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| W 460 | Continued From page 57<br>that R23 frequently coughs during meals.<br><br>An Immediate Jeopardy was called on 7/24/08 at 2:30pm due to food being prepared and served to individuals that were of the wrong texture and consistency.<br><br>The Immediate Jeopardy was removed on 8/6/08 at 10:10 AM: when the surveyor verified a plan for removal which includes the following:<br><br>1. Beginning on 7/24/08 at the supper meal an LPN will be assigned to assess the 7 pureed diets before the meals leave the kitchen to make sure that the meals are served at the proper consistency. An LPN will assess meal consistency for 2 weeks.<br>2. A dietician will be at the facility to train staff on preparing pureed diets.<br>3. All dietary assessments will be reviewed to ensure that we meet the requirements.<br>4. Effective immediately all pureed diets will be completely prepared in the kitchen by dietary staff prior to being delivered to the dining room.<br>5. All thickened drinks will be prepared by dietary staff.<br>6. No staff will assist a resident with eating while standing up.<br>7. All dietary, direct care staff and QMRP's will be trained related to special diets, snacks and thickened drinks.<br>8. All nursing staff will be trained on thickened drinks used during med pass.<br><br>Although the Immediate Jeopardy is removed, noncompliance continues at the exit since the facility has not had an opportunity to evaluate the plan. | W 460 | | |
| W9999 | FINAL OBSERVATIONS | W9999 | | |

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| W9999 | Continued From page 58<br>LICENSURE VIOLATIONS<br><br>350.620a)<br>350.1060a)<br>350.1060b)1)<br>350.1060c)1)2)<br>350.1060d)<br>350.1060e)<br>350.1060h)<br>350.1060j)<br>350.1210b)<br>350.1230b)7)<br>350.1230c)<br>350.1230d)1)<br>350.3240a)<br>350.3240f)<br><br>Section 350.620 Resident Care Policies<br><br>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.<br><br>Section 350.1060 Training and Habilitation Services<br><br>a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.<br><br>b) Each resident shall have individual evaluations which shall:<br>1) Be based upon the use of empirically reliable | W9999 | | |

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| W9999 | Continued From page 59<br>and valid instruments whenever such tools are available.<br>2) Provide the basis for prescribing an appropriate program of training experiences for the resident.<br><br>c) There shall be written training and habilitation objectives for each resident that are:<br>1) Based upon complete and relevant diagnostic and prognostic data.<br>2) Stated in specific behavioral terms that permit the progress of the individual to be assessed.<br><br>d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.<br><br>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.<br><br>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.<br><br>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 | W9999 | | |

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| W9999 | Continued From page 60<br>and shall become a part of the resident's record.<br><br>Section 350.1210 Health Services<br><br>The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:<br>b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.<br><br>Section 350.1230 Nursing Services<br><br>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:<br>7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.<br><br>c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.<br><br>d) Direct care personnel shall be trained in, but are not limited to, the following:<br>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.<br><br>Section 350.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>f) Resident as perpetrator of abuse. When an | W9999 | | |

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| W9999 | Continued From page 61<br>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.<br><br>These Regulations were not met as evidenced by:<br><br>1.Based on interview, observation and record review, the facility failed to implement their written policies and procedures to prohibit mistreatment and abuse/neglect for 2 individuals outside the sample (R11 and R12) when the facility a) failed to review the behavioral incidents to determine patterns and trends of peer to peer aggression with potential to impact all clients R1-R97 and b) failed to make revisions to behavior programs to ensure client protection for 2 of 2 individuals (R11 and R12) who have patterns of physical aggression.<br><br>2. Based on interview and record review, the facility has failed to develop and implement a policy or protocol, to ensure that further neglect or potential abuse did or does not occur during unsupervised home visits for one of one client (R15) outside the sample who has a temporary guardian, with an Office of Inspector General substantiated claim of neglect.<br><br>Findings Include:<br><br>1. Per review of R11's IHP (Individualized Habilitation Plan) of 2/21/08, R11 is a 53 year old | W9999 | | |

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| W9999 | Continued From page 62<br>verbal ambulatory male who functions in the profound range of mental retardation with an additional diagnosis of Downs Syndrome, Intermittent Explosive Disorder and Agitation. R11 functions at an age level of 2 years 4 months according to his 2/8/08 SIB (Scales of Independent Behavior).<br><br>R11 has a behavior plan of 6/17/08 to address physical aggression (any attempt, or act of, spitting, pushing, kicking and /or striking others) and threatening behavior (yelling, gestural aggression shaking fist).<br><br>Per review of R12's IHP ( Individualized Habilitation Plan) of 1/25/08, R12 is a 62 year old verbal ambulatory male who functions in the profound range of mental retardation with an additional diagnosis of Depression and Impulse Control deficit. R12 has an overall functioning level of 3 years and 7 months according to his SIB (Scales of Independent Behavior).<br><br>R12 has a behavior plan of 4/16/08 to address physical aggression (physically hurting peers and/or staff, attempts to hurt peers and/or staff), verbal aggression (yelling at peers and/or staff in an aggressive manner), emesis (self-induced vomiting, attempts to induce vomiting and inserting object in mouth to induce vomiting), and property destruction (destroying property through aggressive acts).<br><br>Per review of 3 months of behavioral incidents during Task 2 of the survey:<br>7/20/08-R11 hit R12 in the face/head<br>7/8-R12 went after peer<br>7/3-R12 punched peer in the middle of back<br>7/20-R12 hit R11 in face and chest | W9999 | | |

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| W9999 | Continued From page 63<br>7/5-R12 hit peer in the back<br>7/13-R12 hit and kick staff<br>7/13-R12 hit peer 3x with his hand and remote control of TV and then hit staff 4xs in the back and kicked her 2x in the leg<br>(Per interview with E1 on 7/22/08 at 10:00am, all of July's incident reports were not given to the surveyor due to not having access to the reports.)<br><br>6/5/08-R11 hit R12 in face/chest<br>6/5-R12 hit R11 who was going through his things<br>6/23-R12 hit peer and pushed him to the floor<br>6/26-R12 hit R11 and R11 hit him back<br>6/19-R12 hit R11<br>6/7/-R12 hit peer 5x in back<br>6/3/-R11 hit peer<br>6/26-R11 hit R12<br>6/19-R12 hit R11<br>6/25-R12 hit peer 4x in back<br>6/12-R12 hit peer<br>6/13-R12 hit staff<br>6/10-R12 hit staff<br>6/11- R12 hit peer<br>6/12-R12 went after R11<br>6/10 R11 hit 2 peers<br>6/10 -R11 hit peer<br>6/10-R12 hit peer<br><br>5/8/08-R12 hit peer<br>5/13-R11 hit peer<br>5/14-R11 hit R12 with clothes hanger<br>5/18-R12 hit staff with hat<br>5/23-R12 hit peer<br>5/24-R11 hit peer at 8:40am<br>5/24- R11 hit peer at 12:15pm<br>5/26-R12 hit peer<br>5/26- R11 punched peer in back<br>5/30-R11 hit peer | W9999 | | |

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| W9999 | Continued From page 64<br>5/31-R11 hit peer in dining room<br>5/31-R11 hit peer in shower stall<br>5/31-R12 hit peer<br><br>The wing roster and room assignments (undated) were given to the surveyor on 7/22/08. R11 and R12 reside on the same wing and share a bedroom.<br><br>Per interview with E8 (Qualified Mental Retardation Professional) and E9 (Social Service Director) on 7/23/08 at 10:00am, the facility does not keep track of how often an individual aggresses upon another individual. E8 and E9 also stated, when R11 and R12 hit other individuals, there is no apparent physical injury to others. E8 and E9 did agree, there is potential for injury.<br><br>The facility tracking system sent to the Department was reviewed on 7/30/08. The Behavior Committee met 28 times between 12/11/07 through 7/24/08. Documentation of meeting dates describes reason for meetings. Topics include R12's aggression at the nurses station, medication and supervision changes, stealing behaviors, emesis/induced vomiting, desensitization programming, medical planning, diet orders and sleep pattern monitoring.<br><br>There is no documentation to show that the team evaluated trends and patterns of R12's physical aggression to and from R11, or made any recommendations for R11's or R12's client protections.<br><br>E8 was interviewed on 7/23/08 at 10:00am. E8 stated that the IDT (Interdisciplinary Team) is determining whether R12's aggression is medical | W9999 | | |

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| W9999 | Continued From page 65<br>or behavioral. When asked why R11 and R12 are living on the same wing and are roommates, E8 stated that "moving R11 and R12 would only cause more behavioral problems and both individuals are set in their ways."<br><br>E8 stated that R12's behavior plan was revised on 7/16/08 from 4/16/08. When asked what revisions were made to the program, E8 responded, that updates were made to discontinue Ativan and Risperdal. E8 stated that Invega was started for behavioral issues. The team also agreed to modify diagnoses as follows: 1)remove Intermittent Explosive Disorder, 2) remove the "history of " from his depression diagnosis, as he is currently treated for depressive symptoms with Paxil, and 3) add Somatic Preoccupation as listed in his formal diagnoses on the chart.<br><br>There is no evidence, in R12's 4/16/08 behavioral program, that the team revised the program. There is no element of monitoring patterns and trends within the program.<br><br>Interventions in R12's behavior program are:<br>-Help R12 avoid noisy areas by redirecting him to another room/area<br>-When R12 begins to yell aggressively, staff should react immediately to diffuse the situation as this is often an antecedent to an aggressive behavior. Remove the targeted resident from R12's line of sight as this will often stop the behavior. Give him a choice or ask him a question rather than give a directive.<br>-Help R12 avoid certain residents.<br>-Avoid confrontations with R12 over his personal possessions.<br>-Use diversional activities such as watching a | W9999 | | |

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| W9999 | Continued From page 66<br>movie, watching baseball, talking about past events which he has enjoyed or going on an outing.<br><br>Per observation on 7/22/08 at 4:15-5:30pm, R12 was walking around his wing. R12 was never directed to an activity. He was observed roaming from activity room into the TV room. No activities were offered by staff that afternoon.<br><br>E13 (DSP on wing 200) was interviewed on 7/29/08 at 9:10am. E13 stated that all the residents on the wing are scared of R11 and R12 and will move away from them. R18 will get very loud and R12 will go after him. R18 will try and run away from him. E13 stated that the guys now seem very relaxed since R12 was transferred to a different wing. (Transferred 7/24/08 following Immediate Jeopardy called on 7/23/08).<br><br>Per review of an incident report dated on 6/7/08 at 2:30pm, R8 was hit in the back 5 times by R12 "for no reason." The IDT (Interdisciplinary Team) notes of 7/24/08 state that a meeting was held for R8 on 7/3/08, "on this date, an IDT meeting was held to discuss medication issues and a change of rooms...This move was prepared in light of a recent incident in which R8 was struck by another resident (R12) in the wing shower room. While R8 sustained no injury from the incident, his mother and father both continued to be concerned for his safety." The meeting was held 47 days after the incident occurred.<br><br>Per interview with E8 on 7/23/08 at 10:30am, R8 was moved to a different wing and room after the meeting. | W9999 | | |

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| W9999 | Continued From page 67<br>The facility policy and procedure (undated) regarding abuse was reviewed. "Physical abuse refers to the infliction of injury on a resident that occurs other than by accidental means and requires (whether or not actually given) medical attention. Neglect means a failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. The failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours."<br><br>Per review of R11's behavior plan of 6/17/08, there is no reproducible evidence within the program that the facility has revised R11's behavior plan. There also was no reproducible evidence provided to surveyor when documentation was requested regarding facility monitoring of patterns and trends.<br><br>2. During a review of R15's 30 Day Staffing for the Individualized Habilitation Plan dated June 23, 2008, R15 is an 18 year old individual with a diagnosis of Spastic Cerebral Palsy, Mood Disorder, Depression and Constipation. R15 has an IQ of 72 and an adaptive behavior score of 1 year 10 months placing him in the Profound range of mental retardation. R15 is verbal and makes his desires known to others.<br><br>Upon review, of Investigative Report OIG ( Office of Inspector General) Case No. (number) 1508-611 dated 5/27/08, it was discovered that on 6/21/07 a complainant reported an allegation of abuse and neglect. "The caller reported that (R15) consistently came to school covered in | W9999 | | |

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| W9999 | Continued From page 68 | W9999 | | |

feces and soaked in urine." A synopsis of this report further states that Z3 and Z5 both struck R15. This section also related "R15 did not want any of his family interviewed for fear of reprisal. Thus, we could not verify the allegations of abuse." Under "Findings" on this same report it states "we substantiate the allegation of neglect against Z3."

The above noted case was referred to Central Illinois Service Access on 5/14/08 by the Office of the Inspector General "for possible residential placement." This case was also referred to the "Division of Developmental Disabilities and the Division of Rehabilitation Services."

A 24 hour log dated 5/19/08, wings:300/500 was reviewed by this surveyor. R15's name was found on this form along with a synopsis of circumstances surrounding the admission of R15 to the facility. This form states "showered, purple bruise to right lower quadrant over pelvic bone to right hip, penis and scrotum reddened." "What a mess."

A Letter of Temporary Guardianship of Disabled Person dated 5/21/08 filed in the Circuit Court for the Seventh Judicial Circuit of Illinois Sangamon County, Springfield, Illinois was found in R15's record. The temporary guardianship was awarded to Z3, on the noted date. On the same date, in the same court, Z4 was awarded Guardian ad Litem of R15.

Upon review of the facility Nurses Notes dated 5/23/08 at" 0900," R15 left on a home visit, he is noted to have returned on 5/25/08 at "1600." On 5/26/08 at "1000" R15 reported to staff that" (immediate family member) hurt (L) arm while on

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| W9999 | Continued From page 69<br>HV (home visit)."<br><br>There are four additional overnight home visits documented on the Facility Nurses Notes of R15 dated 5/30/08 to 6/26/08. On 7/23/08 surveyor observed R15 leaving for home visit with Z3. There was no further documentation found in R15's record.<br><br>On 5/27/08 a Psychological Report was conducted on R15. The report states R15 "reported his mother did not treat him right and did not clean him after his bowel movements." R15 "reported he was neglected by his mother." This report goes on to say R15 "is also afraid of one of his step brothers who has hit him. His mother has also hit him."<br><br>Upon review of Psychological/Intellectual Report dated 6/8/08 under recommendations it states, R15 has "Relatively good memory and factual information skills."<br><br>During review of an interoffice e-mail at the facility provided by E1 Administrator, it was found that E2 Residential Services Director (RSD) sent an e-mail to E1 dated 6/12/08 at 9:30AM that stated "This is one of those 'in the know' e-mails. (R15) came to me this morning saying that (staff) was upset with him because he heard E10 call E17 a 'faggot' and then told E17 about it. E17 was involved with this, as well.<sic>as she heard it said by (R15) in the dining room. I talked with (R15, E10, E16 and E17) and it turned out that (R15) 'thought' he heard E10 say the word but he was not sure it was E10. (R15) then said it was somebody on wing 300 but probably not E10. E10 emphatically denied using the word, as it is very hurtful. E17 also said he has never heard | W9999 | | |

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| | 14G039 | A. BUILDING _____ B. WING _____ | 09/15/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROTHER JAMES COURT | 2500 ST. JAMES ROAD SPRINGFIELD, IL 62707 |

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| W9999 | Continued From page 70<br>that word used before here. I am inclined to chalk this one up to (R15) if you agree."<br><br>During the same review of interoffice e-mail provided by E1 Administrator, another e-mail was located. This e-mail was dated 6/12/08 at 11:20 AM authored by E2 RSD, and sent to E1 Administrator, titled (R15) II. This e-mail was another statement of an incident involving R15 accusing a staff person of a wrong doing. E2 writes "I am fearing that this might be the start of some targeting of E10 on (R15's) part."<br><br>A memo written by E5 QMRP (Qualified Mental Retardation Professional), dated 6/20/08 states "(R15) was admitted to (facility) on May 29, 2008. Since his admission to (facility) we have found (R15) to be making false statements, both about his family and about (facility) staff. Below are a brief list of the false statements that we have been able to disprove." This memo then goes on to list three occasions of R15 making false statements. In paragraph 3 of this document it states "After an intensive investigation, based on the reports other staff members present submitted, no inappropriate language was used in front of (R15)."<br><br>During an interview conducted on 7/30/08 at 2:30 PM surveyor asked E1 for the results of the above noted investigations into these false statements. E1 stated, "I don't know how intensive these were. I'll have to check but they weren't thoroughly investigated. We really didn't need to investigate them." When surveyor asked E1 how the statements could be disproved without an investigation E1 stated, "I know, let me check." On 7/30/08 at 3:06 PM surveyor received copies of the above noted interoffice | W9999 | | |

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| W9999 | Continued From page 71<br>e-mails sent by E2 RSD and sent to E1. Neither of the two interoffice e-mails provided evidence of a thorough investigation into these statements.<br><br>On 7/29/08 at 9:02 AM E3 QMRP was interviewed to determine if safeguards were in place for R15's home visits. E3 stated that the facility must allow home visits with Z3 as she is R15's temporary guardian, "she could charge us with kidnapping." E3 assured the surveyor that R15 "is checked when he comes home, he is usually hungry but we get him a sandwich. Nursing checks him, there aren't any safety issues here, I haven't seen any."<br><br>On 7/29/08 at 9:12 AM E4 Director of Nursing (DON), was interviewed. E4 was asked if there was a skin assessment done on R15 upon return from home visits, or in lieu of that how was R15's condition assessed upon return? E4 stated "they should document it in the nursing notes, we watch him closely because of his braces. We have a skin sheet. You need to talk to E6 (Licensed Practical Nurse (LPN) the nurse on duty, see if she has a sheet."<br><br>E6 LPN was interviewed on 7/29/08 at 9:15 AM and was asked if a skin assessment was completed on R15 upon return from home visits? E6 stated "no we don't routinely check, we don't do an assessment on his return from home visits."<br><br>R15 was interviewed on 7/29/08 at 12:30 in the conference room of the United Cerebral Palsy Center. R15 was asked how his home visits were going. R15 stated "I don't want to go home but my Mom makes me. We get into it. I am afraid to go home." R15 was asked if he feels | W9999 | | |

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| W9999 | Continued From page 72<br>that he gets enough to eat while on home visit. R15 related that all he eats is "chips, fruit snacks and sandwiches and it is not enough." R15 was then asked if anyone is mean to him during his home visits. R15 stated "they don't hit me they just yell at me." Surveyor asked R15 if he knew who he should tell if someone hurt him. R15 stated, "I don't know." R15 went on to state "my Mom's my guardian, I don't want her to be but I don't have a choice until I get in front of a judge." R15 said in closing "I need to talk to E9 (Social Service Director), I guess I better do that today."<br><br>E1 Administrator furnished this surveyor with an information summary of a meeting that was held with R15 on 7/29/08. In attendance at this meeting was E1 Administrator, E2 RSD, E3 QMRP, E5 QMRP and E9 Social Services Director. In this summary is documentation to substantiate R15's earlier interview with this surveyor. R15 again relates that he does not want to go on home visits with Z3, that Z3 is "mean, she raises her voice." When R15 was asked why he had not reported this information to the facility in the past, his response was, "My Mom wants me home every weekend and I don't want to put you guys in the middle, do you see what I am saying."<br><br>R15 then goes on during this meeting to make further allegations of verbal abuse and physical neglect. R15 states that he has asked for food and had the request denied. "No all I ate this weekend was some chicken and I was home five days. I had chicken and noodles Saturday all day." R15 was asked if he received his medication while on home visit, "No." When asked if he had been hurt while on home visit R15 stated that a two year old child had hurt his | W9999 | | |

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| W9999 | Continued From page 73<br>arm but that his sister had asked him not to say anything.<br><br>Z4 was interviewed on 7/30/08 at 4:20 PM by telephone. Z4 related that he did not investigate the previous home of R15 as Z4 was assured that R15 was returned to the facility after the first home visit with Z3. When this surveyor asked if Z4 had any concerns regarding Z3, he stated "yes I do." Z4 was asked if he had prior knowledge of the allegations against Z3 in regards to abuse and neglect? Z4 stated "I knew and I tended to believe it." Z4 related that in his opinion R15 does not require a guardian.<br><br>Per review of the (undated) facility policy and procedure regarding abuse on 7/23/08, Physical Abuse refers to the infliction of injury on a resident that occurs other than by accidental means and requires (whether or not actually given) medical attention. Neglect means a failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. The failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours. (typed as written)<br><br>(A) | W9999 | | |