STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G249	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTLAKE HOME	**2090 WEST LAKE DRIVE CARLYLE, IL 62231**

(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
W 186	Continued From page 25 15 individuals, 3 require toileting every 2 hours with staff assistance. In addition, R3 requires a wheelchair for his mobility, 2 to 3 staff for all transfers and 2 staff for bathing per interview with E3, DSP on 6/8/10 at 3:00 P.M. Interviews with direct care staff E2, E3, and E4 confirmed they were the only staff in the facility at the time of the incident on 5/24/10 to supervise and assist all 15 individuals.	W 186		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.1060h) 350.3240a) 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 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	W9999		

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W9999	Continued From page 26 available to administer these programs. 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. 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) These Regulations were not met as evidenced by: Based on observations, interview, and record review the facility failed to develop a policy to prevent sexual abuse for 1 of 1 individual in the sample (R1) who was sexually abused by another client (R2) who resided at the same facility. The facility failed to: 1. Ensure their policy for preventing neglect and abuse includes client to client abuse; 2. Ensure the level of supervision necessary to prevent sexual abuse by R2 to R1 during R2's 15 minutes of not having 1:1 staff supervision; and 3. Ensure sufficient number of staff to monitor R1 and R2 during R2's 15 minutes of time of non 1:1 staff supervision. Findings include:	W9999		

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W9999	Continued From page 27 1. The facility's policy titled POLICY FOR REPORTING AND INVESTIGATING ALLEGATIONS OF ABUSE/MISTREATMENT/NEGLECT/PSYCHOLOGICAL SEXUAL ABUSE, dated 06/10/01 as the last revised date, states "An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident." This policy states that "abuse means any physical injury, sexual abuse or mental injury inflicted on a resident, other than by accidental means... Psychological sexual abuse (sexual harassment) means any unwelcome physical contact, sexually explicit language or gestures, uninvited or unwanted sexual advances, or an offensive overall environment, including the use of vulgar language, the presence of sexually explicit materials, and the telling of sexual stories." The policy continued to list types of abuse and neglect and under the heading of SEXUAL ASSAULT, documents "Sexual contact that results from threats, force, or the inability of the person to give consent, and involving a range of activities, including but not limited to, assault, rape, or sexual harassment...Any sexual activity that occurs when an individual cannot or does not consent." This facility policy does not address client to client sexual abuse. E6, the facility administrator, was asked on 6/10/10 at approximately 3:00 P.M., if the facility had any other policy addressing client to client abuse, specifically sexual abuse. E6 said he would check and he returned within a few minutes and said that the facility did not have a policy regarding client to	W9999		

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W9999	Continued From page 28 client abuse. However, at the time of exit, the Administrator presented 2 additional pages, titled POLICY FOR REPORTING AND INVESTIGATING ALLEGATIONS OF ABUSE/MISTREATMENT/NEGLECT/PSYCHOLOGICAL SEXUAL ABUSE with a revision date of 3/3/03. 2.a. On 5/24/10 the Illinois Department of Public Health (IDPH) received a report from the facility regarding an incident that occurred at the facility on 5/23/10. This report states in the INITIAL NOTICE sent to IDPH of an incident of R2 sexually abusing R1 at the facility. R1 and R2 resided at the facility at the time of this incident. A facility Incident Report dated 5/23/10 regarding R1 states, "A male peer (R2) notified staff that (R1) was in her room 'naked'. Male peer was questioned by staff as to how he knew she was in her room 'naked'. Male peer gave no answer, but went directly to his bedroom and turned on his door alarm. Male peer remained in his room with the alarm on, while staff went to (R1). Staff went to (R1's) room and found her wearing no clothing with her soiled depends in her hand. Staff asked (R1) why she was not wearing any clothes. (R1) stated that '(R2) took them off'. The facility staff dressed (R1), while another staff contacted the supervisor on-call. Staff were instructed not to bathe (R1), to keep her soiled depend. Nurse on call recommended (R1) be taken to the ER (Emergency Room) for assessment due to the facility staff not being fully aware of what happened to (R1)...." An additional facility report titled DATA	W9999		

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W9999	Continued From page 29 COLLECTION FORM dated 5/23/10 documents the allegation of abuse by R2 towards R1 on 5/23/10 occurred at 2:00 P.M. The report states, "(R1) was found standing naked holding all her clothes tightly in her bedroom. When staff asked why she was naked she said '(R1) took them off '. Staff asked what else he did and she said '(R1) touched me'. Staff then asked her to point where (R2) touched her and immediately she pointed to her breasts and vagina." Another Incident Report dated 5/23/10 regarding R2 also documents the incident occurred at 2:00 P.M. This report is signed by E1/Qualified Support Person (QSP) and states "(R2) reported to staff that a female peer was 'in her room naked'. When asked how he knew this, he ran from staff and went to his room. Staff immediately went to the female peer who was found completely undressed in her room, holding only her soiled depend. Staff asked if someone had been in her room. Female peer then stated that (R2) had been in there and that he had 'touched her private parts'. Staff asked female peer why she wasn't wearing any clothes. Female peer stated that (R2) had taken them off. (R2) was then advised to stay with his staff at all times. Female peer was taken to the ER (Emergency Room)...ER staff notified the (local police) to interview (R2). Police officer questioned (R2) as to what had happened. (R2) admitted to touching the female peer's breasts 'softly' and also admitted to inserting his fingers into her vaginal area. Police then contacted the (Z2),(name of county) States Attorney for further recommendations. (Z2) advised for (R2) to either be incarcerated or to go home with his father...." The investigating police officer's (Z1) report dated	W9999		

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W9999	Continued From page 30 5/23/10 shows Z1 interviewed the alleged perpetrator, R2, at the facility, before he went to the hospital to interview R1. Z1's report documents that "(R2) was able to carry a normal conversation." According to this report (R2) stated "he went into (R1's) room and she was laying on her bed with the T.V. (television) off. (R2) said he undressed (R1) and he touched her breast softly." When Z1 asked him if he touched her vagina, R2 said, "yes." and when he put his fingers in her vagina it was wet. Z1 interviewed R1 at the Emergency Room with E10, a facility direct care staff and E5, Staff Supervisor, present. Z1's report dated 5/23/10 states, "From my understanding along with (E5's) understanding from asking (R1) numerous questions and getting short answers. (R1) said she was in her room when (R2) came in and said she needed to take a bath and began undressing her in the bathroom. From further understanding (R2) began touching her breast and putting his fingers in her vagina. I asked (R1) where (R2) touched her and she pointed to breast and vagina and started to wiggle her fingers, I asked (R1) if (R2) took his pants off and she stated yes. I asked three times (R1) if (R2) had his penis on her or in her and she replied no. I also asked (R1) if (R2) touched her with his penis and she stated yes." According to the facility's INITIAL NOTICE report dated 5/24/10, R1 is a 54 year old female who functions in the Profound Level of Mental Retardation. This report documents R1 has diagnoses of Attention Deficit Hyperactivity Disorder, Cerebral Palsy with Spastic Quadriplegia, Generalized Anxiety Disorder, Psychotic Disorder, Osteoporosis, and Urinary	W9999		

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W9999	Continued From page 31 Incontinence. R1's Inventory for Client and Agency Planning, (ICAP) dated 8/13/09 documents that R1's overall age equivalent is three years and five months (3-5). According to R1's Psychological Report dated 12/12/95, she has an Intelligence Quotient (IQ) of below 20, which places her in a Profound Level of Mental Retardation. This was ascertained by testing R1 with a Stanford-Binet Intelligence Scale-Form L-M on 12/12/95. This Psychological report states that "(R1) spoke repetitively and continuously throughout the testing. She speaks loudly and repetitively and her sentences are generally not related to each other. She lost interest very easily throughout the testing and required continuous verbal prompting to continue. Twice she got up and left the testing area and had to be physically directed back to the examining room. Although (R1) is able to state simple facts about events in her immediate life, she has a great deal of difficulty coming up with her own spontaneous questions or spontaneous information that has not already been pointed out to her." According to R1's Individual Support Plan (ISP) dated 8/20/09, R1 "has 24 hour 7 day a week staff supervision to insure her safety." Review of the Safety Skills Assessment dated 8/20/09, R1 would not be able to recognize "that she is being assaulted and would need assistance if she were a victimized person." The Safety Skills Assessment also states staff "will continue to ensure a safe environment for all individuals living at (name of facility)."	W9999		

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W9999	Continued From page 32 Per review of R1's Human Sexuality Evaluation dated 8/20/09, R1 does not understand public and private issues of hugging or kissing. R1 is able to identify a boy and a girl, but is not able to identify specific body parts such as "buttocks, breasts or penis." The assessment also states R1 does not "show an understanding of sexual contact" and does not know what to do "if another person gets uncomfortably close." The Sexuality Evaluation states staff "will continue to assist (R1) with knowledge of sexual body parts and their functions." R1 was interviewed on 6/8/10 at 4:50 P.M. Initially, surveyor was accompanied by E1, QSP. E1 introduced surveyor to R1 and initiated general conversation about her photo albums with pictures of her family. After a few minutes, E1 left the room and surveyor talked with R1 privately. During the interview, when surveyor said R2's name to R1, R1 repeated R2's name and rubbed her hands over her breasts. 2.b. According to the facility's INITIAL NOTICE report sent to IDPH regarding the incident of 5/23/10, R2 is a 24 year old male. This report states R2 functions in a Moderate Level of Mental Retardation and has diagnosis of Pervasive Developmental Disorder. According to R2's Inventory for Client and Agency Planning dated 4/14/10, R2's overall age equivalent is 7 years 2 months (7-2). R2's Psychological Consultation for 30-day Individual Program Plan dated 5/20/03 documents his IQ as 54, which places R2 as functioning at the high end of Moderate Mental	W9999		

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W9999	Continued From page 33 Retardation. Testing was conducted by Wechsler Adult Intelligence Scale, Third Edition (WAIS-III) on 10/25/02. The Social History report dated 4/14/10, lists both of R2's parents as his legal guardians. This report states, "He takes items from others and touches people inappropriately at times. (R2) has displayed inappropriate sexual behavior with a female non consenting peer. Due to (R2) sneaking out of his room and attempting acts of a sexually inappropriate nature, (R2) now has a door alarm and a one on one staff to monitor (R2) at all times." Review of the Behavioral Assessment, dated 4/14/10, shows R2 "will touch others under their clothes in an inappropriate manner. When confronted when he is caught in the act of this, he will state that he is looking for something. (R2) will touch others in the genital area when he is doing this behavior.....(R2) didn't start this particular behavior until a female peer moved into the home around April of 08. This particular female was nonverbal and had no mobility of her legs. She had no way of telling anyone that anything inappropriate was occurring. (R2) didn't specifically start the touching until almost a year later. (R2) was put on a 15 min (minute) checklist and the female was put on a 10 minute checklist. Door alarms were put on both individuals' rooms to be set to on when they were in their rooms. Eventually, the door alarm protocols were increased for the females to be set on when this particular female and her roommate were in their room together or separately. Then (R2's) checklist was increased to 1:1 with staff and within eyesight at all times because he was still able to accomplish touching in between the	W9999		

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W9999	Continued From page 34 checks.....(R2) would wait until staff were occupied doing something and then would take advantage of the free moment." This Behavioral Assessment of 4/14/10 also states the the facility "will continue the one on one staffing with (R2) and his door alarm to help to prevent this maladaptive behavior." Review of the Human Sexuality Evaluation dated 4/14/10, shows R2 can identify "genders, ages, and general body parts" that were presented to him but was not able to "identify all sexual body parts or functions." This assessment states R2 can identify appropriate places for public and private activities, but does not understand why people need privacy. The sexuality evaluation also shows R2 does not understand "informed consent for sexual activity & intercourse.....and does not know how to "avoid getting a sexually transmitted disease." According to an Interdisciplinary Team (IDT) report for (R2) and dated 5/11/10, the IDT reviewed "Incident Reports and Key Factors Contributing to Restrictions for (R2)." This report shows that between the months of January 2009 and March 2009, "a female peer (non-verbal quadriplegic) was found completely undressed. (R2) was found hiding in her closet on two separate occasions." In March of 2009, R2 "was found by a staff person with his hand up this female peer's nightgown. His hand was found in her peri-area region." Per interview with E8, Direct Support Person (DSP) on 6/10/10 at 9:30 A.M., E8 said she remembered the prior incidents with R16. E8 said R16 was non-verbal, unable to walk and E8	W9999		

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W9999	Continued From page 35 believed this is why R2 targeted R16. E8 said that R16 was R1's roommate and that the 1:1 staff supervision started after an incident with R16. The door alarm was put on R2's bedroom door as well as R1 and R16's bedroom door. R16 no longer lives at this facility. E8 verified that the door alarm was removed from R1 and R16's room when R16 moved out of the facility. After these incidents the IDT met in March of 2009 and R2 "was placed with restrictions of a door alarm on his bedroom door and also was given a one on one staff to help with his whereabouts at all times.....A one to one staff has been implemented during waking hours at home and at workshop (R2) is to be within eyesight at all times." On 10/16/09, the Human Rights Committee approved a decrease in 1:1 staffing for 15 minutes when R2 returned home from workshop. Neither the ID team nor Human Rights Committee addressed the actual level of supervision R2 required during this 15 minutes. It is not clear whether staff should be aware of R2's whereabouts during the 15 minutes non 1:1 time. During an interview with E6, Administrator, on 6/9/10 at 2:50 P.M., the surveyor asked E6 what level of supervision R2 was to have during the 15 minutes of non 1:1 time. He said he would have to say "none, if answering before checking (R2's) behavior plan. After checking, E6 said he was not able to find specific information regarding the level of supervision expected for R2 during the 15 minutes of non 1:1 staff supervision. The only documentation of staff training presented to the surveyor was dated 11/18/09,	W9999		

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W9999	Continued From page 36 on the Monthly Staff Meeting Agenda document which referenced a 1:1 decrease. During this interview with E6, E6 said this information was to let the staff know that R2's behavior support plan was revised for R2 to have 15 minutes of non 1:1 supervision each day. According to R2's Behavior Support Program (BSP), R2's behavior plan was not revised until 11/23/09. R2's BSP states, "in order to prevent (R2) from touching others underneath their clothing throughout each day, (R2) will have one-on-one staff supervision (in conjunction with a reduction plan.)." No reduction plan was specified in R2's BSP, however. R2's current Behavior Support Program (BSP) has 5/4/10 listed as the latest revision date. This program states the title as being, "Behavior Support for Appropriate Social Interactions." Listed in this BSP as maladaptive behavior to be addressed are "Inappropriate touching defined as (R2) hugging, rubbing arms, standing too close, or otherwise invading the personal space of others, usually women. (R2) has also been found touching another underneath her clothing in the genital area, (R2) has also been found going into the rooms of others at night when others are sleeping. Occasionally, (R2) has been physically aggressive when he hit, punched, or otherwise harmed or attempted to harm his roommate...." According to his BSP, "In order to prevent (R2) from going into the rooms of others at night, a. An alarm will be placed on (R2's) door to alert staff when (R2) exits his bedroom. b. Staff will remind (R2) that he will need to notify	W9999		

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W9999	Continued From page 37 staff before he attempts to exit his bedroom. c. Whenever staff hear the door alarm to (R2's) bedroom door or if they hear other noise at night when residents are in bed, staff should investigate. d. If (R2) is still up, awake and outside of his bedroom after others have gone to bed, then i. A staff member must maintain visual contact with (R2). ii. If there is no staff member available to maintain visual contact with (R2), then (R2) will need to go into his bedroom." According to hand written notes by E1 in the BSP Revisions, dated 10/16/09, the decision was made "in regards to reduction plan for door alarm: Team feels, at this point, the reduction of the door alarm shall not be attempted. Team agrees to start with 15 min. (minute) reduction of 1:1 staff instead...(Sign for no) touching sexually under clothing this quarter - will D/C (discontinue) 1-on-1 for 15 minutes each day until next quarter - this 15 minutes should be shortly after (R1) arrives home from work, early afternoons on Sat/Sun.(Saturday/Sunday) Staff to be given some leaveway in re (regards) to exact time of 15 minute non-1-on-time w/ (with) respect to other things going on in the house." 3. Per review of the facility's staffing schedule titled DSP WEEKLY SCHEDULE for the date and time of the alleged sexual abuse incident of 5/23/10 at 2:00 P.M., three direct care staff, E2, E3, and E4 were on duty at the facility.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G249	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTLAKE HOME	**2090 WEST LAKE DRIVE CARLYLE, IL 62231**

(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 38 According to the facility's individual time records called Hourly Time Sheet - 2 Week Pay Period, on 5/23/10 day shift, E2, Direct Care Staff, worked at the facility from 7:00 A.M. to 8:30 P.M., E3, Direct Care Staff, worked from 10:00 A.M. to 6:00 P.M., E4, Direct Support Person (DSP), worked from 7:00 A.M. to 11:00 P.M.. and E9, Direct Care Staff, worked from 7:00 A.M. to 11:00 A.M.. E5, Staff Supervisor, on 6/09/10 at approximately 10:00 A.M., said when she does the staff schedules, the DSP WEEKLY SCHEDULE reflects how she originally plans for the staff to work. Then as changes occur the staff's HOURLY TIME SHEET documents the actual times and total of hours worked for a two week period. During this interview with E5, she said E11, DSP was scheduled to work on 5/23/10 as a cook from 7:00 A.M. to 3:00 P.M., but E5 arranged for another staff, E12/DSP to work on 5/23/10 from 7:00 A.M. to 3:00 P.M.. Then on 5/21/10, E12 had surgery and was not able to work on 5/23/10, as scheduled for E11. E5 said she usually has three staff scheduled to work from 7:00 A.M. - 3:00 P.M. on the weekends and one staff works from 10 A.M. to 6:00 P.M.. She said this number includes the one staff who does the 1:1 staff supervision with R2. She said three staff were on duty at the facility from 11:00 A.M. to 3:00 P.M., and that this included the one staff who was doing 1:1 supervision with R2 leaving 2 staff to monitor the 14 remaining clients (R1, R3-R15), prepare lunch, and administer medications. An interview was conducted with E3, Direct Care Staff, on 6/08/10 at 3:00 P.M.. She said she was	W9999		

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	14G249	A. BUILDING _____ B. WING _____	C 07/07/2010

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WESTLAKE HOME	**2090 WEST LAKE DRIVE CARLYLE, IL 62231**

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W9999	Continued From page 39 on duty from 10:00 A.M. to 6:00 P.M. on 5/23/10 and that she had worked at the facility approximately a month at the time of the incident. She explained that two other direct care staff (E2 and E4) were also working. E4 was working in the kitchen and the other staff, E2 was doing one-on-one supervision with R2. She was the only staff working on the floor with the other 14 clients. E3 stated that she did laundry as well. According to E3, R1 and R3 require toileting every two hours, and R3 requires a wheelchair for his mobility and two to three staff for all of his transfers. E3 continued by saying that E2 asked her to help her change R3 and E2 told E4 to "keep an eye" on R2. She stated that R2 was watching television in the living room and he was fine with no behaviors, and that his 15 minutes without one-on-one supervision could be anytime when he was "being good." E2, DSP was interviewed on 8/8/10 at 4:00 P.M.. She said that as of 5/23/10 she would have worked at the facility almost two months. R2 was on his 15 minutes of "free time" and was watching his favorite baseball game. E2 said that it was a "good time" to do his 15 minutes without one-on-one supervision. Before she went to R3's bedroom on the men's end E2 told E4, who was in the kitchen, "to keep an eye on him (R2)." Then she and E3 went to R3's bedroom to bathe R3. She said, "Takes about 10 minutes to bathe him. We had him dressed and up in his wheelchair when (R2) came into the bedroom and whispered that (R1) was naked." After E2 asked R2 about R1's location, he told her she was in her bedroom.	W9999		

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W9999	Continued From page 40 E4 on 6/9/10 at 12:36 P.M. was interviewed. She said she was working in the kitchen of the facility on 5/23/10. She said E2 and E3 told her they were going to give a "wheelchair client a bath and I told them I would check on (R2). The one-on-one staff, said she would give (R2) his 15 minutes of free time as he was watching his (name of his favorite team) game. He had been good all day. I checked him about 10 minutes after I was told to check him and he was still in living room recliner watching tv. Approximately 5 minutes after that (E3) came into the kitchen and told me (R2) had come to (R3's) room and told them (whispered) that (R1) was naked." E4 said that "sometimes (R1) takes her clothes off and wants a bath so she can have her favorite outfit put on and I thought she had done this, but (E3) said (R1) said that (R2) had undressed her. Then I immediately went to (R1's) room and assisted (E3) with interviewing (R1)". E4 stated that "I thought (R1) would scream if anyone tried to undress her as she screams when staff undress her for her bath. She likes one outfit best and wants to wear it all of the time." Per review of the facility roster given to surveyor on 6/8/10, there were 15 individuals residing in the facility at the time of the incident. There are 5 individuals who function at the Profound level of Mental Retardation, 2 at the Severe level, 4 at the Moderate level and 4 at the Mild level ranging in age from 34 years old to 89 years old. Of the 15 individuals, 3 require toileting every 2 hours with staff assistance. In addition, R3 requires a wheelchair for his mobility, 2 to 3 staff for all transfers and 2 staff for bathing per interview with E3, DSP on 6/8/10 at 3:00 P.M..	W9999		