2, "doesn't like (R1) and

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W9999	Continued From page 87 is 'tired of her,' claiming her roommate (R1) hits her". R2 was interviewed on 1/11/07 in a resident input/individual program plan questionnaire. In this questionnaire when asked about living arrangements, R2 states, "I would like to change rooms." When asked what you like most about this home - R2 stated, "my new roommate" (R1). When asked what she liked least - "(R1)." When asked if she likes her roommate - "No." When asked if she would like to share a room with someone else - "Yes, (R9)." When asked if R2 has things in her home/room she really likes and if there are some other things she would like to have - "A new roommate." When asked if there is anything else you can tell us to help make you happier here - "You should move my room." (In review of this interview, there is only one discrepancy in R2's replies - with consistency in wanting a different roommate). R1 was interviewed on 7/25/07 in a resident input/individual program plan questionnaire. In this questionnaire, when asked what she liked least about the facility, R1 replied, "roommate" and when asked if she liked her roommate (R2), R1 replied, "no." In review of a facility policy entitled, RESIDENT ROOM ASSIGNMENTS, it states, "It is the policy of the facility that all efforts will be made to place individuals with compatible roommates...Roommates will be determined by considering the individual's interests, individual requests and level of functioning." 3). Facility level of functioning documents,	W9999		

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guardian lists and interview with E2 on 8/17/07 at 10:40 a.m., establish that there are currently 14 individuals who reside in this facility (3 who function in the mild range of mental retardation; 1 who functions in the moderate range of mental retardation; 4 who function in the severe range of mental retardation and 6 who function in the profound range of mental retardation); 13 of 14 individuals have a guardian; 6 individuals are non-verbal; 3 are interviewable and 1 requires a walker/wheelchair for mobility safety.

In review of R1's current physician's orders of 8/1/07, R1 was admitted to this facility on 2/10/03, functions in the mild range of mental retardation, stands 5 foot, 4 inches tall and weighs 239 pounds.

R1's history of physical aggression, her continued physical aggression for the past year, and her jeopardy for continued placement at this facility is well documented in her 1/25/07 IPP, 1/25/07 social service update, 1/10/07 and 7/25/07 ICAP's, 8/16/07 psychiatric evaluation, and staff universal notes.

Additionally, her 8/16/07 IPP documents, (in discussion of her 7/25/07 ICAP), "a significant decrease from last years score in generalized behavior. This may be contributed to (R1's) increase in maladaptive behaviors. The ICAP also showed a decrease in service score/level from a 5 to a 4, extensive personal care and/or constant supervision."

Per review of R1's personal file, R1 had a provisional behavior management program with no date found for the implementation of this program. In an interview with E1 (Administrator)

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on 8/17/07 at 2:00 p.m., E1 stated that he believes the implementation date to be 04/06.

There is a 9/1/06 behavior management program with a revised date of 10/12/06. This program deletes two steps, one to maintain a journal and one to meet in a group for self-regulation. No additions were made to the program of 9/1/06.

Surveyor requested behavioral incidents for R1 for one full year. As per example #1, R1 has had 12 incidents of physical aggression from 11/8/06 to 7/15/07, including the following:

In a phone interview with Z2 on 8/17/07 at 9:00 a.m., there is an undated incident of physical aggression by R1 to R2. Z2 stated that R2 told Z2 that R1 had pushed her down to the floor and kicked her.

8//3 or 8/4/07 - physical aggression to R2 - resulting in a swollen lip, a cut inside R2's mouth, two hematomas (left side of forehead and top of forehead), bruising on chin, lower back and upper left shoulder.

Additionally, there are facility documents entitled, "BEHAVIOR TRACKING FORM," that is also utilized for documenting R1's aggressive behaviors. At the bottom of the page, aggressive behavior is defined as yelling, swearing, bossing others, hitting or any attempt to hit others. Behaviors are the documented with a check mark on the date of occurrence. However, the behaviors are not further detailed and there is no indication of which of the aggressive behaviors occurred.

In an interview with E2 on 8/17/07 at 12:00 p.m.,

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E2 stated that one should be able to find a chronological for each behavior. When surveyor compared the behavioral chronologicals with the check marks from 01/07 to 8/4/07, not all of R1's aggressive behaviors could be identified.

When asked (same interview as above), E2 agreed that for the behaviors checked on the data sheet that have no matching chronologicals, there is no way to identify the exact aggressive behavior that occurred related to R1's aggression. E2 further agreed that without accurate data, one cannot accurately assess R1's progress or lack thereof and therefore, program modifications could not be accurately made.

Further, in an interview with E2 on 8/17/07 at 10:00 a.m., with E1 present, E2 confirmed that R1's 10/12/06 behavior management program does not provide further interventions for staff when verbal prompting is not successful in managing R1's aggressive behavior.

In a phone interview with E2 on 8/28/07 at 9:30 a.m., E2 stated that it was not until 8/7/07 (after Z2 notified E2 that R1 had caused R2's swollen lip and other injuries on 8/4/07), that the facility increased R1's level of supervision by implementing hourly checks to monitor R1's physical aggression; and on 8/10/07, implementing 15 minute checks for R1.

In an interview with E1 (Administrator) on 8/21/07 at 12:00 p.m., E1 confirmed that R1's behavior management program was not revised until 8/20/07 and confirmed that R1's 15 minute checks were not upgraded to one-on-one monitoring until after the Immediate Jeopardy was called (on 8/17/07 at 4:15 p.m.).

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In review of the facility's policy entitled "ABUSE AND NEGLECT", it defines neglect as, "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." It further states, "It is the policy of this facility that all residents have the right to be free from ...neglect...including, but not limited to,...facility staff...other residents...."

4) R1's history and current practice of high-risk sexually inappropriate behavior is well documented:

11/2/05 - letter to guardian from past facility administrator - discusses R1's behaviors of going into bars, getting drunk and being out of facility for entire evenings - of great concern - current behavior placing her in danger.

1/25/07 IPP - R1 is very friendly and can be overly friendly to male service providers that come into the building; does not seem to treat strangers any differently than those she knows.

04/06, 9/06 and 10/06 behavior management programs - R1 has history of demonstrating inappropriate sexual interaction, is very sexually assertive and demonstrates poor impulse control without regard to consequences.

1/25/07 social service update - R1 is suggestive/provacative to strangers/men in community, involved with all boyfriends' "sexual requests," including erotic choking - going home with strangers, going into strangers' apartment - is believed she can no longer adequately protect herself from sexual exploitation due to her

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relationship with her boyfriend and reports from boyfriend with claims she had sex with someone in the bar - recommends community monitoring to ensure R1 is not using drugs when in community, relationship counseling and community safety.

However, R1's 1/25/07 IPP (under the RIGHTS section), validates that R1, "accesses the community when walking and has no restriction of visitors."

In review of the 1/25/07 IPP, there is no reproducible documentation that the interdisciplinary team provided for R1's physical safety needs when the interdisciplinary team failed to implement a level of supervision for R1's community access based on her assessed high-risk sexual behaviors.

R1's 10/12/06 behavior management program addresses R1's socially inappropriate behaviors - further defined as touching others in a sexual or non-sexual manner in the absence of consent; kissing others in the absence of consent; sitting or standing too close to others. Per this program, when R1 exhibits socially inappropriate behavior staff are to verbally prompt R1 to stop and provide separation by redirecting R1 to another area in the immediate environment and provide protective observation for 10 minutes. Further review of this program provides no level of supervision for R1's community access and no further interventions for staff to implement if verbal direction is not successful in redirecting R1's high-risk sexual behaviors.

In an interview with E2 (RSD/QMRP) on 8/17/07 at 2:10 p.m., E2 confirmed that R1's formal programs at the 1/25/07 IPP were as follows:

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W9999	Continued From page 93 self-medication, check register/money, toothbrushing, exercise and the above described 10/12/06 behavior management program. A 7/25/07 Resident Sexuality Assessment for R1 documents the following: - sits/stands too close to others - sits/stands touching others -allows strangers to kiss her - touches others inappropriately and allows others to touch her inappropriately - participates in oral, anal and vaginal sex - participates in sexual activity in social areas - cannot identify two male and female sex organs - cannot tell how to identify high risk partners A 7/20/07 health and safety assessment for R1 documents the following: - yes/no for being able to answer the door appropriately without allowing a stranger to enter - yes/no for being able to identify strangers versus acquaintance, versus close friends - no for walks away from strangers who approach her from a car/on the street - yes/no for confirms to rules and safety practices yes/no for understands instructions requiring decisions (if this_____then this____). A 7/25/07 ICAP documents R1's need for, "extensive personal care and/or constant supervision." An 8/14/07 social history/psychosocial assessment for R1 documents the following: - makes poor judgements regarding personal relationships - must be monitored to ensure she is not taking drugs or drinking alcohol while in the community - relationship training is listed as a need	W9999		

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R1's 8/16/07 IPP documents the following:
- is often inappropriately sexually
- talks to strangers
- still engages in unprotected sex
- engages in sexual activity with her boyfriend in social areas

In an interview with E9 (DSP) on 8/21/07 at 2:30 p.m., E9 stated R1 told her that she is not using the condoms provided for her by the facility and takes her birth control pills when she wants to.

However, R1's 8/16/07 IPP states that R1 only has to alert staff when she leaves the facility and has no restriction of persons.

In review of R1's 8/16/07 IPP, there is no reproducible documentation that the interdisciplinary team provided for R1's physical safety needs when the interdisciplinary team failed to implement a level of supervision for R1's community access based on her assessed inappropriate high-risk sexual behaviors.

It was not until the 8/16/07 IPP (R1 admitted 2/10/03 with documented history of inappropriate sexual behaviors), that a recommendation was made for a referral to a planned parenthood organization; and a referral made for STD/HIV screening every 6 months for R1.

In a faxed communication received from the facility on 8/24/07, a copy of the STD testing completed on 8/21/07 validates that R1 tested positive for Gardnerella. An 8/27/07 note from E2 stated that R1 was prescribed Metronidazole 500 MG tablet BID X 7 days.

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W9999	Continued From page 95 In an interview with E1 (Administrator) on 8/21/07 at 12:00 p.m., E1 confirmed that R1's behavior management program of 10/12/06 was not revised until 8/20/07 (after the Immediate Jeopardy was called on 8/17/07 at 4:15 p.m.) and prior to the revision, did not contain interventions for staff should R1 leave the facility without staff knowledge. In review of the facility's policy entitled, "ABUSE AND NEGLECT", it defines neglect as, "failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness". It further states, "It is the policy of this facility that all residents have the right to be free from....neglect...including, but not limited to, facility staff, other residents...". (A)	W9999		