STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G359	A. BUILDING _____ B. WING _____	03/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW HOUSE	555 BURNHAM UNIVERSITY PARK, IL 60466

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W 312	Continued From page 29 On 3/23/09 at approximately 10:00 a.m. E3 said R2's behaviors have increased since the reduction of Abilify in November, after review by the attending physician.	W 312		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060e) 350.3240a) 350.3240e) 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	W9999		

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W9999	Continued From page 30 residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 3 of 4 clients in the sample (R1, R3, and R4) and 12 outside the sample (R5 to R16) are free from abuse or potential abuse from 1 client (R2). Finding include: R2's Physician's Order Sheet dated 2/1/2009 states R2 is a 38 year old female with a diagnosis of Severe Mental Retardation, Impulse Control Disorder with Compulsion, and Bipolar Disorder. R2 has a Behavior Support Plan dated 11/17/2008 for Physical Aggression, Self-Injury, and Leaving without staff supervision. Speech Assessment dated 5/1/2005 states R2 communicates with the use of a communication book and spoken language. R2's Individual Program dated 11/12/2008 states R2 ambulates independently in the home. R2's Individual Program dated 11/12/2008 states R2 has an IQ 30 and Adaptive Behavior Score (ICAP) 5 years and 2 months. On 3/16/09 from 3:10 p.m. until 6:45 p.m. R2 was observed in her home. At approximately 3:45 p.m., R2 hit R8 (a 19 year old male whose diagnosis includes Severe Mental Retardation). At approximately 5:30 p.m. R2 attempted to hit R5 (a 43 year old female whose diagnosis	W9999		

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W9999	Continued From page 31 includes Profound Mental Retardation). At 5:45 p.m. R2 was observed attempting to hit R9 (a 29 year old female whose diagnosis is Profound Mental Retardation, blind, Cerebral Palsy, and confined to a wheelchair). E7 (direct care) observed standing between R9 and R2 to prevent R2 for hitting R9. R2 proceeded to try to hit E7, and E7 was observed blocking and re-directing R2. E1 (Residential Services Director) was interviewed on 3/16/09 at 6:05 p.m. E1 said R2's behaviors are not predictable. E1 said R2's Lexapro was recently reduced by her attending physician. E1 said R2's psychoactive medication is not being prescribed by a psychiatrist. R2 has never had a psychiatric evaluation while on psychoactive medication while living at the facility. On 3/17/2009 from 6:30 a.m. to 9:00 a.m., R2 was observed in her home walking around with her coat on. At 6:45 a.m. R2 was observed slapping E9 on his arm. R2 was re-directed to a table for breakfast. At 7:05 a.m. R2 completed breakfast. R2 proceeded into the TV area. R14 (a 54 year old female with Profound Mental Retardation) was standing at the south hallway door, and R2 made a fist and was shaking her fist at R14 then R4 (a 41 year old female with a diagnosis of Profound Mental Retardation) who was in her wheelchair by the TV. R2 started saying repeatedly "Bi***h. At 7:25 a.m., R5 (a 38 year old female with a diagnosis of Profound Mental Retardation) was observed sitting on one end of the couch, and R2 was sitting at the other end of the couch in the TV	W9999		

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W9999	Continued From page 32 area. R2 was observed attempting to take R5's coat away from her. R5 started screaming and staff came into the area and took R5 out of the room. At 7:40 a.m. R2 was observed trying to kick R9's wheelchair wheels and telling R9 to get out (of the TV room). No staff in the area. Then R2 proceeded to hit her head with her fist. At 8:05 a.m. staff were observed taking clients to the bus. As R14 was being moved from the TV room, R2 began kicking at R14's wheelchair and then R2 made a fist and punched toward R15. E4 (direct care staff) was interviewed on 3/17/2009 at 7:30 a.m. and asked about how other clients in the home feel toward R2. E4 stated clients (in the home) are scared of R2. E5 (direct care staff), also interviewed on 3/17/2009 at 7:33 a.m., stated that R2 liked to take other (client's) things. R2 is aggressive and she has put all these holes in the wall. On 3/23/2009, E2 (QMRP) notified the surveyors that on 3/18/2009 at 3:35 p.m. and 3/19/2009 at 6:20 a.m., R2 hit R6 on the hand while R2 was on 1:1 supervision. E8 (maintenance) was interviewed on 3/17/2009 at 7:10 a.m. and stated R2 has repeatedly put holes in the walls to the point the wall cannot be repaired. E8 stated a vinyl floor tile must be placed over the holes in the wall and R2 still is able to put holes in the wall. Surveyor observed 7 large floor tiles on the wall (covering 7 holes in the wall). Three of the floor tiles had indentations and E8 placed a new tile over the old tile. This	W9999		

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W9999	Continued From page 33 prevented the hole in the walls from being seen. Review of data from the workshop document the following. R2's workshop Maladaptive/Adaptive Behavior Tracking Form dated March 2009 documents the following: March 4 - Physical Aggression - (occurred) All Day; Self Abuse - (occurred) All Day; Property Damage - 2; Escaping to leave building - 1; Head Banging and Hitting Others - 10; Spitting on others - 5. March 5 - Physical Aggression - (occurred) All Day; Self Abuse - (occurred) All Day - 98x; Property Damage - 4; Escaping to leave building - 0; Head Banging and Hitting Others - 20; Spitting on others - 2. March 6 - Physical Aggression - (occurred) All Day; Self Abuse - (occurred) All Day - 170x; Property Damage - 12; Escaping to leave building - 0; Head Banging and Hitting Others - 15; Spitting on others - 5. March 12 - Physical Aggression - 24; Self Abuse - 2; Property Damage - 12; Escaping to leave building - 0; Head Banging and Hitting Others - 4; Spitting on others - 4. March 13 - Physical Aggression - 2; Self Abuse - 15; Property Damage - 0; Escaping to leave building - 0; Head Banging and Hitting Others - 8; Spitting on others - 2. Z3 (Workshop Trainer for R2) was interviewed on 3/17/2009 at 12:08 p.m. Z3 was questioned	W9999		

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W9999	Continued From page 34 regarding R2's physical aggression. Surveyor referenced March 4, March 5, March 6, March 12, and March 13 and asked Z3 since R2 had physical aggression theses days, who did she hit. Z3 stated R2 hits other clients and staff. Surveyor asked which clients did R2 hit, and Z3 did not know which clients R2 was physically aggressive toward and she did not have any reproducible record of who R2 hit. R2's Incident Reports were reviewed on 3/16/2009 and these were the only two documented incidents of physical aggression: 1/30/2009 and 2/25/2009. No additional incident or injury reports were presented to the surveyor as of 3/16/2009. R2's QMRP/Psychiatric Notes dated 2/20/2009 document "(R2) is very physically aggressive toward the other residents (56 incidents of physical aggression- Nov, Dec, Jan, Feb) and staff; has punched numerous holes in the walls and has (increased) self-abusive behaviors. (increased) anxiety at beginning and end of each week." QMRP/Psychiatric Notes dated 11/18/2008 document "(R2) note calming down as suspected after B-day. Frequency (increased), Severity (decreased) need adjustment (99 incident of physical aggression - July, Aug, Sept, Oct)." R2's Quarterly Behavior Support Program Review (Human Rights Committee) dated 1/21/2009 states the following (recommendations): "Continue Behavior Service Plan....Behavior improvement since medication (decrease). Quarterly Behavior Support Program Review dated 10/29/2008 states "Amend Change	W9999		

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W9999	Continued From page 35 Behavior Service Plan to nail polish daily." Review of these Quarterly Human Rights Committee Meeting Minutes did not address the high incidents of physical aggression and how all clients will be protected from R2's physical aggression. In addition, the Committee did not review clients that R2 had aggression toward in order to protect those individuals in the home and workshop. The facility's Abuse and Neglect Policy for Detection and Prevention was reviewed and states: "Abuse is the willful infliction of injury, ...intimidation, or punishment with resulting physical harm, pain or mental anguish. Physical Abuse: The use of physical force may may result in bodily injury, physical pain, or impairment. Pushing, slapping, hitting, shoving, shaking, striking with or without an object, pinching, kicking, burning.... Resident as perpetrator of abuse: When a investigation of a report of suspected abuse of a resident, based upon credible evidence, that another resident of the long term care facility is the perpetrator of the abuse, the 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." Review of Human Right Committee Meeting Minutes for 2008 and 2009, patterns and trends,	W9999		

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W9999	Continued From page 36 the facility does not have a system to monitor abuse or potential abuse from resident to resident aggression. The facility has failed to implement a systematic process to prevent recurrent resident-to-resident abuse at the home and the workshop. (A)	W9999		