STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G355	A. BUILDING _____ B. WING _____	C 05/07/2009

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W 127	Continued From page 15 resident abuse occurs and if the facilities actions were sufficient to protect the other residents. If it was not, the plan(s) will be revised to ensure the safety of the other residents. This will be completed by 05/16/09 and on an ongoing basis. The responsible staff will be the Assistant Administrator (E2). -All staff will be inserviced as to what 1:1 supervision is for R1 as well as for any other individuals requiring one to one supervision. Only those staff inserviced will be allowed to provide one-to-one supervision with R1. This will be completed by 05/08/09. The responsible person will be the RSD. - All staff will be inserviced on resident to resident abuse. This will be completed by 05/08/09. The responsible person will be the RSD. Although the Immediate Jeopardy is removed, non-compliance continues at the time of exit since the facility has not fully implemented their plan and has not had an opportunity to evaluate it's effectiveness.	W 127		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.630b) 350.1060e) 350.3240a) 350.3240f) Section 350.630 Admission, Retention and Discharge Policies	W9999		

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W9999	Continued From page 16 b) Residents shall only be admitted who have had a comprehensive evaluation covering physical, emotional, social and cognitive factors, conducted by an appropriately constituted interdisciplinary team. Section 350.1060 Training and Habilitation Services 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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 Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 7 of 14	W9999		

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W9999	Continued From page 17 individuals of the facility (R2, R3, R4, R5, R6, R7, and R8) are not subjected to abuse by another resident of the facility (R1) when the facility failed to: 1) Consider the ages, abilities, health, and safety of all residents of the facility (R2-R15) when the interdisciplinary team recommended admitting R1, who is an 18 year old male with history of physical aggression. 2) Provide necessary staff supervision to prevent client to client abuse after R1 was admitted to the facility. 3) Assess R1's level of supervision after he pushed R3 down. R3 required emergency room treatment for a laceration to his head. 4) Ensure that sufficient safeguards were in place and implemented to prevent further occurrences of client to client abuse. 5) Develop a behavior plan to address R1's level of supervision across all environments and during all times of the day and night to prevent further occurrences of client to client abuse. Findings include: 1) The facility failed to consider the ages, abilities, health, and safety of all residents of the facility (R2-R15) when admitting R1. The facility's roster (no date) identifies that there are fifteen male individuals (R1-R15) living at the facility functioning at a severe to profound level of mental retardation.	W9999		

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W9999	Continued From page 18 In reviewing the facility's roster with E11 (Licensed Practical Nurse/LPN) on 04/30/09 at 9:45 A.M., it was noted that R2 through R15 ages range from 40 years of age to 75 years of age. During this review E11 stated, "R2 is 73 years old and is being followed by a cardiologist for heart problems... R3 is a 62 years old and is blind and also has diagnosis of seizures. R3 also has been recently diagnosed with heart problems and like R2 is being followed by a cardiologist... R5 and R10 are legally blind... R7 is a 66 year old male who had breast cancer and is still receiving Tamoxifen... R4 is 66 year old male with a few medical problems..." When asked by the surveyor if these individuals (R2, R3, R4, R5, R7, and R10) would be able to defend themselves from aggression from others, E11 stated, "No." The Medication Administration Record dated 04/16/09 thru 05/15/09 states that R1 is an 18 year old male who functions at a profound level of mental retardation and has diagnoses which include Anxiety, Abnormal Sexual Function, Libido Changes ,and Feeling Agitated. In review of the Interdisciplinary Progress Notes from 01/24/09 thru 02/24/09 documentation reflects that R1 visited the facility weekly prior to his admission to the facility on 02/24/09. Within these notes, the following behavioral incidents were documented during R1's visits to the facility. - 01/27/09 9:00 A.M. "... Res (resident/R1) kicked male peer (R5) in right left and hit peer (R4) to mid back while riding back to ***** (name of the facility) on *** (name of the facility's workshop) bus... will monitor closely."	W9999		

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W9999	Continued From page 19 - 01/29/09 5:30 P.M. "Staff heard loud bang from res. room found hole in drywall and drywall on res head..." - 02/11/09 6:00 A.M. "Res was having a behavior stomped on male peer's left foot when trying to leave the dining room, He then kicked a lg. (large) hole in his bedroom wall. Pillows were used to protect res. from injury..." (These notes do not identify who the male peer was.) The Incident Report dated 02/11/09 identifies the male peer as R3. - 02/22/09 10:40 A.M. Incident Report "R8 was sitting on (the) couch when male peer (R1) came up and hit him in (the) back." In reviewing R1's records for his pre-admission information, documentation is noted (no title or date was noted on this document) regarding his preferences as well as his behaviors which include, pinching, hitting, biting, kicking, and head butting peers. In reviewing the signature pages of the Interdisciplinary Team for the pre-admission to determine if the facility would be able to meet R1's needs, varying dates of signatures were noted for the Administrator/E1 (02/20/09), Assistant Administrator/E2 (02/23/09), prior QMRP/E12 (02/24/09), Vocational Coordinator/E8 (03/05/09), facility's Medical Director/E13 (02/11/09), and the consulting Psychologist/Z1 (02/06/09). No documentation was contained within these pages identifying that the team had considered the ages, abilities, health, and safety of the residents of the facility (R2-R15) when deciding to admit R1 to the facility.	W9999		

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W9999	Continued From page 20 Per review of the facility's Face Sheet, R1 was admitted to the facility of 02/24/09. 2) The facility failed to provide necessary staff supervision to prevent client to client abuse after R1 was admitted to the facility. After R1's admission to the facility, the following behavioral incidents have been recorded: 03/04/09 Incident Report 7:50 A.M., " Res (R1) kicked cabinet causing wood to split." 03/09/09 Incident Report 4:30 P.M., "R1 agitated for unknown reason. R1 was found kicking furniture and hitting walls with his arms... slight bruising to left outer elbow..." 03/14/09 Nurse's Notes 6:52 P.M. "Res lunged at male peer. Male peer back(ed) away from him screaming. R1 and the male peer were separated and res was taken to his room. No one was hurt..." The male peer was not identified. (During the interview with E7 (Direct Care Staff) on 04/29/09 at 4:10 P.M., E7 identified the male peer as R9.) 03/21/09 Nurse's Notes 10:30 A.M. "R1 was in DR (dining room) was asked to finish snack and put dishes away. R1 then kicked R7 in his left outer calf and pushed R6 while still sitting in chair... R1 assisted to his room and he began kicking and hitting his dresser. After approximal. (approximately) 15 min (minutes) of redirection R1 finally calmed with no further probe (problems)."	W9999		

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W9999	Continued From page 21 03/24/09 Incident Report 8:23 A.M. "Res had SIB (self injurious behavior) picking old scabs making them bleed. Res arms (bilateral) were cleaned et bleeding stopped." 03/27/09 Nurse's Notes 2:30 P.M. "...Nurse called from WS (workshop) stating res had a behavior in class room hitting back of head on wall. He was taken to the AQA (alternative quiet area) where he hit the backs of his heels on wall..." 03/28/09 Nurse's Notes 11:30 A.M. "Res was in hallway when he pushed a male peer down. Res was agitated was redirected to his room. Res did hit himself on top of his head..." The Incident Report dated 03/28/09 identifies the male peer as R2. The facility's Incident Report Investigation dated 03/28/09 identified that at 12:30 P.M. R2 had an unobserved fall in his bedroom requiring emergency room treatment. The facility concluded that R2 lost his balance and fell. 03/31/09 Nurse's Notes 7:45 P.M. "R1 was on south end of hall way staff noted R1 pushing peer (R3) causing peer to fall forward..." The Incident Report dated 03/31/09 notes that R3 received a 1 and 1/2 inch laceration to the center of his forehead. E7 (Direct Care Staff) was interviewed on 04/29/09 at 4:00 P.M. and stated, "R1 targets older men, the ones that can't defend themselves. He doesn't just push them down, he	W9999		

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W9999	Continued From page 22 pushes them hard and shoves... When R2 fell on 03/28/09, no one saw him (R1), but he (R1) was in the area of R2's room when he fell...." The facility's room assignments sheet (no date located on this document) identifies that R1 shares a room with R10 (Bedroom #1) and that R2's bedroom is diagonally across from R1's bedroom. 3) The facility failed to assess R1's supervision level after he pushed R3 down. R3 required emergency room treatment for a laceration to his head. In reviewing the facility's roster with E11 (Licensed Practical Nurse / LPN) on 04/30/09 at 9:45 A.M., E11 stated , "... R3 is a 62 years old and is blind. R3 has diagnosis of seizures. R3 also has been recently diagnosed with heart problems..." R3 was observed on 04/29/09 at 10:00 A.M. sitting in a wheelchair in the living room of the facility. E10 (Direct Care Staff) was present with R3 and informed the surveyor that R3 had just come from an appointment with a heart specialist. E10 went on to say that the specialist recommended that R3 have a stent put in his heart, but the procedure would have to be approved by his (R3's) guardian. When E10 was asked about the use of the wheelchair for R3, E10 stated, "We're using the wheelchair now because he's unsteady on his feet." In reviewing the facility's Unusual Incident Report/Abuse - Neglect and/or Theft Incident Report dated 03/31/09 identifies that R3	W9999		

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W9999	Continued From page 23 received a laceration to his head and was sent to **** (name of hospital stated) for evaluation and treatment after being pushed by R1. This report identifies that the facility concluded that R1 pushed R3 for unknown reason(s). However no change in R1's level of supervision was recommended or implemented after he injured R3. Review of the Emergency Room report dated 03/31/09, R3 required liquid skin adhesive to close the, "2 cm (centimeter)" laceration to his forehead. Two days after pushing R3, R1 pushed R4 on 04/02/09. The Nurse's Notes (dated 04/02/09 7:16 P.M.) states, "Res was standing in hallway when male peer came out of nurse's station after getting his medication. He pushed male peer but he did not fall." The facility's Unusual Incident Report/Abuse - Neglect and/or Theft Incident Report identifies that on 04/02/09 at 7:10 P.M. R1 pushed R4 causing him (R4) to stumble. Additional documentation states that staff were, "again instructed to keep R1 from standing in the hallway as R1 likes to stands in the hallway and may have felt R4 was invading his personal space..." It was also noted that R1 had been taken from the facility by his parents for a medical procedure and was to be placed on increased supervision upon his return back to the facility. R1's Nurse's Notes states that he was out of the facility from 04/03 through 04/07/09. After R1's supervision was to have been	W9999		

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W9999	Continued From page 24	W9999		

increased, R1 continued to have documented incidents of physical aggression towards other peers at the facility and one documented incident at the facility's day training site. Documentation identified:

04/09/09 1:03 P.M. Day Training's Injury/Illness Report "Hit male peer on left side... Consumer is one-on-one..."

04/11/09 Nurse's Notes 4:13 P.M. "Res (resident) observed going into living room area sat down on couch next to male peer observed res kick male peer to right leg.. res calm after staff took res to his room."

The Incident Report dated 04/11/09 identifies the male peer as R8.

04/14/09 8:50 A.M. Nurse's Notes "Res was redirected from QMRP ('s) office because he was looking for paper clips was re-directed to go into living room where he elbowed male peer in the middle of his back. He was re-directed to go to his room where he stomped and hit things in his room..."

The Incident Report dated 04/14/09 identifies the male peer as R5.

04/15/09 Nurse's Notes 5:17 P.M. "Res pushed male res to floor when res tried to sit near him on couch. Res immediately redirected and taken to is room..."

The Incident Report dated 04/15/09 identifies the male peer as R3.

04/18/09 Nurse's Notes 12:50 P.M. "R1 elbowed

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W9999	Continued From page 25 a male peer on his left side male peer landed on his buttocks. Resident was on 1:1 he was taken to his room..." The Incident Report dated 04/18/09 states, "12:50 P.M. R1 was sitting at dining room table when a male peer got up moving around (the) table. R1 then elbowed male peer in left side, male peer landed on buttocks. R1 placed on 1:1..." Another Incident Report dated 04/18/09 identifies the male peer as R3. This report also states, "Res was examined no redness noted. Bruising noted on stomach but some bruising res came back with from Hosp. (hospital) Lavomox inj. (injection)..." E6 (Direct Care Staff) was interviewed on 04/29/09 at 3:50 P.M. and stated, "... R1 has been targeting R3. R3 is now in a wheelchair and can not protect himself..." 4) The facility failed to ensure that sufficient safeguards were in place and implemented to prevent further occurrences of client to client abuse. E3 (QMRP) was interviewed on 04/29/09 at 12:30 P.M. and stated, "R1 was placed on one-on-one supervision on 04/13/09." In reviewing R1's behavior data sheets for April 2009, no behavioral incidents were documented. Further review of R1's record did not identify that R1 was started on one on one staff supervision at any time during the month of April 2009. Per continued interview with E3 , R1's behavior incidents for 04/14, 04/15 and 04/18/09 were	W9999		

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W9999	Continued From page 26 reviewed with E3, E3 stated, "R1 was to have been on constant one-on-one supervision. I don't know why staff did not document any of R1's behavior incidents on his behavior tracking sheets. On 04/18/09 I had come in and no staff were with R1. He was up and wandering around the dining room. E15 (prior Direct Care Staff) had been assigned to R1 and we found her asleep in R1's bedroom. R1 elbowed R3 causing him to fall while we were looking for E15... We keep sheets on the clipboard for individuals who are one-on-one." E3 was asked at this time for the documentation logs and or evidence to show that one-to-one staff supervision had been implemented during the month of April 2009 for R1. After looking, E3 stated that the she could not find any documentation for the month of April 2009 to show that R1 had been on one-to-one staff supervision. E4 (Direct Care Staff) was interviewed on 04/29/09 at 4:15 P.M. and stated, "R1 has been hitting anyone and everyone. None of the individuals that he is targeting can defend themselves. R1 has been on one-to-one staff supervision for about a week. Prior to that there was nothing in place..." 5) The facility has failed to develop a behavior plan to address R1's level of supervision across all environments and during all times of the day and night to prevent further occurrences of client-to-client abuse. The Behavior Treatment Plan dated 02/24/09 for agitation leading to aggression identifies the following interventions when dealing with R1's aggression:	W9999		

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W9999	Continued From page 27 1) When R1 becomes physically aggressive or threatens physical aggression towards others STAFF MUST IMMEDIATELY CLEAR THE AREA OF OTHER RESIDENTS TO PREVENT INJURY TO OTHERS. Staff will remain two (2) feet away from R1 as he tends to seek out others to hit/kick when he is agitated. 2) Prompt R1 to stop by saying "no". 3) Attempt to redirect R1 toward a preferred activity.... 4) Limit personal attention as much as possible. 5) If the agitation/aggression continues, take him to a quiet calming area... 6) Implement the calming procedure... 7) If R1 attempts to leave the calming area before he is calm, redirect him through the use of verbal or gestural prompts. 8) If R1 continues to escalate and becomes more agitated and aggressive during the re-direction effort and becomes a danger to himself or others and all other alternatives have been exhausted, it may be necessary to implement a CPI (Crisis Prevention Institute) restraint in accordance with the facility guidelines for use of such a procedure. 9) Per policy, staff will immediately notify the Assistant Administrator whenever physical aggression occurs or is attempted. Further review of the behavior plan does not identify that the plan has been updated to identify the need for one-to-one staffing as described by E3 (QMRP) on 04/29/09 at 12:30 P.M.. Additionally, this behavior plan does not address R1's level of supervision to, during and from day training, and or the level of supervision needed during bedtime hours. E14 (Midnight Shift Direct Care Staff) was	W9999		

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ORCHARD COURT	1430 STATE ROUTE 127 SOUTH JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 28 interviewed on 04/30/09 at 9:15 A.M. and stated, "R1 is not on one-on-one at nights. We check on him every 15 minutes." During the interview with E4 (Direct Care Staff) on 04/29/09 at 4:15 P.M., E4 stated, "R10 is R1's roommate. R10 is blind and would not be able to defend himself against R1. The facility's Policy and Procedure for Abuse and Neglect (dated revised 04/26/06) states, "Residents must not be subjected to abuse by anyone, including, but not limited to other residents... " This policy also defines physical abuses as, "... the infliction of injury on a resident that occurs other than by accidental means and that requires (whether or not given) medical attention... Physical abuse may include, but is not limited to such acts as: hitting, slapping, kicking punching, hair pulling, pinching..." In reviewing the behavior incidents for R1 from 01/24/09 to 04/18/09, client-to-client abuse has occurred and the facility neglected to provide necessary staff supervision to ensure that R2 - R15 were not subjected to physical abuse from R1. (A)	W9999		