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

ALLEN COURT	0033571
Facility Name	I.D. Number
1650 EAST MAIN STREET, CLINTON, ILLINOIS 61727	
Address, City, State, Zip	
02509, 18196	AUGUST 13, 2008
Reviewed By	Date of Survey
IRI OF JULY 5, 2008	10074
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.

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)
350.1060a)
350.1060b)1)2)
350.1060c)1)2)
350.1060d)
350.1060e)
350.1060f)
350.1060h)
350.1060j)
350.1082c)
350.1082e)
350.1082f)1)2)3)4)5)
350.1084c)
350.1084d)
350.1084e)
350.3240a)
350.3240b)
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 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:

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

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, 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.

j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record.

Section 350.1082 Nonemergency Use of Physical Restraints

c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the restraint is used.

e) A physical restraint may be applied only by staff trained in the application of the particular type of restraint. (Section 2-106(d) of the Act)

f) Whenever a period of use of a physical restraint is initiated, the resident shall be

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

advised of his or her right to have a person or organization of his or her choosing, including the Guardianship and Advocacy Commission, notified of the use of the physical restraint. A period of use is initiated when a physical restraint is applied to a resident for the first time under a new or renewed informed consent for the use of physical restraints. A recipient who is under guardianship may request that a person or organization of his or her choosing be notified of the physical restraint, whether or not the guardian approves the notice. If the resident so chooses, the facility shall make the notification within 24 hours, including any information about the period of time that the physical restraint is to be used. Whenever the Guardianship and Advocacy Commission is notified that a resident has been restrained, it shall contact the resident to determine the circumstances of the restraint and whether further action is warranted. (Section 2-106(e) of the Act) If the resident requests that the Guardianship and Advocacy Commission be contacted, the facility shall provide the following information, in writing, to the Guardianship and Advocacy Commission:

1) the reason the physical restraint was needed;
2) the type of physical restraint that was used;
3) the interventions utilized or considered prior to physical restraint and the impact of these interventions;
4) the length of time the physical restraint was to be applied; and
5) the name and title of the facility person who should be contacted for further information.

Section 350.1084 Emergency Use of Physical Restraints

c) If a resident needs emergency care and other less restrictive interventions have proven ineffective, a physical restraint may be used briefly to permit treatment to proceed. The attending physician shall be contacted immediately for orders. If the attending physician is not available, the facility's advisory physician or Medical Director shall be contacted. If a physician is not immediately available, a nurse or QMRP with supervisory responsibility may approve, in writing, the use of physical restraints. A confirming order, which may be obtained by telephone, shall be obtained from the physician as soon as possible, but no later than within eight hours. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used. The resident must be in view of a staff person at all times until either the resident has been examined by a physician or the physical restraint has been removed. The resident's needs for toileting, ambulation, hydration, nutrition, repositioning, and skin care must be met while the physical restraint is being used.

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d) The emergency use of a physical restraint must be documented in the resident's record, including:

1) the behavior incident that prompted the use of the physical restraint;
2) the date and times the physical restraint was applied and released;
3) the name and title of the person responsible for the application and supervision of the physical restraint;
4) the action by the resident's physician upon notification of the physical restraint use;
5) the new or revised orders issued by the physician;
6) the effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident; and
7) the date of the scheduled care planning conference or the reason a care planning conference is not needed, in light of the resident's emergency need for physical restraint.

e) The facility's emergency use of physical restraints shall comply with Sections 350.1082(e), (f), (g), and (j).

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.

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These Requirements were not met as evidenced by:

Based on observation, interview and record review, the facility has failed to implement their system to prevent neglect for R's 1-15.

The facility failed to:

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

1) implement their own policies and procedures of abuse/neglect to ensure the physical safety of individuals of this facility. The facility failed to take appropriate steps to address R2's documented 33 acts of physical aggression (between 1/25/08 & 7/23/08) towards residents of this facility; including R1's physical injury of a fractured hip. The facility failed to provide a level of supervision and safeguards to effectively protect individuals of the facility (R1 & R's 3-15).

2) identify and provide interventions regarding R2's pattern of physical and verbal aggression towards R3.

3) ensure advocacy services for 3 of 3 individuals of the facility, who have been the recipient of R2's physical aggression, and who do not have an advocate (R1, R4 & R6); and 1 of 1 individual of the facility who has a power of attorney for health care (R3).

4) notify R5's guardian of R2's physical aggression toward R5, for 1 of 1 individual who was R2's roommate until the week previous to 7/22/08.

5) ensure a thorough investigation regarding R1's 7/5/08 fall which resulted in a hip fracture, for 1 of 1 individual of the facility sustaining a hip fracture on 7/5/08, as a result of R2's physical aggression.

6) provide a hierarchy of behavioral interventions for staff to implement when R2's physical aggression towards other residents escalates.

7) provide concurrent objectives regarding R2's east wing restriction, for 1 of 1 individual of the facility who has mobility restrictions within the facility, due to her physically aggressive behavior.

8) document R2's restraint holds, implemented on two separate occasions, for 1 of 1 individual of the facility, for whom restraint holds were implemented as an emergency technique.

9) ensure follow-up authorization for R2's emergency restraint of 5/8/08, for 1 of 1 individual of the facility for whom a restraint hold was implemented as an emergency technique.

Findings include:

In review of an undated facility document that validates level of functioning, there are 15 individuals who currently reside in the facility with functioning levels as follows: 1 who functions in the mild range of mental retardation (R3); 7 who

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function in the moderate range of mental retardation (R's 1, 5, 6, 7, 8, 9 & 10); 6 who function in the severe range of mental retardation (R's 4, 10, 11, 12, 13 & 14); and 1 who functions in the profound range of mental retardation (R15).

A 7/1/08 guardian list provided by the facility documents that 8 individuals have guardians (R's 2, 5, 7, 8, 11, 12, 14 & 15). R3 has a power of attorney for health care. There are 6 individuals who do not have guardians (R's 1, 4, 6, 8, 10 & 13).

R15's current physician's orders of 6/25/08 document an additional diagnosis of being Mute.

During observations at the facility on 7/22/08 at 3:20 p.m., R6 utilized a rolling walker when ambulating. Her 9/20/07 Individual Program Plan (IPP) documents a medical diagnosis of Chronic Inflammatory Demyelinating Neuropathy in her legs, causing an unsteady gait during ambulation.

1) In review of an undated facility document that validates level of functioning, R2 functions in the moderate range of mental retardation. Her 3/19/08 Stanford Binet L/M documents an IQ of 38. Her 9/17/07 SIB validates an overall functioning level of 6 years/2 months. Per R2's undated 'Physical Characteristics" sheet, and a 7/9/08 Progress Note from the Registered Nurse (RN), R2 is 5'5" tall, and weighs 155 pounds.

A 6/25/08 physician's orders document an admission date of 8/22/05, and validate a diagnosis of Organic Affective Disorder. R2's 7/14/08 Behavior Management Resident Rights Committee (BMRRC) note documents the use of Zyprexa to assist in behavior control. R2's Behavior Management Program (BMP) of 3/1/08 validates her maladaptive behavior of physical aggression, further defined as kicking or hitting peers and staff.

A 7/1/08 guardian list provided by the facility lists R2's parents as her legal guardians.

During observations at the facility on 7/22/08 at 3:30 p.m., R2 ambulated independently and verbalized in complete sentences.

A 4/21/08 BMRRC documents that Risperdal .25 mg, 1/2 tab in the a.m. and p.m. and 2.5 mg in the HS was started on 2/22/08 due to an increase in aggressive behaviors of verbal and physical aggression. Risperdal was discontinued on 4/11/08. Zyprexa 5 mg. in the HS was started on 4/11/08. This medication was discontinued on 5/29/08 with new physician's orders for Zyprexa, 2.5 mg. in the a.m. and 5 mg. at HS. On 7/7/08, R2's Zyprexa was increased to 5 mg., BID.

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

A 7/15/08 BMRRC note states that since the last meeting, R2's Zyprexa (10 mg twice day - BID) has been increased due to an increase in frequency and severity of her maladaptive behaviors.

R2's Behavior Management Program (BMP) of 3/1/08 describes maladaptive behaviors of verbal aggression, self abusive behavior, non-compliance with routine requests and physical aggression. Physical aggression is defined as kicking or hitting staff or peers. When R2 is displaying verbally aggressive behaviors of yelling and screaming, R2 may escalate to hitting or kicking whoever is closest to her. Staff is to re-direct R2 to her room or another part of the facility to calm down. If R2 refuses, staff is to position themselves between R2 and her peers to assure that R2 does not kick anyone. If needed, all individuals are to be removed from the area until R2 is calm.

In an interview with E2 (Team Leader), on 7/22/08 at 3:45 p.m., E2 stated that R2 considers R4 to be her boyfriend. Relative to this relationship, E2 further stated that R4 likes his independence and sometimes wants to be left alone. (R4 declined attempted interview with surveyor).

'Consult Reports' (from 1/14/08 - 5/7/08) in R2's file validate R2's involvement in weekly mental health counseling sessions, with the purpose of working with R2 on her anger and behavior control skills. The last session was 5/7/08. Per this document, the therapist was leaving. A facility Progress Note dated 4/11/08 states that R2's mother did not wish for R2 to continue the counseling past May, as R2 will not discuss her behaviors or problems.

In review of a facility form entitled 'Maladaptive/Adaptive Behavior Recording Form' (1/25/08 - 07/23/08) and facility GP-2 and GP-15 Progress Notes (1/25/08 - 07/23/08), the following behaviors are documented for R2:

1/25/08 - day training - R2 took R4's soda and grabbed him by the neck and head.

2/2/08 - facility - R2 kicked R3 on her bottom leg. R3, per her undated Physical Characteristics page and her current physician's orders of 6/25/08, is 4'11" tall, weighing 157 pounds. R3 does not have a guardian, but has a power of attorney for health care. R3 functions in the mild range of mental retardation and has an additional diagnosis of Down’s syndrome. R3's 3/6/08 Stanford-Binet L/M documents an IQ of 51, with a mental age of 8 years/6 months. Her 5/20/08 SIB validates an overall functioning level of 7 years/5 months.

3/1/08 - 7:30 a.m./facility - R3 was kicked in the right leg by R2.

3/8/08 - facility - R3 was sitting in a rocking chair and R2 told her to get out of the chair - continued to yell at R3.

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

3/17/08 - 5:45 a.m./facility - R2 was in the kitchen helping. R2 came to the dining room telling R3 to, "Shut up." "(R3) was no where near (R2). (R3) was sitting in the living room watching t.v." R2 began showing threatening behavior by acting like she was going to kick residents. Residents had to be directed out of the room as they were becoming agitated.

3/17/08 - day training site - R2 hit R4 and R4 hit R2 back in her face. A review of R4's undated 'Physical Characteristics' form and his IPP of 10/12/07 document that R4 is 5' 9" tall and weighs 222 pounds. His Stanford-Binet L/M of 10/18/04 documents an IQ of 34 and a mental age of 5 years/10 months. His SIB of 10/11/07 validates an overall functioning level of 5 years/8 months.

3/25/08 - 6:00 p.m./facility - R2 was finishing dinner and R3 was clearing food bowls and the water pitcher from the table. "(R2) took the water pitcher from (R3). (R3) walked off." R2 told R3 and other residents to, "shut up." Staff directed all other residents to their rooms and other activities.

3/26/08 - 7:15 p.m./facility - R2 was telling R4 to go to hell. She then started telling other individuals to, "go to h---/,b--------."

3/29/08 - 11:20 a.m./facility - R2 was yelling at R4. R4 was going to the laundry room and R2 told him to stop. R4 was not saying a word and staff asked R4 to please stay in his room for a few minutes. R2 ran after R4 and tried to hit R4. Staff was able to get in between them. R2 then began taking everything off of R4's bed and throwing things at him. R2 began cussing at R4 ("f---- you, go to h---"). When R2 went to the living room she, "threw the chair to (R3) then hit her in her left arm (sic) while staff try to get (R2) away she kick (R3) in her left leg...." A 3/29/08 Progress Note for R3, 11:40 a.m. also states that R2 kicked R3 in her left shin.

E6, was interviewed on 7/23/08 at 12:30 p.m. E6 stated, "She's (R2) pretty strong." R2 threw R4's sheets and bears at him. E6 and E10 (Cook) were going to escort R2 out of R4's room, but R2 threw herself down on R4's bed. E6 stated that R2 did not actually pick up the rocking chair, but shoved it at R3. E6 further stated that it took two staff (E6 and E2 - Team Leaders), to get in between R2 and R3.

4/27/08 - 9:30 p.m./facility - R2 came into the living room. R3 was sitting talking with staff. R2 became verbally aggressive with R3, telling her to move. R2 continued to tell other residents to, "shut up" and "move." Staff directed residents to their rooms. R2 followed other residents into the bathroom. Staff had to stand between R2 and the two residents who were brushing their teeth. R2 "charged" staff, pushed through staff and hit R3. R2 left the bathroom and went into her room. R5 (who is documented as R2's roommate in this report), was in the room. R2 began targeting R5. Staff removed R5

CONT.

from the room (her own room). R2 shoved staff into the door and pushed R5 into the dresser. R5 moved through the hallway and into the med (medication) room. R2 followed, and hit R5 in the right side of her chest.

In an interview with E1, on 7/24/08 at 4:00 p.m., (E3 {Regional Trainer} - also present), E1 stated that R2 and R5 were roommates until last Thursday or Friday. (Per a 2008 calendar this would be July 18th or 19th/2008). R5's Health History and Assessment for 3/08 documents that R5 is 4' 11' tall and weighs 107 pounds. R5 has a state guardian.

4/28/08 - day training bus - R2 started hitting R4 in the back and head - 2 swings made contact. R2 then began hitting R3 - 1 swing made contact.

5/7/08 - facility/8:00 a.m. - Staff heard a door shut. R2 and R5 were arguing. When staff checked on them R2 was telling R5 what to do. R5 kept telling her to leave her alone. R2 kept telling R5 to shut up and stop, while R5 was making her bed.

5/8/08 - 8:20 a.m./facility - R2 was standing by the love seat and R3 sat down on it. R2 started yelling at R4, telling him to "shut up (R4)." R2 then grabbed R4's lunch bag and was fighting with him. Staff got R2 away from R4 and took R2 to her room. R2 "attacked" R4 on the way to her room. Staff got R2 to her room and came back up front. R2 returned to the area and started "going after" R4 again. Staff, "got a hold of (R2).

(R2) took staff down and they landed on (R3) who was still on the love seat then rolled to the floor. They sat there for a minute then when staff tried getting her (R2) up started attacking (R4) by kicking him by his feet and his legs". Staff got her to stop and tried to get R2 to her room. R2 went after R4 again, "hitting him repeatedly." Staff got her away from R4 again. R4 then punched R2 in her face. On the way to her room R2 shoved R10 who went into the dining room table.

A facility Progress Note GP -15, for R10, dated 5/8/08 states, "(R10) was upset but was not hurt."

A facility Progress Note GP-15, for R4, dated 5/8/08 states that R4 was kicked in his legs, "over and over."

In an interview with E7 (Team Leader), on 7/23/08 at 3:00 p.m., E7 stated that R4 was, "not doing anything", when R2 became physically aggressive to R4. E7 clarified that E7 and R2 landed on R3, and then fell to the floor. R3 remained seated on the couch. After E7 and R2 got up from the floor, E7 stated she got behind R2. E7 (demonstrating her actions) placed her arms under R2's and around the front, securing R2's crossed wrists with her hands and proceeded to take R2 to her room. E7 further confirmed she had been trained by the facility in specific types of "holds."

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

E7 expressed concern for R2 kicking R4 in his legs, as R4, "has sore legs." E7 stated R4's legs bother him and he complains with them. E7 was not sure of the medical diagnoses related to R4's legs. (In review of R4's current physician's orders of 6/25/08, R4 is 69 years of age and has medical diagnoses of Arteriosclerosis, Varicose Veins, Edema, Arthritis and Cellulitis. R4's current IPP of 10/12/07 documents that R4 does not have a guardian. An undated facility level of functioning document validates that R4 functions in the severe range of mental retardation).

E7 also expressed concern for R10, stating R10 has had a hip replacement and it was the same side that R10 hit on the dining room table. (In review of R10's current physician's orders, R10 is 51 years of age and had a Total Right Hip Replacement in 8/3/06; with additional diagnoses of Osteoarthritis.)

In this interview, E7 stated that when R4 punched R2 in her face, he did so with a closed fist.

E7 further stated that R2 "is strong, has a good grip." Weekends are worse regarding R2's behaviors, especially Saturday.

5/17/08 - 3:30 p.m./facility - A resident informed staff that R2 was in the laundry room cussing and yelling at R4 (identified as R2's boyfriend in this note). R2 was hitting R4 on the back and continued to yell and cuss at R4.

5/17/08 - 6:30 p.m./facility - R2 began bossing (R3) around and verbally attacking her. R2 continued, "Harassing (R3) who did nothing to provoke the attack." Staff walked R3 to her room to remove her from the situation. "(R2) soon followed and started kicking (R3's) door. Staff asked her to stop. R2 opened the door and shoved staff away, then started hitting R3 on the arms and face. R3 tried to stop R2 by grabbing her arms. R2 jumped on R3's bed and started kicking R3. Other staff arrived and led R2 away from R3's room.

A 5/17/08, 6:30 p.m., facility Progress Note GP-15 states that R3 was also hit in the face by R2. "Some red marks on all areas have faded everywhere except her right leg. Still red beside her knee and a bruise on her knee."

5/17/08 - 6:45 p.m./facility - R2 came out of her room and began yelling at different residents, telling them to shut up. Staff asked R2 to stop and tried to redirect R2 to her room. R2 went around staff and slapped R7 on her right leg. Staff stood between R2 and R7.

A facility GP-15 Progress note for R7, dated 5/17/08 at 6:45 p.m., was reviewed. R7's leg was red and R7 stated it hurt.

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

5/18/08 - 7:00 a.m./facility - R2 came out of her room and began staring at R3. R3 was not doing anything. R2 proceeded to yell at R3, telling her to shut up, telling her to move. Also yelling at R4.

5/18/08 - 2:00 p.m./facility - R2 was in the living room with other residents. R3 went to sit on the couch by R5 and R5's boyfriend. (In an interview with R5 on 7/22/08 at 3:20 p.m., R5 stated that her boyfriend does not live at this facility). R2 became immediately agitated using verbal aggression towards R3, telling her to "shut up" and "move." "(R3) was doing nothing." Staff asked (R2) to stop and tried to redirect her to her room. R2 continued to tell other residents to shut up. The residents got up and went outside or to their rooms.

5/25/08 - 1:30 p.m./facility - R3 was sitting on the sofa watching a movie when R2 kicked her on the lower part of her leg. This note also documents a mark about 2 inches long, red and starting to bruise.

A facility Progress Note GP-15 dated 5/28/08 at 2:30 p.m. states that R2 used the toe of her shoe to kick R3's leg. "It is a least 2 inches long, red and starting to bruise. (R3) says it is tender and hurts."

6/1/08 - 3:45 p.m./facility - R2 kicked R4 in his right leg while he was sitting watching television.

6/7/08 - 4:45 p.m./facility - R2 was putting her clothes away and her roommate came in to gather items for her bath. R2 told at her to get out, that it wasn't her room. R2 slammed the door on her roommate and told her to stay out. (R5 and R2 were roommates on this date, as confirmed in above 7/24/08, 4:00 p.m. interview with E1).

6/15/08 - 9:10 a.m./facility - R5 and R3 were sitting on the love seat. R2 sat on the arm of the chair by R3. R2 began shoving R3. E7 asked R2 to move. R2 said no and told R3 to shut up. Staff asked R2 again to go to her room. R2 then began shoving and hitting R3. Staff again tried to get R2 to go to her room. R2 refused and continued yelling at R3. R2 then began yelling at R5 while R5 was on the telephone.

A facility Progress Note GP-15, for R3, dated 6/15/08 at 9:15 a.m., clarifies that R3 was shoved three times by R2.

6/17/08 - 8:45 a.m. - R2 was trying to kick and hit R4 while on the workshop bus.

6/17/08 - 7:00 p.m./facility - R2 began yelling at R3 for no apparent reason. Staff tried to redirect, with no success. After upsetting several residents R2 began to calm down.

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

6/19/08 - 3:30 p.m./facility - Staff asked R2 to leave R4's room. R2 refused. "(R2) barred the door so (R9) could not get in...." Staff repeatedly asked for R2 to leave the room and let R9 in. R9 finally got through the door.

In a phone interview with E16 (Clerk), on 7/31/08 at 12:08 p.m., E16 confirmed that R4 and R9 had been roommates until 3-4 weeks ago.

Staff asked R2 to go to her room. R2 kicked one of the residents in the leg as she passed and shoved a chair into the resident's arm, smashing it in between the chair and table. R2 came out of her room again, yelling and threatening residents, "causing (R6) to become very upset...." R2 then began yelling at (R3) and threatening to hit her. R2 was again escorted to her room.

E2 was interviewed on 7/22/08 at 3:45 p.m. R5 was the individual who was kicked in the leg and shoved into a chair.

R2 left her room again and, "continued to yell at (R6) advancing toward her...." Staff stepped in between R2 and R6. "One of the men became upset over (R6) crying and said he would punch (R2) in the nose."

R6 (undated Physical Characteristics document, & IPP of 9/20/07), is 4' 8" tall, weighs 106 pounds and is 56 years of age. R6 has further diagnoses of Probable Heart Murmur, Cerebral Palsy and an unsteady gait due to Chronic Inflammatory Demyelinating Neuropathy in her legs. R6 has a roller walker to assist in her ambulation. R6 has no guardian.

A facility Progress Note GP-15, for R5, dated 6/19/08 at 3:35 p.m. stated that R2 kicked R5 on her right ankle and pushed the chair top into R5's left forearm.

6/21/08 - 7:30 a.m./facility - R2 started yelling at R4 for no reason and was redirected to her room - hit R3 on her arm.

A facility Progress Note GP-15 dated 6/21/08 at 7:30 a.m. also documents that R2 kicked R3's right foot near her ankle.

6/25/08 - 6:50 a.m./facility - R2 R4 several times - shoved E7 and E6 several times before calming

6/28/08 - 9:00 p.m./facility - R2 was upset that R4 would not sit beside her. R2 hit and kicked R3.

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

The facility Progress Note GP-15 dated 6/28/08 at 9:00 p.m. clarifies that R3 was kicked in her right calf and hit on the right upper arm.

6/29/08 - 3:00 p.m./facility - R2 blocked the door by the dining room table. E4 (Team Leader) went outside and asked R2 why she wouldn't let R3 in the house. R3 had her right hand on the door frame and R2 elbowed her hand, pushing R3's hand into the door frame.

A facility Progress Note GP-15 dated 6/29/08 at 3:20 p.m. states that an ice pack was placed on R3's hand.

In an interview with E4 on 7/23/08 at 2:30 p.m., E4 stated that R2 and R3 were outside on the back concrete patio. E4 went outside as she noticed that R3 was trying to come inside and R2 was blocking the door with her whole body. R3 was positioned to the right of the door, trying to reach in between R2 and the door, attempting to get to the door knob. One of R3's hands was placed on the door frame. R2 used her elbow (on top of R3's hand - behind the fingers), to push R3's hand into the door.

7/5/08 - 9:00 p.m./facility - R2 was in R4's bedroom and would not leave. R2 hit R4 and threw things at him. R4 continued to tell R2 to leave his room, but she would not. R2 continued to hit R4, tore his bed apart and threw his boots at him, continuing to throw whatever she could. Since staff could not get her to cooperate, staff asked R4 to leave his room and come to another room with staff. R2 followed and continued to hit R4.

After arriving in the dining room, R2 continued to hit R4, then shoved another resident. (The resident is not identified in this report). A facility Progress Note GP-15, for R4, dated 7/5/08 at 9:00 p.m. further states, R2, "was hitting and kicking him (R4) over and over in his arms and legs." A follow-up note dated 7/6/08 documents a small bruise on R4's left thigh.

A 7/5/08, 9:15 p.m. Progress Note GP-15 for R1 states that staff observed R1 fall between the dining room and living room. R1 complained of pain on her right side. The ambulance was called and she was transported to the hospital for evaluation. (This report does not state what caused R1's fall).

A 7/12/08 facility letter to the Illinois Department of Public Health (IDPH), states that the facility Safety Committee of 7/7/08 met to review a witnessed fall by R1. The Safety Committee recommended that the facility's Administrative Investigative Committee convene, as the the fall, "was secondary to another resident, (R2), pushing past her (R1) during a behavioral episode."

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R1's 8/28/07 IPP states that R1 does not have a guardian. R1 has speech fluency problems which significantly affect her intelligibility.

In review of an undated facility document that validates level of functioning, R1 functions in the moderate range of mental retardation. Her IQ is 37 (Stanford Binet L/M of 6/15/04). Her overall functioning level is 5 years/1 month (SIB of 8/28/07). R1 is 70 years old, with additional medical diagnoses of Systolic Heart Murmur, Arteriosclerosis Obliterans, Tremors, Seizures and Benign Essential Tremor (R1's physician's orders of 6/25/08).

Nursing notes dated 7/6/08 state that the QMRP notified this writer that R1 was admitted to the hospital for surgery regarding her right hip fracture (after R2 pushed R1 curing a behavioral episode - Safety Committee meeting of 7/7/08).

Nursing notes dated 7/11/08 states that R1 was transferred to a nursing home for physical therapy and post operative care.

In an interview with E2, on 7/22/08 at 3:45 p.m., E2 stated she was working at the facility on 7/5/08. E2 stated that R2's aggressive behaviors towards R4 began at approximately 9:00 p.m. When R1 got up to leave, R2 said to R1, "Get out of here (R1)." That is when R2 pushed on R1's back with both of her hands. E2 checked R1 and called E10 to see if she could come in and help. E2 stated that R2 was still screaming at R1. E2 remained standing over R1 as she was concerned that R2 would come after R1.

A 7/12/08 letter to IDPH - from E1 states, "The Committee (identified in the first paragraph of the letter as the Administrative Investigative Committee) determined this to be accidental, not abusive in nature."

In an interview with R1 on 7/24/08 at 1:20 p.m., R1 did not remember the date of her fall, but remembered that she was sitting in a chair by the dining room wall, opposite of the medication room door. R1 was waiting to take her "pill." R1 stated that when she had gotten up to take her pill, is when R2, "pushed me on my back....yeah her did...used both hands." R1 then stated she fell to the floor and pointed to her right hip. R1 stated that E2 was the only staff in the building, but that E10 came in and went with me to the hospital. R1 stated it, "hurt when I fell....a lot." R1 stated that she cried. R2 was having a behavior. R1 stated she has seen R2 hit other people at the facility (staff and residents). "They (nursing home) won't let her come over here.....she (R2) did this to me...." "I'm afraid of (R2)...that's why I stay away from her...that's why I stay in my room...not afraid of nobody else, just (R2)...I don't know about going back, just not sure."

R1 further stated she has a walker and exercises to do at the nursing home. R1 said there is a lady who helps me with my exercises, stating that it hurts her right leg. (R1 was

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seated in a straight back chair and lifted her right foot up off of the floor a few inches - stating that this was one of the exercises). R1 grimaced when she demonstrated the right leg lift.

In review of the R1's nursing home chart, R1 had a Right Subcapital Femoral Neck Fracture, now pinned. R1 is receiving physical and occupational therapy.

In an interview with E1 on 7/22/08 at 10:22 a.m., E1 stated she was not sure, but thought that R1 would not be discharged from the nursing home until end end of August.

7/10/08 - 6:30 a.m./facility - R2 started yelling at R4, calling her names. R3 tried to get out of the way. R2 kicked R3 in the leg.

7/10/08 - 6:15 p.m./facility - R2 hit R5 on the right shoulder and chased R3 from the room. R6 was scared and crying so staff removed R6 and several residents from the room. R2 again approached R6, yelling at her. Staff stood between them.

A facility Progress Note GP-15, for R5, dated 7/10/08 at 6:30 p.m., documents that R5 was sitting on the sofa couch in the living room. R2 went up behind her and punched her on the back on the right side shoulder blade...."some redness." At 8:00 p.m. the area was, "still a little red."

7/18/08 - facility - R2 began yelling at R5 while both residents were in their bedroom. R2 punched R5 in her left arm. Staff got her away from R5, but R2 kept coming after R5. E7 called another staff in the building for help. E6 came and E1 was also called. R5 tried to leave the room and R2 tried to kick her, but staff got between them.

A facility Progress Note for R5, dated 7/18/08 at 6:50 a.m., states R2 punched R5 on her left arm..."was red...."

7/23/08 - 8:30 a.m./facility - Residents were in the living room watching television or sitting in the dining room talking. Without warning R2 came up behind R3 and started hitting her. Staff were able to get R2 to leave the area and asked her to stop. This was unsuccessful. R2 was redirected to her room. This was also unsuccessful. R2 began quickly moving through the house. R2 pinched and hit R14, hit R12, hit R4 and kicked and hit R3. R2 was taken to the emergency room for a possible psychiatric admission.

A GP-15 facility Progress Notes dated 7/23/08 for the above incident was reviewed for R14, R12, R4 and R3:

R2 hit R14 on the right upper arm and on the right back side of her head. R14's arm has two bruises on the right upper arm the size of quarters. R14, per her current physician's

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orders of 6/25/08 is 62 years of age, functions in the severe range of mental retardation; with additional diagnoses of Osteoporosis and Anxiety.

During 7/24/08 observations at the facility, at 3:30 p.m., R14 approached surveyor and spontaneously showed her right arm to the surveyor. Three vertical bruises were observed. The two documented from 7/23/08 were now a darker purple. A third bruise had appeared and was also a dark purple.

R2 hit R12 in the right shoulder.

R2 hit R4 on his right should twice.

R2 hit R3 in her left upper arm and kicked her right leg.

In an interview with E3, on 7/23/08 at 3:25 p.m., E3 stated that he and E6, E10, E14 (Team Leader), and E15 (Team Leader), were at the facility when R2's maladaptive behaviors occurred. E3 confirmed that R2 was admitted to the hospital for psychiatric care, "just a little while ago."

E3 stated that on 7/23/08, R3 was in a rocking chair in the living room and R2 began to hit her. Staff went to redirect R2 and got R3 to come to the dining room table. At that time R2 then became aggressive to R4. While staff was, "getting in between" R2 and R4, all of the other individuals were directed out of the room. R2 was trying to get in the dining room. E3 stated that some residents were in the dining room, some went to their bedroom, and some were outside. R14 was sitting at the end of the dining room table closest to the living area. R2 pinched R14. Once again staff tried to get in between R2 and the residents R2 was aggressing on. R2 was hitting and kicking staff while they were trying to block her aggression to other residents. R2 saw R4 on the front porch and went outside after R4. Staff went after R2. E3 was not sure if R4 was hit or not. R2 was redirected back to her room. R2 came out again and went outdoors. The majority of the residents were now in the facility driveway. E3 stated he then put R2 in a supportive hold. R2 stopped and came and sat with me (E3), at the picnic table. E3 contacted E1 and E1 transported R2 to the hospital emergency room.

E3 demonstrated the "supportive hold" for surveyor. E3 stood behind surveyor and brought his arms around to surveyor’s front upper abdominal area. E3 then took surveyors right wrist with his left hand and surveyors left wrist with his right hand, crossing surveyors hands over at the wrist area.

In an interview with R3 on 7/22/08 at 4:15 p.m., R3 stated that R2 gets mad easy and calls her names. R3 was hesitant to repeat the names that R2 has used. ("B------"). R3 stated that R2 always wants to sit where I am already sitting (when in the living room).

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

R2 hits me on my arms and legs, "hard...hurts." Some times R2 comes into my room. When I ask her to leave, R2 gets mad. "I don't want her (R2) in my room."

When asked if R3 was afraid of any staff, R3 replied no. Before surveyor could ask if R3 was afraid of any residents, R3 said, "Just (R2).....gonna get hit."

R3 further stated that sometimes staff have to, "hold (R2)...hold her arms and legs...so can't kick...keep her from hitting me and others....2-3 staff to hold her...too strong." R3, who was sitting on her bed, then pointed to her left lower inner thigh, just above the knee, stating she had had a bruise there (could not give a specific date), from being kicked by R2.

R5 was interviewed on 7/22/08 at 3:20 p.m. R2 hit her while she was on her own bed, stating they were roommates at the time (could not give a specific date). R5 stated she was getting dressed and R2 "hit me for no reason and told me to shut up." As R5 was speaking, R5 gestured to her left upper arm. R5 further states, "I don't know what she (R2) was mad about. Staff asked her to do something and she took it out on me....think it was Friday morning." R5 stated E7 was in the room and called E6 for help during this episode, as R2 was trying to hit me again. R5 further stated that staff, "had to hold her back to keep her from me. E7 couldn't do it by herself...both of them (E6 and E7) grabbed her around the waist, one in front and one in back...maybe for five minutes or so." R2 says things to upset me (R5), like telling me to stay away from my own boyfriend (not a resident at this facility).

R5 stated, "don't like someone hitting me....afraid of (R2)...I just stay away from her (R2)."

In an interview with R6 on 7/25/08 at 8:30 a.m., R6 stated that R2, "stepped on my feet during a behavior...tried to punch me in the stomach...I was crying." When asked if R6 was afraid of any staff, R6 stated she was not. R6 then said, spontaneously, "Not afraid of any staff...I'm afraid of (R2) only...only person in this place I'm afraid of."

In review of R2's personal chart, R2's annual IPP was held on 9/21/07. This IPP states that R2..."has recently increased attention seeking behaviors." It also states that R2 has some issues with personal space and appropriate social skills, further stating that R2 will have programs which address these issues.

R2's social skills program of 10/4/07 was reviewed. Per this objective, R2 is to correctly state the appropriate conduct for a variety of social situations A review of the QMRP's monthly summary for 6/08 documents that R2 is working on tolerating redirection and maintaining an appropriate distance when told to shake hands with staff, co-workers and strangers.

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On 2/22/08 R2 (per a BMRRC meeting of 4/21/08), began Risperdal, .25 mg., 1/2 tab in the a.m. and p.m. and .25 mg. at HS, due to an increase in behaviors of verbal and physical aggression.

On 3/1/08 R2's BMP was revised. This program describes behaviors of verbal aggression, self abusive behavior, non-compliance with routine requests, and physical aggression. When R2 is displaying verbally aggressive behaviors of yelling and screaming, R2 may escalate to hitting or kicking whoever is closest to her. Staff is to re-direct R2 to her room or another part of the facility to calm down. If R2 refuses, staff is to position themselves between R2 and her peers to assure that R2 does not kick anyone. If needed, all individuals are to be removed from the area until R2 is calm.

On 4/11/08 a meeting was held regarding R2's increased behaviors at the facility. R2's psychotropic medications were discussed. R2's Risperdal was discontinued on this date and changed to Zyprexa 5 mg. at HS. R2 sees her neurologist on 4/24/08 for a yearly follow-up. The neurologist will be updated on the medication changes and R2's behaviors. R2 will continue her counseling sessions until May, when the counselor is leaving. R2's did not want the counseling to continue past May, as R2 will not discuss her behaviors or problems. "We will continue to monitor the behaviors and medications" (4/11/08 meeting).

In an interview with E8 (Director of Operations), on 7/25/08 at 1:30 p.m. (E1 and E3 present), E8 stated that a recommendation was made at the 4/11/08 meeting for R2 to have an MRI. E8 stated that R2's guardian had been hesitant to place R2 on medication for behaviors and wanted to rule out any medical condition. E8 further stated that this information was not documented on the 4/11/08 meeting, but had been discussed.

(Nursing notes dated 6/11/08 document that R2 had an MRI on 5/19/08. An Arachnoid Cyst was noted in the posterior fossa with no definite compression. There is no evidence of hemorrhage, mass or mass effect).

5/29/08 - A physician's order on this date documents Zyprexa 5 mg. at HS was discontinued. There is a new order for Zyprexa 2.5 mg., in the a.m. and 5 mg. at HS.

While the facility was in the process of ruling out medical causes for R2's aggressive behaviors, adjusting R2's psychotropic medications, continuing counseling, ruling out medical conditions that might contribute to R2's physically aggressive behavior, and notifying the neurologist at the 4/24/08 appointment, there is no evidence of increasing R2's level of supervision regarding her continuing physical aggression towards other residents of the facility.

ALLEN COURT 0033571
Facility Name I.D. Number

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Between 1/25/08 and 4/11/08, there are five (5) documented acts of physical aggression by R2 towards residents of the facility (see GP-15's and GP-2's cited above).

Between 4/11/08 and 7/23/08 there are twenty-eight (28) acts of physical aggression toward residents of this facility from R2 (see GP-15's and GP-2's cited above).

It was not until after R1's 7/5/08 fall and subsequent hip fracture, caused by R2's physically aggressive behavior, that the facility called a special Interdisciplinary Team Meeting (IDT) again on 7/14/08.

The facility failed to implement their own policies for neglect, with regards to the following:

The facility's 10/04 'Investigative Committee' policy was reviewed.

Neglect is defined as the, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Further, the purpose of the committee is to, "review and determine of alleged violations of any individual's rights including...neglect, have occurred."

The undated “Abuse/Neglect Reporting & Investigation Procedure" states, "neglect may include, but is not limited to physical, mental...by any staff, other resident...towards a facility resident."

The facility's 01/05 'Resident Rights' policy was reviewed. It states, "Each individual shall be free from mental and physical abuse...."

The facility's 01/08 'Resident Record' policy states, "A full written report of any serious incident involving an individual shall be placed in the individual's record...report shall include the date and time of each incident/accident and the action taken shall include...any incident/accident that has or is likely to have a significant effect on the health, safety or welfare of an individual...."

2) GP-2 and GP-15 Progress Notes between 1/25/08 and 7/23/08 document R2's physical and verbal aggression, towards R3.

Between 1/25/08 and 7/23/08, R2 was physically aggressive towards R3 on thirteen (13) separate occasions.

Between 1/25/08 and 7/23/08, R2 was verbally aggressive towards R3 on ten (10) separate occasions.

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

When compared with R2's physical and verbal aggression to other residents of this facility, R2 is aggressive to R3 (in both areas), more than any other resident of this facility.

On 7/22/08 at 2:40 p.m., E1 was interviewed regarding how the facility monitors for trends and patterns. E1 stated that trends and patterns are identified through the GP-2 and GP-15 Progress Notes. E1 further stated that BMRRC meeting notes document each individual's maladaptive behaviors per month and per specific behavior identified in the individual's BMP.

In review of 4/21/08 BMRRC notes for R2, dated 4/21/08, R2 had one act of physical aggression for March/08. Her 7/15/08 BMRRC notes document two acts for 04/08; 7 for 05/09 and 8 for 06/08.

4/21/08 BMRRC notes for R2, dated 4/21/08, document 10 acts of verbal aggression for R2 for 03/08. Her 7/15/08 BMRRC notes document 4 for 04/08; 11 for 05/08; and, 9 for 06/08.

R2's BMP of 3/1/08 describes behaviors of verbal aggression, self abusive behavior, non-compliance with routine requests and physical aggression. When R2 is physically aggressive, staff is to re-direct R2 to another room or another part of the facility to calm down. If R2 refuses, staff is to position themselves between R2 and her peers to assure that R2 does not kick anyone. If needed all individuals are to be removed from the area until R2 is calm.

In review of R2's 3/1/08 BMP, her 09/21/07 IPP, R2's BMRRC notes of 4/21/08 and 7/15/08, and the 4/11/08 special meeting, there is no evidence regarding R2's targeted physical and verbal aggression toward R3; and, no specific interventions are provided for staff regarding R2's pattern of physical and verbal aggression towards R3.

3) In review of an undated facility document that validates level of functioning, R1 functions in the moderate range of mental retardation. Her intelligence quotient (IQ) is 37 (Stanford Binet L/M of 6/15/04). Her overall functioning level is 5 years/1 month (Scales of Independent Behavior {SIB} of 8/27/07). R1 is 70 years old, with additional diagnoses of, Arteriosclerosis Obliterans, Tremors, Seizures and Benign Essential Tremor (R1's physician's orders of 6/25/08). A 7/1/08 guardian list documents that R1 does not have a guardian. In review of this document and R1's Individual Program Plan (IPP), of 8/28/07, there is no evidence of anyone acting as an advocate for R1.

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R2's physical aggression toward R1 resulted in R1's fractured hip, subsequent surgery and rehabilitation therapy in a nursing home (GP-15, GP-2 Progress Notes of 7/5/08, R1's hospital notes of 7/6/08, and a 7/22/08, 10:15 a.m. interview with E1, Qualified Mental Retardation Professional/Administrator).

In review of an undated facility document that validates level of functioning, R3 functions in the mild range of mental retardation. R3 (per her undated Physical Characteristics page and her current physician's orders of 6/25/08), is 4' 11" tall, weighing 157 pounds. R3 does not have a guardian, but has a power of attorney for health care only (guardian list of 7/1/08). R3 has an additional diagnosis of Down syndrome. Her 3/6/08 Stanford-Binet L/M documents an IQ of 51, with a mental age of 8 years/6 months. Her 5/20/08 SIB validates an overall functioning level of 7 years/5 months.

GP-2 and GP-15 Progress Notes from 1/25/08 through 7/23/08 document that R2 was physically aggressive (hitting, kicking, pinching, blocking door access), towards R3 on thirteen (13) separate occasions; and verbally aggressed on ten (10) times (yelling and cursing).

In review of an undated facility document that validates level of functioning, R4 functions in the severe range of mental retardation. R4's Stanford-Binet L/M of 10/18/04 documents an IQ of 34. His SIB of 10/11/07 validates an overall functioning level of 5 years/8 months. A 7/1/08 guardian list documents that R4 does not have a guardian.

GP-2 and GP-15 Progress Notes from 3/1/08 through 7/23/08 document R2 was physically aggressive towards R4 on 10 separate occasions.

R4 declined an interview.

E2 (Team Leader), stated on 7/22/08 at 3:45 p.m., that R2 considers R4 to be her boyfriend. R4 likes his independence and sometimes wants to be left alone. However, when R4 leaves the living area, R2 will follow R4 to his room.

E6 (Team Leader), stated (on 7/23/08 at 12:30 p.m.), that when R2 gets angry at R4 she will "trash" him room, throw items at him and refuse to leave his room.

In review of an undated facility document that validates level of functioning, R6 functions in the moderate range of mental retardation. A 7/1/08 guardian list validates that R6 does not have a guardian.

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During observations on 7/22/08 at the facility at 3:20 p.m., R6 utilized a rolling walker when ambulating. Her IPP of 9/20/07 documents a medical diagnosis of Chronic Inflammatory Demyelinating Neuropathy in her legs, causing unsteady gait and ambulation.

A GP-2 of 6/19/08 documents that R6 was crying during one of R2's physically aggressive episodes. A GP-2 of 7/10/08 documents that R2 was scars and crying during one of R2's physically aggressive episodes.

Interviews were conducted with R1(on 7/24/08 at 1:20 p.m.); R3 (on 7/22/08 at 4:15 p.m.); and R6 (on 7/25/08 at 8:30 a.m.). R1, R3 and R6 stated they were afraid of R2.

In an interview with E1 (Qualified Mental Retardation Professional /Administrator) on 7/23/08 at 3:10 p.m., E1 confirmed that R1, R3, R4 & R6 do not have guardians. E1 further confirmed that these individuals do not have relative or friend that acts as an advocate for them. E1 stated there is no one to notify regarding R2's physical aggression towards these individuals.

4) In review of an undated facility document that validates level of functioning, R5 functions in the moderate range of mental retardation. Her 3/19/08 Stanford Binet L/M documents an intelligence quotient (IQ) of 43. Per her 3/10/2008 SIB, R5 functions at at overall level of 6 years/10 months. A list of residents and guardians dated 7/1/08 validates that R5 has a state guardian. R5's 4/4/08 Health History and Assessment verifies that R5 is 4'11" and weighs 107 pounds.

GP-2's, GP-15's and 'Maladaptive/Adaptive Behavior Recording forms' for R2 and R5 document R2's physical aggression towards R5 on: 4/17/08, 6/7/08, 6/19/08, 7/10/08 and 7/18/08.

In an interview with R5 on 7/22/08 at 3:20 p.m., R5 stated she was afraid of R2.

In an interview with E1, on 7/24/08 at 4:00 p.m., E1 confirmed that R2 and R5 had been roommates until Thursday or Friday of last week. (The dates would be July 17 or July 18, 2008, per a 2008 calendar). E1 stated that R5 and R6 were now roommates, and R2 has no roommate. E1 could not be specific, but thought they had been roommates for at least a year.

In a phone interview with Z2 on 7/29/08 at 12:30 p.m., Z2 stated she was R5's guardian. Z2 was not notified of any of the above incidents. Z2 stated she would

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expect to be notified of all of the above incidents, regardless of injury or not. Z2 further stated this lack of notification created significant concern.

5) Hospital notes dated 7/6/08 document that on 7/5/08, R1 was pushed down by another resident, and complained of hip pain. These notes document a Subcapital Right Hip Fracture.

A facility document entitled, "Safety Committee," dated 7/7/08 states that the committee members reviewed the 7/5/08 incident regarding R1's fall, further documenting that R2 had pushed R1 during a physically aggressive episode. Per this document, GP-15's and R1's medical records were reviewed. A recommendation was made for the Investigative Committee to review this incident.

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The 7/9/08, "Administrative Investigative Committee Findings" documents that the committee reviewed R2's IPP, assessments/evaluations, medications, training records and programming. Members of this committee were: E11 (Administrator), E13 (Facility Representative), E3 (Regional Trainer), and E5 (RN).

In an interview with E2 (Team Leader), on 7/22/08 at 3:45 p.m., E2 stated that she was the only staff member in the facility when R2 pushed R1 to the floor on 7/5/08. E2 called E10 (Cook), at her home to ask E10 to come in. E2 stated that R2 continued to scream at R1. E2 remained standing over R1 as she was concerned that R2 would, "come after" R1 again.

In an interview with E7 on 7/23/08 at 3:00 p.m., E7 stated that, "weekends are worse," regarding the frequency of R2's behaviors, especially Saturdays. There is no evidence that the facility interviewed staff after the 7/5/08 incident. E7 further stated that on 5/8/08 she had to utilize a two-arm support hold on R2 during a physically aggressive episode.

In an interview with E3 on 7/24/08 at 4:00 p.m., E3 validated that during R2's 7/23/08 physically aggressive episode there were 4 direct care staff at the facility and him (E3). R2 is very fast and staff was not able to catch her. A two-arm support was utilized during this behavior.

R3 (7/22/08 at 4:15 p.m.), stated that sometimes when R2 is having a physically aggressive behavior, it requires 2-3 staff to hold her arms and legs to keep R2 from hitting me (R3) and other residents.

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R5 (7/22/08 at 3:20 p.m.), stated that when R2 was having a physically aggressive behavior towards R5, that it took both E6 and E7 to keep her from me (R5), and had to hold R2 around the waist.

In a 7/23/08, 3:10 p.m. interview with E1, when asked, E1 stated that no interviews had been conducted from the 07/05/08 incident. What E2 had written on the GP-2/GP-15 Progress Notes for R1 and R2 was the documentation/information taken to the safety committee.

In the daily status meeting on 7/23/08 at 4:00 p.m. with E1 and E3, E3 stated that until this meeting he was not aware that there was only one staff on duty on 7/5/08 when R1 was pushed down by R2. E3 was one of the members of the Investigative Committee which convened on 7/9/08 (as per the 7/9/08 Investigative Committee signature sheet).

There is no evidence from the Safety Committee meeting of 7/7/08, or the Investigative Meeting of 7/9/08 that the committee further investigated the facility's staffing pattern; further investigated R2's physically aggressive behavior patterns; or interviewed staff and residents in order to provide a level of supervision and safeguards to effectively protect individuals of the facility.

6) R2's Behavior Management Program (BMP) of 3/1/08 was reviewed. When R2 displays physically aggressive behaviors staff are to first re-direct R2 to her room or another part of the facility to calm down. If R2 refuses, staff is to position themselves between R2 and her peers. If needed, staff is to remove all residents from the area until R2 has calmed.

E7 stated (7/24/08 at 3:15 p.m.) that during R2's physically aggressive episode of 5/8/08, E7 implemented a two-arm support.

R2's 3/1/08 BMP does not provide a further hierarchy of interventions for staff (redirection, positioning staff between R2 and peers and removing residents from the area), should these interventions prove ineffective in protecting residents of the facility.

E3 stated (7/23/08 at 3:25 p.m.) that at 8:30 a.m. on 7/23/08, R2 became aggressive to R3, R4, R12 and R14. There were four staff in the facility (E10 {Cook} E6, E14 & E15 {Team Leaders}), as well as himself (E3). E3 stated it became necessary to place R2 into a two-arm supportive hold.

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R3 (7/22/08 at 4:15 p.m.) stated that sometimes when R2 is having a physically aggressive behavior, it requires 2-3 staff to hold her arms and legs to keep R2 from hitting me (R3) and other residents.

R5 (7/22/08 at 3:20 p.m.) stated that when R2 was having a physically aggressive behavior towards R5, that it took both E6 and E7 to keep her from me (R5), and had to hold R2 around the waist.

R2's revised 7/16/08 BMP was reviewed. This program states R2 has a history of non-compliance and physical aggression. R2's physical aggression is described as kicking, pushing and hitting others. It further states that the severity of behavior incidents has been increasing in the past couple of months.

Per the program, when R2 is becoming upset, staff is to ask R2 what is upsetting her. If R2 does not respond, staff should assess the environment to determine the cause. Staff then attempt to correct the situation or redirect R2 to another activity. If this is unsuccessful and R2 becomes physically aggressive, staff is to ask R2 to stop in a firm voice. If this is not successful, staff is to redirect R2 to another area where she can be alone. If this is unsuccessful, other residents are to be directed out of the area. If staff is not successful in calming or redirecting R2 and R2 becomes a danger to herself or others, they are to call 911 and ask for police assistance.

R2's 7/16/08 BMP does not provide a further hierarchy of interventions for staff (ask R2 what is upsetting her; correct situation or redirect R2; stop; redirect R2 to an area where she can be alone; direct residents of of area) should theses interventions prove ineffective in protecting residents of the facility until police arrive.

7) A facility GP-15 dated 7/14/08 states that a special staffing was held due to R2's increased behaviors. One of the outcomes from this meeting restricts R2's access to the men's wing on the east side of the facility.

Per the 7/15/08 the Behavior Management Resident Rights Committee (BMRRC) notes R2's access to the east wing of the facility is being put in place to help reduce maladaptive behaviors associated with R2's attempts to gain attention from R4. Additionally, when R2 completes her laundry program, she will be accompanied by staff at all times to ensure her appropriateness. (Per observations on 7/22/08 at 4:00 p.m., the resident laundry room is located on the east wing).

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

Per this summary, the restriction will not be reviewed until the next quarterly Behavior Management Committee (BMC) meeting. If the restriction has been successful, a behavior program will be implemented in order for R2 to work on re-gaining access to the east wing.

In review of R2's special staffing dated 7/14/08 and R2's current programs, there is no evidence of a concurrent objective for R2 to regain access to the east wing.

In an interview with E1, on 7/22/08 at 2:40 p.m., E1 (Qualified Mental Retardation Professional/Administrator) stated that the east end restriction was in effect as of 7/15/08. E1 further confirmed that there is no concurrent objective in R2's behavior program for R2 to regain access to the east wing.

8) In an interview with E7, on 7/24/08 at 3:15 p.m., E7 stated that during a 5/8/08 behavioral episode, she had to get behind R2 and use a two-arm support, holding R2's crossed arms with her hands. E7 stated she performed this hold as per the facility training she had received. (Per the 5/8/08 GP-2 R2 was physically aggressive to R4 and R10).

There is no documentation of the use of the two-arm support in the 5/8/08 GP-2 behavior incident documented by E7.

Per a 7/23/08 GP-2 at 8:30 a.m., R2 was physically aggressive to R14, R12, R4 and R3. R2 was eventually taken to the emergency room for a possible psychiatric admit.

In a 7/23/08 interview with E3, at 3:25 p.m., E3 confirmed that he was present during the 7/23/08 behavioral incident. E3 stated that when the above behavioral techniques did not work, E3 had to place R2 in a supportive hold. At surveyor request, E3 demonstrated the two-arm support as described in the 'Physical Intervention' - Behavior Management - Students Manual.

Per the training manual - "Begin with a one-arm support. Emphasize the importance of timing in gaining hold of the second arm, catching it as it crosses in front of the body. Be sure to have opposite hands holding with the person's arms crossed. When the hands are holding the same arms of the person, this is known as a basket hold and is not safe for staff or the individual. A second staff member can assist in gaining the second flailing arm if needed."

In review of 7/23/08 report for R2, there is no reproducible evidence of the two-arm restrictive technique having been utilized.

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

9) In an interview with E7 on 7/24/08 at 3:15 p.m., E7 stated that on 5/8/08, R2 was physically aggressive towards R4. E7 stated that she had to get behind R2 and use a two-arm support, holding R2's crossed arms with her hands. E7 stated she performed this hold as per the facility training she had received.

An undated staff training document, entitled 'Behavior Management - Student's Manual', further states that any time physical restraint is required, the House Manager, RSD (Residential Services Director), or Administrator must be notified. The RN (Registered Nurse) consultant must be notified due to the potential for injury and to ensure notification of the individual's primary care physician. (A portion of this manual was faxed to the surveyor on 7/25/08 at 12:20 p.m. by E8 (Director of Operations). E8 confirmed that this was the document used in training staff regarding physical interventions with residents

There is no documentation of the use of the two-arm support in the 5/8/08 GP-2 behavior incident documented by E7.

In review of R2's personal chart no follow-up authorization was found for the restrictive hold.

During a 1:30 p.m., 7/25/08 meeting, E1, E3, and E8, E1, E3 and E8 confirmed that they were not aware that a restrictive hold had been implemented on 5/8/08. No further documentation regarding the 5/8/08 incident was presented prior to the survey exit date, including an emergency authorization.

The facility failed to implement their own policies for neglect, with regards to the following policies:

The facility's 10/04 'Investigative Committee' policy was reviewed. Neglect is defined as the,"Failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness." Further, the purpose of the committee is to, "review and determine if alleged violations of any individual's rights including...neglect have occurred".

The 'Abuse/Neglect Reporting & Investigation Procedure', states that, " neglect may include, but is not limited to physical, mental.....by any staff, other resident.....toward a facility resident".

The facility's 01/05 'Resident Rights' policy was reviewed. It states, "Each individual shall be free from mental and physical abuse. Each individual shall be free from chemical and physical restraints unless authorized by a physician, in

ALLEN COURT | 0033571
Facility Name | I.D. Number

CONT.

writing, for a specified period of time....Each individual shall be treated with consideration, respect, and full recognition of his/her dignity and individuality...."

The facility's 01/08 'Resident Record' policy states, "A full written report of any serious incident involving an individual shall be placed in the individual's record... report shall include the date and time of each incident/accident and the action taken...shall include...any incident/accident that has or is likely to have a significant effect on the health, safety or welfare of an individual...."

The facility's 07/04 'Hierarchy of Behavior Management Techniques', "...will make all efforts to use the least intrusive program methods first before using other methods...if...more intrusive methods are needed to address the behavior, the program will reflect these methods."

The facility's 07/04 'Restraint of Individuals' policy states, "The reason for using any type of physical restraint shall be documented in the individual's record."

In review of a facility policy entitled, 'Quality Assurance Committee', it states: "The facility shall have a Quality Assurance Committee to review individual's incident reports". This policy further states that the committee will, "Review all incidents and accidents....to ensure no patterns or trends are occurring. Committee will implement a plan of correction when necessary to prevent future incidents..."

(A)