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| W 369 | Continued From page 52<br><br>An 8/10/10 physician's order provides for R5 to receive Nystatin Powder to inguinal folds "TID" (three times a day). No stop order was located in R5's record.<br><br>On 10/6/10, the a.m. medication administration was monitored by E3 (Habilitation Aide - HA). R5 entered the medication area at 6:52 a.m. R5 did not receive Nystatin Powder at this medication administration.<br><br>A review the 10/10 MAR documents that the facility has been "out" of the medication since 10/1/10.<br><br>In an interview with E1 (Residential Services Director/Qualified Mental Retardation Professional - RSD/QMRP), on 10/6/10, at 10:00 a.m., E1 stated that the facility has been out of the medication since 10/1/10, further confirmed that the MAR documents that the medication had been applied at the 10/6/10 a.m. medication administration, and confirmed the medication has not been discontinued by the physician as of this date. | W 369 | | |
| W9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>350.620a)<br>350.1060a)<br>350.1060b)2)<br>350.1060e)<br>350.1060j)<br>350.1610b)<br>350.1610c)1)2)<br>350.3240a) | W9999 | | |

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| W9999 | Continued From page 53<br>350.3240b)<br>350.3240c)<br>350.3240d)<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>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 | W9999 | | |

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| W9999 | Continued From page 54<br>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>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.<br><br>Section 350.1610 Resident Record Requirements<br><br>b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.<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. (Section 2-107 of the Act) (A)<br><br>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. (Section 3-610 of the Act)<br><br>c) A facility administrator who becomes aware of | W9999 | | |

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| W9999 | Continued From page 55<br>abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)<br><br>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)<br><br>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)<br><br>These Regulations were not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to prevent abuse when the facility failed to implement their policy for abuse and neglect. The facility failed to provide and implement a reproducible system that:<br>1a) provides for prompt notification of R4's maladaptive behaviors to the Residential Services Director/Qualified Mental Retardation Professional (RSD/QMRP), Administrator, Guardian, and the Department.<br>b) provides evidence of investigating R4's choking, R4's peer to peer physical aggression, and R4's behavior incidents that have resulted in complaints and/or fear from facility residents. | W9999 | | |

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| W9999 | Continued From page 56<br>c) provides a level of supervision across all environments to ensure R4's eating safety.<br>d) provides a level of supervision across all environments to ensure R4's safety, regarding R4's ingestion of her own hair and clothing.<br>e) provides for appropriate revision/s of R4's behavior management program, regarding R4's known documented behaviors of eating her hair, socks/clothing, and when R4's known documented aggressive behaviors have escalated and are causing residents to be afraid and be unable to sleep at night.<br>f) provides for the protection of rights for facility residents by ensuring that residents are provided an environment that is free from fear and conducive to sleep while in their own residence.<br>2a) provides reproducible documentation of a possible sexual incident between R2 and R15, who were roommates at the time of the incident, and have continued as roommates to date.<br>b) provides reproducible documentation of notification to the RSD/QMRP, Administrator, guardians and the Department of a possible sexual incident between R2 and R15, and two incidents between R2 and R12.<br>c) provides reproducible evidence of facility investigations of all three sexual incidents relating to R's 2, 12 and 15.<br>d) provides for assessment of possible sexual assault for R15 after possible inappropriate sexual interaction between R2 and R15.<br>e) provides for a level of supervision to ensure R15's safety, regarding R2's known, documented possible sexually inappropriate behavior, when R2 and R15 were roommates at the time of the incident, and have continued as roommates to date.<br>f) provides for assessing and providing active treatment as determined by the Interdisciplinary | W9999 | | |

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| W9999 | Continued From page 57<br>Team (IDT), regarding consensual/non-consensual individual exprssion of sexuality, regarding R's 2, 12 and 15.<br>g) provides for protection of R2 and R12's rights regarding their relationship, when R2 and R12's rights were restricted, without an active treatment program, and without guardian and human rights review/approval.<br>h) provides for relevant information within R2, R12 and R15's Individual Habilitation Plan (IHP), regarding pertinent sexuality information; for 2 of 4 in the sample, and 2 additional individuals (R's 2, 4, 12 & 15).<br><br>Findings include:<br><br>1) In review of an undated facility roster that validates level of functioning, there are sixteen (16) individuals in the facility. R's 1, 12 and 13 function in the mild range of mental retardation; R's 2, 3, 5, 7, 8, 11, 15 & 16 function in the moderate range of mental retardation; R's 4, 6, 9, 10 & 14 function in the severe range of mental retardation. R's 1, 2, 4, 6, 11, 14 & 15 require medications to assist with maladaptive behaviors. An undated facility document presented documents that R's 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15 & 16 have legal guardians. R1 has a power of attorney (10/13/10, 3:35 p.m., phone interview with E1), and R3 is legally competent. R5 is non-verbal (10/15/2010 facility document).<br><br>Per observations at the facility, on 10/5/10, at 4:00 p.m., R2 requires a wheeled walker for mobility and R5 requires a wheelchair or staff assistance with a gait belt. R14 (10/15/10 facility document) utilizes a walker for mobility assistance. | W9999 | | |

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| W9999 | Continued From page 58<br>In review of R4's 8/17/10 Individual Habilitation Plan (IHP), R4 functions in the severe range of mental retardation. Additional diagnoses include Obsessive-Compulsive Disorder (OCD), Trichotillomania (compulsion to pull out ones own hair - Stedman's Medical Dictionary ), and Gastro Esophageal Reflux (GERD). R4 has a legal guardian. R4's 8/10/10 Inventory for Client and Agency Planning (ICAP), documents an overall age equivalent of 4 years and 1 month. Her 4/18/05 Stanford Binet 5th documents an intelligence quotient (IQ) of 22.<br><br>The 8/15/10 nursing report for the 8/17/10 IHP states that R4, "pulls out her hair and apparently eats it at times...Staff also report she is also shredding and eating her socks at this time."<br><br>The 8/17/10 IHP documents that R4 has difficulties with choking. R4's 10/1/10 physician's orders document the order for a pureed diet.<br><br>During observations on 10/5/10, at 4:00 p.m., R4 is edentulous, independently ambulatory, speaking in 3-4 word phrases and complete sentences. The top of R4's head is is bald, with the baldness extending down the sides and back of her head. The remaining hair surrounding the bottom of her hairline is cut short, approximately 1-1/4 inches in length.<br><br>R4's 8/17/10 Behavior Development Plan documents R4's maladaptive behaviors of: physical aggression (defined as hitting and kicking staff); self-injurious behavior (defined as scratching her skin, banging her head, and pulling out her hair).<br><br>The goals of the program are: 1) decrease | W9999 | | |

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| W9999 | Continued From page 59<br>aggression towards objects or others; 2) and, decrease self-injurious behaviors. Adaptive behaviors to be developed are: demonstrate appropriate social interactions with peers and staff; maintain her personal possessions in appropriate settings; and, maintain only her possessions in her room.<br><br>10/12/10 psychiatric orders document the current medications to assist in maladaptive behavior control for R4: Depakote 250 mg. BID for agitation; Seroquel 25 mg HS for sleep; Ativan .5 mg BID, and continue Anafranil (psychiatric orders of 10/1/10) at 50 mg. HS.<br><br>1a) "Universal Progress notes," and facility incident/accident reports documenting R4's behaviors were reviewed. From 10/31/09 through 10/9/10 there are sixty-six (66) separate (some on same dates/different shifts) handwritten notes from direct care staff regarding R4's maladaptive behaviors. These include throwing items from her room, throwing items from the office into the dining room, throwing items from the living area activity closets into the living area, screaming, slamming windows and doors open and shut, slamming on toilet rails and bathtub, punching her closet, pounding on windows, taking her dresser apart and throwing drawers into the hall, breaking mirror, breaking bathroom ceiling light, tearing her closet door off of the top hinge, shaking entertainment center in her room, taking the boards off and banging on the wall, throwing items at other individuals, banging/hitting on walls in her room and common areas of the facility, yelling and hitting the dining table during meals, head banging, pulling and eating own hair, shredding and eating own socks, skin picking, biting and hitting staff. Behaviors | W9999 | | |

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| W9999 | Continued From page 60 | W9999 | | |

are described as loud, consistently disrupting other individuals sleep during the night, causing individuals to complain, stating they are afraid. Universal progress notes of 5/27/10 , 6/1/10, 7/1/10 and 8/21/10 document lengthy and loud tantrum behaviors lasting from 1and 1/2 hours to 6 nd 1/2 hours at a time.

Some of R4's behaviors are documented as follows:

- E9's (employed since 4/08 - Health Care Worker Background Check -HWBC), 7/14/10 entry states that at around 10:00 p.m., while assisting R4 to bed, R4 became physically aggressive, bit, scratched and hit staff. "I (E9) sustained a full force punch to the chest with both her hands while trying to keep her from biting me in the stomach...she (R4) cried and bawled til (until) 11:30." E9 (habilitation aide), was interviewed on 10/12/10, by phone, at 3:00 p.m., regarding the facility "Universal Progress Note" dated 7/14/10. E9 confirmed that she worked on this date, was on duty at the time of R4's behavior, and wrote the 7/14/10 entry. E9 stated that she (referring to herself), is not a small woman, but R4, "knocked the wind out of me...I spit up." E9 stated all of this was, "very loud...residents (R's 8, 9 & 10), put their hands over their ears." E9 stated that the behavior of other residents is escalating as a result of R4's behavior.

- E12's (former employee - per E1 (RSD/QMRP on 10/8/10, at 11:10 a.m.), 8/21/10 entry documents that R4 broke her ceramic dish, punched her bedroom walls from 3:30-9:00 p.m., bit her hands, slammed closet doors numerous times, knocked down two kitchen chairs, and

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| W9999 | Continued From page 61<br>threw a lamp at staff.<br><br>- E9's 8/28/10 entry states that R4's behaviors, "have caused the other residents on A hall to be afraid to come out of their rooms to use the restroom. 2 residents in particular have voiced their apprehension to me. I hope for their sake this is resolved soon. It must be hard to be afraid in your own house." E9 (phone interview of 10/12/10, at 3:00 p.m.) confirmed that she worked on this date, was on duty at the time of R4's behavior, and wrote the 8/22/10 entry. E9 stated that R's 8, 9 and 10 all get up during the night to use the restroom. On this night they were afraid to come out of their rooms to go to the bathroom. R9 said, "Oh God...oh God...honey...not again." R8 stood by her bed, stating she needed to use the bathroom. E9 stated she closed R4's door and held it shut so (R8) could get to the bathroom. R's 8, 9 & 10 all stated they were afraid to come out of their rooms, asking it if was okay to come out yet.<br><br>- E4's (employed since 11/08 - HWBC) 9/1/10 entry states that after 7:00 p.m., R4 was in her room, began hitting the wall and kicking her drawers. When staff would walk in, she would stop, after about an hour of this behavior, around 8:45 p.m. E4 (habilitation aide) was interviewed on 10/8/10, at 2:30 p.m., regarding a facility "Universal Progress Note" dated 9/1/10. On the way to the restroom, "at full force slammed her head into the wall." After returning to her room, R4 began banging her head on the walls, calmed for about fifteen minutes, then stated she wanted to go to bed. Returning to the bathroom, R4 began hitting the sink, kicking the walls and garbage can. Two staff tried to assist her..."she was becoming more at harm in the bathroom | W9999 | | |

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| W9999 | Continued From page 62<br>where she could bust the mirror and slam her head on the counter." E4 confirmed that she worked on this date, was on duty at the time of R4's behavior, and wrote the 9/1/10 entry. Regarding this universal note, and referring to R4 in the bathroom, E4 stated, "That was an awful night...wasn't a hit or knock...was a slam...scared me...no warning...trying to bang head on bathroom mirror...." E4 stated that even with E8 (habilitation aide), who is a male staff, helping her, it was hard to keep R4 from banging her head on the mirror.<br><br>- E10's (employed since 4/09 - HWBC), 9/19/10 entry states, "(R4) has been in a very dangerous & (and) uncontrollable mood since midnight all the way to the early morning hours. Things she has done are as follows: screaming @ (at) the top of her lungs - yelling - slamming doors - knocking loudly on wall - throwing everything in her room @ (at) wall, staff, residents, & (and) in A-Hallway - shoving staff also trying to hit & (and) smack staff...being very unruly & (and) violent to herself...whenever asked to calm down to stop trying to hurt residents and staff, she would just cry & (and) scream & (and) try to hurt others - by shoving & (and) throwing items from her room...tried bothering other residents - who @ (at) this time were awake & (and) afraid - just blocked her from other residents, (R4) shoved trying to get to residents, but staff never let her get to other residents...Also she had very dangerous mood swings - example - she would cry - than laugh - then scream in anger - then be calm - then became dangerous & (and) uncontrollable - then it would start all over...seems very confused and very unsure why she is acting the way she is...continued til (until) med-pass in a.m." Per this note, E1 was notified | W9999 | | |

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| W9999 | Continued From page 63<br>and instructed staff to take all dangerous items out of her room so she could not hurt herself or others and try to keep her calm. In an interview with E1 on 10/8/10, at 11:10 a.m., E1 confirmed that the staff signature on these hand written notes was that of E10 (habilitation aide).<br><br>- E9's 9/26/10, entry states, that during a behavior, R4 twisted E9's fingers backward, noting that R4 slept only 3 hours last night. "The rest of the night she sat on her bed...threw her dominoes around the room the rest of the night." E9 (phone interview of 10/12/10, at 3:00 p.m.) confirmed that she worked on 9/26/10 and wrote the 9/26/10 entry. E9 stated that regarding this notation, "(R4) was pretty aggressive...didn't think I was going to get my hand out of that one." E9 stated that on this night R4 continually threw oversized dominoes against her bedroom wall, waking up other individuals.<br><br>- E9's 9/28/10, entry states, "(R4) has slept 3 hrs. (hours) the last 3 nights. This staff has worked all 3 nights. She has been in her room opening & (and) closing her window and drawers. Banging her dominoes around and playing her weather radio." E9 (phone interview on 10/12/10, 3:00 p.m.) stated that R4's behaviors were "loud", that R4 would open and then slam the window and drawers, again waking up individuals in the night.<br><br>- E4's 10/2/10 entry states that R4 was sitting in the A hall living room, throwing items out of the activity closet into the middle of the room, and at her peers. Another staff was in A hall and assisted other "scared" residents in leaving the area. "She (R4) had her peers so scared that a few started crying. After about thirty mins. | W9999 | | |

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| W9999 | Continued From page 64<br>(minutes) she calmed down. E4 was also interviewed on 10/8/2010, at 2:30 p.m., regarding a facility Universal Progress Note dated 10/2/10. E4 (10/8/10, at 2:30 p.m.) confirmed that she worked on this date, was on duty at the time of R4's behavior, and wrote the 10/2/10 entry. E4 stated she herself was not scared, but was "more scared for clients." R11 and R9 cried, verbally stating they were scared. E4 stated R9 was, "pretty scared that day...R10's facial expression (functions in the severe range of mental retardation per undated facility roster), says he is scared...(R8) would ask, 'Is it safe yet?'...and the scares go down the hall...when (clients) get scared it spreads."<br><br>- E11's (employed 10/3/95 - HWBC) 10/3/10 entry states that prior to lunch R4 was throwing her shoes, socks, stuffed animals, jewelry and trash can in the hall, "almost hitting another resident." R4 threw the table decorations outside the dining room doors and banged her head. R4, while in the A-hall living room, tore up games and threw pieces across the room. Other residents were complaining. R4, then in her room, hit her window, and tore her closet door off of the top hinge. In an interview with E1, on 10/8/10, at 11:10 a.m., E1 confirmed that the staff initials on this note (MR), are E11's (habilitation aide).<br><br>- In an interview with E3 (habilitation aide), (employed since 10/04 - HWBC), on 10/8/10, at 9:05 a.m., E1 stated that R9 has complained to her about R4's yelling and not being able to sleep. R10 has complained about R4's "fits"' and not being able to sleep. E1 stated that she can see that R4's behaviors might make other clients "fearful" of R4. | W9999 | | |

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| W9999 | Continued From page 65<br>Of R4's 66 documented behaviors between 10/31/09 and 10/09/10, R4's behavior incidents of 8/19/10 , 8/21/10, 8/31/10, 9/1/10, 11/24/09, and 12/19/09 are recorded on facility incident reports. These are the only behavior reports that provide documentation regarding who and when administrative staff were notified. The remaining 60 behaviors are documented on Universal Progress Notes. Per these notes, there is no evidence of when, or if, the facility RSD/QMRP, Administrator, physician, guardian or Department were notified.<br><br>In a 10/14/10, 10:10 a.m. phone interview with E1, E1 stated that direct care staff record behaviors on both incident/accident reports and universal progress notes. The facility form for incident/accident reports provides an area to document who was notified and when. The universal progress notes are simply lined sheets. E1 further confirmed that regarding who is notified, and when, if it is not documented on the incident/accident report, there is no provision for documentation elsewhere as to who was notified, and when.<br><br>In a 10/14/10, 3:23 p.m., phone interview with E1, E1 stated that when direct care staff complete a universal progress note, the note is filed in a binder for that particular individual. E1 further stated that he does not review these notes on a daily basis, but that the facility is changing this system as a result of the Department's current survey.<br><br>Regarding the facility's system for notification of significant incidents, E2 (Administrator), stated on 10/6/10, at 4:20 p.m., that E1 "usually calls me." However, no further reproducible evidence of | W9999 | | |

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| W9999 | Continued From page 66<br>notifying the Administrator regarding R4's documented behaviors recorded on universal progress notes was presented prior to survey exit.<br><br>In a 10/14/10, 4:30 p.m. phone interview with E1, E1 stated that the Department was not notified of any of R4's behaviors between 10/31/09-10/09/10.<br><br>1b) A facility incident report dated 7/29/10, documents that R4 choked on her pureed meat at 6:00 p.m.<br><br>Another facility incident report dated 8/28/10, documents that R4 choked on food at 6:00 p.m. This report states that R4 choked on food for a long time, almost falling out of her chair.<br><br>In an interview with E1 on 10/5/10, at 2:00 p.m., E1 confirmed that R4's choking incidents had not been investigated regarding possible needs in program changes, diet and/or staff training.<br><br>- Facility universal progress notes dated 7/30/10, document that R4 smacked another resident in the back. The resident is not identified in this note.<br><br>In an interview with E1, on 10/6/10, at 1:30 p.m., E1 confirmed that he did not know who R4 hit, did not know if the other resident sustained injury or not, and the facility had not further investigated this incident.<br><br>- Facility universal progress notes document the following behaviors for R4:<br>8/28/10 - "other residents on A-Hall were afraid to come out of their rooms to use the restroom." | W9999 | | |

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| W9999 | Continued From page 67<br>The residents are not identified in this note.<br>9/18/10 - R4's maladaptive behaviors resulting in all residents being awake and afraid, and trying to hurt other residents, staff blocking R4's attempted aggression. The residents are not identified in this note.<br>10/2/10 - R4's behaviors,"had her peers so scared that a few started crying." The residents are not identified in this note.<br>10/3/10 - R4's behaviors causing other residents to complain. The residents are not identified in this note.<br><br>In an interview with E1, on 10/6/10, at 1:30 p.m., E1 stated that for the 8/28/10, 9/18/10, 10/2/10, and 10/3/10 incident reports, he does not know the identity of the other residents who were identified as afraid, crying and who R4 was trying to aggress on.<br><br>In an interview with E1, in a 10/14/10, 10:10 a.m. phone interview with E1, E1 confirmed that the above documented incidents have not been investigated by the facility.<br><br>1c) Per R4's 8/17/10 IHP, page 2, R4 has difficulties with choking and several swallowing evaluations have been performed, further stating that R4 is now on a pureed diet. However, under the "Plans To Address Identified Needs" section of the IHP, under "Eating," it states, "No significant need in this area." Under the "Support Services" section it states, "Encourage independence to maintain current skills."<br><br>A 7/29/10 facility incident report documents that R4 choked at 6:00 p.m. on her pureed meat; and, again on 8/28/10 at 6:00 p.m. The food is not identified in this report, but states, "(R4) was | W9999 | | |

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| W9999 | Continued From page 68<br>eating her food and choked. She coughed for a long time, almost fell out of her chair. She finally calmed down and ate the rest of her food coughing throughout."<br><br>Per review of R4's 8/17/10 IHP, however, there is no reproducible evidence regarding a level of supervision across all environments, to ensure R4's eating safety.<br><br>In a phone interview with E1, on 10/13/10, at 3:35 p.m., E1 stated that R4's level of supervision for eating requires staff to be in the same room, and confirmed that this level of supervision is not documented in R4's current 8/17/10 IHP.<br><br>1d) R4's 8/17/10, IHP (page 2) documents that R4 has had "numerous" choking episodes and is on a pureed diet. Her 8/27/10 speech /language evaluation documents that R4 is edentulous. The 8/15/10 nursing report for the IHP states that R4 pulls out her hair and eats it at times. R4 is also shredding and eating her socks at this time.<br><br>Nursing notes of 7/29/10 document that R4 was released from the hospital on this date. This note further states, "A nurse at the hospital observed her eating her hair and then could hear wheezes in her throat apparently from the hair she had swallowed."<br><br>Nursing notes of 8/10/10 document that R4 continues to, "pick at her head and her clothing and eat the hair and the strings."<br><br>The 10/10 quarterly nursing assessment states, "Occ (occasional) cough - presumed hair caused it." | W9999 | | |

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| W9999 | Continued From page 69<br>Universal progress notes document R4's eating of hair and clothing as follows:<br>7/18/10 - R4 eating her hair.<br><br>7/30/10 - R4 was in bed coughing. "I went in and seen hair in her mouth."<br><br>8/14/10 - "(R4) ate a big portion of her brand new sock."<br><br>8/17/10 - "Tore apart and ate part of her sock."<br><br>In review of R4's 8/17/10 IHP, there is no reproducible evidence regarding a level of supervision to increase her safety, regarding the ingestion of her own hair and clothing.<br><br>In a 10/8/10, 12:30 p.m. interview with E1, E1 stated that the facility has not implemented a level of supervision regarding R4's eating of her hair and clothing.<br><br>1e) R4's 8/17/10 Behavior Development Plan documents R4's maladaptive behaviors of: physical aggression (defined as hitting and kicking staff); self-injurious behavior (defined as scratching her skin, banging her head, and pulling out her hair).<br><br>The goals of the program are: 1) decrease aggression towards objects or others; 2) and, decrease self-injurious behaviors. Adaptive behaviors to be developed are: demonstrate appropriate social interactions with peers and staff; maintain her personal possessions in appropriate settings; and maintain only her possessions in her room.<br><br>Staff are to offer praise for appropriate staff and | W9999 | | |

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| W9999 | Continued From page 70<br>peer interaction; maintaining personal possessions in her room, maintaining only her possessions in her room and praise for not exhibiting self-injurious behavior.<br><br>R4 has a room care program and staff are to encourage R4 to leave personal items in her room, rather than carrying items to work, and on outside activities.<br><br>When praise and discussion do not remedy R4's aggressive behavior/s, staff will escort R4 to her room, holding R4's hands to her side or across her chest, staying with R4 until she is calm.<br><br>This plan documents that R4 will receive short haircuts so she is not tempted to pull her hair. Staff are to praise R4 for leaving her hair alone.<br><br>10/12/10 psychiatric orders document the current medications to assist in maladaptive behavior control for R4: Depakote 250 mg. BID for agitation; Seroquel 25 mg HS for sleep; Ativan .5 mg BID, and continue Anafranil (psychiatric orders of 10/1/10) at 50 mg. HS.<br><br>Nursing notes and universal progress notes from 7/13/10 through 10/10 document R4's known behavior of eating her hair and socks/clothing. 10/1/10 nursing notes state, "(R4)'s mood has escalated...will one moment laugh inappropriately, and the next start throwing things out of her room...physically aggressive...incidents have escalated to a point where she is becoming a danger to others."<br><br>Notes from E1 to the psychiatrist document R4's escalating behaviors:<br>11/1/09 document that R4's behavior has not | W9999 | | |

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| W9999 | Continued From page 71<br>been controlled by her current medications..."has become more violent...."<br>9/20/10 - "...behavior has rapidly deteriorated...mood swings are volatile and have become dangerous...throws...any object within reach including lamps and shelving units...hits others with her hands as well as with objects...sores on her hands and arms from picking at her skin...pulled out some of her hair."<br>"(R4)'s dramatic improvement in communication skills and reality orientation led us to believe that her current medications were effective in combating her troubling behaviors, unfortunately, those behaviors have become worse. I feel that she may be a danger to herself or others around her...."<br>10/1/10 - "behavior has improved somewhat since addition of Zoloft on 9/8/10...had fallen into habit of throwing everything in her room out into the hall (including drawers, mirrors, and other potentially dangerous items)...."<br>10/12/10 - "(R4) continues to be physically aggressive towards staff...also continues to throw personal items out into the hallway and she is loud when arguing with staff. Other residents have complained of her being too loud. Her behavioral problems need to be resolved due to their disruptive nature..If behaviors remains severe or get worse bring her to the (town) ER (emergency room)."<br><br>In review of a facility map presented to surveyor on 10/7/10, R4 resides in a room by herself on A wing, room A3. Interview with residents further document that residents are frightened by R4's behaviors:<br><br>R12 and R13 are roommates on A wing, room A2, adjacent to R4's room, with a common wall | W9999 | | |

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separating the two rooms. R13 was interviewed on 10/7/10, at 3:10 p.m. (R13 -mild mental retardation per undated facility roster -complete sentences per observations on 10/5/10, at facility, 4:00 p.m.) R13 stated that he is unable to sleep at night because of R4's behaviors, and that R4 also has behaviors before and after dinner, in the living areas and dining areas. R13 stated that, "pretty much every night" R4 throws her shoes, dresser drawers and other items out of her room, stating he got hit on the leg by one of her shoes once. She (R4), "broke a mirror in the bathroom...broke closet door off its hinge...you can see the door in the basement...once she (R4) hit me with a dresser drawer...shoved it at me...pounds on the wall...me and my roommate can't sleep...can hear her pound on the wall in the bathroom...is loud" "Wish I could call the cops...knock it off...her behavior is worse...." "(R3) and (R8) have cried because of (R4)...(R4) hit (R8)...I go to my room to try to get away from stuff (referring to day hours)...staff tell us to go someplace else until (R4) cools down...feels scared...scared I'll get hurt...what's going to happen next?"

Attempts to interview R12 at this time were not successful. R12 did not appear to be able to focus on interview questions, referring constantly to his father who recently passed away in a farm accident.

Per the 10/7/10 facility map, R10 and R11 are roommates and reside directly across the hall from R4, in A4. In a 10/7/10, 3:20 p.m., interview with R10 (functions in the severe range of mental retardation, observed to be verbal utilizing complete sentences on 10/6/10, at 4:00 p.m., at facility), R10 stated that R4, "wakes me up all the

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time...I don't like it...throws things...toys, drawers from dresser...knocks on walls...hits people...hit (R8) on arm...wants some sleep...scared sometimes...getting worse...come to my room (daytime) to get away...."

In a 10/7/10, 3:08 p.m., interview with R11 (functions in the moderate range of mental of mental retardation, verbal per observations on 10/5/10, at 4:00 p.m., at facility), R11 stated that R4, "threw something and hit (R9)...making noise at night...knocks on walls...kinda loud...I say 'stop that'...wakes me up 'a lot' at night...makes me mad...afraid of (R4)...bit (E7)'s hand...slamming doors at night...knocks on windows...can't sleep...takes drawers out...could fall and get hurt...."

Per the 10/7/10 facility map, R9 resides on A wing, across the hall from R4 and down one door, in A5. In a 10/7/10, 3:15 p.m., interview with R9 (functions in the severe range of mental retardation, is verbal per observations on 10/5/10, 4:00 p.m., at the facility), R9 stated that R4 wakes me up when she bangs on the walls at night. R9 stated, "bothers me...scares me...."

Per the 10/7/10 facility map, R's 3 and 7 reside on B wing. Per a scaled to dimensions facility map, presented by E1 on 10/7/10, it is 34 feet from the exit of R4's room on A-hall to the front end of the hall, which then turns right into B-hall. Once on B-hall, it is 52 feet to the entrance of R3 and R7's room.

In a 10/7/10, 4:25 p.m., interview with R3 (functions in the moderate range of mental retardation and is verbal per observations at the facility on 10/5/10, at 4:00 p.m.), R3 stated that at

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| W9999 | Continued From page 74<br>night time she can hear R4 in her room, stating that this does not scare her, but wakes her up.<br><br>In a 10/7/10, 4:30 p.m., interview with R7 (functions in the moderate range of mental retardation, and is verbal per observations on 10/5/10, at the facility, at 4:00 p.m.), R7 stated that at night time R4 bangs her head on her bedroom walls. This wakes her up and she cannot get to sleep. R7 stated she was sitting outside (no date given), not long ago, working on a puzzle. R4 pushed the puzzle off the table. That makes me mad and I just had to go back inside. When R4 has behaviors at the meals, "makes me nervous...and a little bit scared."<br><br>Per the 10/7/10 facility map, R15 resides on B wing. In a 10/7/10, 3:40 p.m. interview with R15 (R15 functions in the moderate range of mental retardation, is verbal per observations on 10/5/10, at 4:00 p.m.) R15 stated that he can hear R4 at night. She, "crys and screams...wakes me up...bangs on walls, sounds like a hammer...scares me at night...feel not so good."<br><br>In review of R4's current 8/17/10 behavior management plan, there are no interventions for R4's behaviors of eating her hair and socks/clothing. Additionally, the program has not been revised to address her known, documentated escalation of behaviors (throwing/destroying large objects and the subsequent documentation of residents expressing fear and being unable to sleep at night).<br><br>R4's 8/19/09 and 8/17/10 behavior development programs were reviewed, and are identical. | W9999 | | |

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| W9999 | Continued From page 75<br><br>In a 10/8/10, 12:30 p.m., interview with E1, E1 stated that R4's behavior control medications have been adjusted throughout this time period, but agreed that R4's current behavior management program does not address her behaviors of eating her socks/clothing or of eating her hair. E1 further agreed that R4's escalating property destruction and throwing of large items, causing residents to be frightened and lose sleep at night, has not been addressed.<br><br>1f) Interviews with E9 (phone interview 10/12/10, at 3:00 p.m.), regarding the 8/28/10 universal note entry, document that R's 8, 9 & 10 were afraid to leave their rooms to go to the bathroom. E4's interview of 10/8/10 at 2:30 p.m., regarding the 9/1/10 entry,documents that R4's behavior scared her. E4's 10/2/10 universal note entry documents that residents were scared and crying. The 10/8/10, 2:30 p.m. interview documents that R's 9 and 11 verbally stated they were scared and both cried. E3 (10/8/10, 9:05 a.m. interview), documents that R9 has complained about R4's fits and not being able to sleep.<br><br>Interviews with R13 (10/7/10, at 3:10 p.m.), R10 (10/7/10, at 3:20 p.m.), R11 (10/7/10, at 3:08 p.m.), R9 (10/5/10, at 4:00 p.m.), R3 (10/7/10, at 4:25 p.m.), R7 (10/7/10, at 4:00 p.m.), and R15 (10/7/10, at 3:40 p.m.) document their feelings of being scared, having to leave the area they are in to get away from R4's behaviors, and being unable to sleep at night due to R4's loud behaviors.<br><br>In a review of R4's 8/17/10 IHP and 8/17/10 behavior support plan, there is no reproducible | W9999 | | |

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| W9999 | Continued From page 76 | W9999 | | |

evidence that the facility has implemented behavioral interventions for R4 relative to her keeping other residents from sleeping at night, and relative to their expression of fear. In an interview with E1 on 10/8/10, at 3:00 p.m., E1 confirmed that R4's IHP and behavior management plan do not provide interventions regarding these issues.

2a) In review of an undated facility roster that validates level of functioning, R2 functions in the moderate range of mental retardation. R2's 8/17/10 IHP documents that he has a legal guardian. R2's 10/1/10 physician's orders document that he receives Mellaril on a daily basis, and has a diagnoses of Histrionic Personality. His 4/4/10 ICAP documents an overall age level at 6 years, 5 months.

In review of an undated facility document that validates level of functioning, R15 functions in the moderate range of mental retardation. R15 has additional diagnosis of Schizophrenia, per his 10/1/10 physician's orders. His 5/5/10 IHP documents that R15 has a legal guardian. His 4/1/10 ICAP documents an overall age level of 5 years, and 5 months.

On 10/5/10, E1 presented surveyor with an undated document validating roommates. Per this document R2 and R15 are roommates.

10/27/09 inservice staff meeting notes documents the following: "(R2) has been exhibiting some sexual behavior. Do not allow him to bother (R15) at night...".

In an interview with E1, on 10/6/10, at 2:45 p.m., E1 stated that R2 and R15 were roommates at

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| W9999 | Continued From page 77<br>the time of the incident, and have continued as roommates. E1 stated there was no reproducible documentation for this incident, other than the typed statement from the in service training above. E1 further confirmed that there was no reproducible evidence that E1 had notified the Administrator regarding the above incident. E1 stated that R2 and R15's guardians and the Department were not notified.<br><br>At the 10/6/10 4:20 p.m. daily status meeting, E2 (Administrator) stated stated that E1 "usually calls me" regarding significant incidents. However, E2 could not provide reproducible evidence regarding notification by E1. In the 10/6/10, 2:45 p.m. interview, E1 confirmed that the facility had not further investigated this incident. E1 stated that he thought that R2 had asked R15 to removed his shirt, but "don't think he ever touched him (R15)."<br><br>In a 10/19/10, 9:00 a.m., phone interview with E2, E2 stated that the facility had not provided a medical assessment for R15, regarding any possible symptoms of physical sexual assault.<br><br>In an interview with E1, on 10/6/10, at 2:45 p.m., E1 stated that regarding his 10/27/09 instructions to staff (do not allow R2 to bother R15 at night), no reproducible level of supervision had been put in place to ensure R15's safety.<br><br>On 10/6/10, at 2:45 p.m., E1 stated that the facility does not provide assessments regarding sexual consensual/non-consensual expression of sexuality abilities of individuals in the facility, and confirmed that no educational programs were implemented regarding sexuality training for R's 2 and 15 after the above incident. | W9999 | | |

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| W9999 | Continued From page 78<br><br>Additionally, in a review of R2's 8/17/10 IHP and R15's 5/5/10 IHP, neither IHP provides for relevant historic information regarding individual expression of sexuality abilities.<br><br>2b) In review of an undated facility roster that validates level of functioning, R2 functions in the moderate range of mental retardation. R2's 8/17/10 IHP documents that he has a legal guardian. R2's 10/1/10 physician's orders document that he receives Mellaril on a daily basis, and has a diagnoses of Histrionic Personality. His 4/4/10 ICAP documents an overall age level at 6 years, 5 months.<br><br>In review of an undated facility roster that validates level of functioning. R12 functions in the mild range of mental retardation. His 10/1/10 physician's orders document an additional diagnoses of Down Syndrome. His 4/23/10 ICAP documents an overall age level of 7 years, 6 months. His 5/5/10 IHP documents that R12 has a legal guardian.<br><br>A 3/4/09 in service staff meeting note states, "Found hugging in the living room, (R2) on (R12)'s lap."<br><br>In an interview with E1, on 10/6/10, at 245 p.m., E1 stated that R12 had expressed interest in R2 prior to R12's move to this facility, regarding holding hands and kissing while on a camping trip.<br><br>A 10/27/09 inservice staff meeting documents the following: "(R2) has been exhibiting some sexual behavior...do not allow him to spend time with (R12) alone." | W9999 | | |

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| W9999 | Continued From page 79<br><br>A facility universal progress note for R2, dated 12/22/09, documents the following: "When I entered the B hall living room, (R2) and (R12) were doing something...I sent them to their rooms. Later (R2) told me (R12) told him to lift up his shirt and rub his chest."<br><br>A facility universal progress note for R2, dated 3/10/10, documents the following: "Staff was walking towards A-Hall lounge and saw (R2) and another resident playing with each others hands. Staff stopped and looked at both residents. Both quickly criss-crossed their hands across their chests. Staff walked up to both residents, reminded them of the "no touching" rule, and told them both if caught again, they would both be going to their rooms...."<br><br>In an interview with E1, on 10/6/10, at 2:45 p.m., E1 confirmed that there was no reproducible evidence of notifying the Administrator of these incidents. E1 further confirmed that R2 and R12's guardians had not been notified and the Department had not been notified.<br><br>At the 10/6/10 4:20 p.m. daily status meeting, E2 (Administrator) stated stated that E1 "usually calls me" regarding significant incidents. However, E2 could not provide reproducible evidence regarding notification by E1. In the 10/6/10, 2:45 p.m., interview, E1 confirmed that the facility had not further investigated the behaviors that occured around 10/27/09, and the 12/22/09 and 3/10/10 incidents between R2 and R12.<br><br>On 10/6/10, at 2:45 p.m., E1 stated that the facility does not provide assessments regarding | W9999 | | |

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| W9999 | Continued From page 80<br>sexual consensual/non-consensual expresssion of sexuality abilities of individuals in the facility, and confirmed that no educational programs were implemented regarding sexuality training for R's 2 and 12 after the above incidents.<br><br>In a review of R2's 8/17/10 IHP and R12's 5/5/10 IHP, neither IHP provies for relevant historic information regarding exprssion of sexuality abilities.<br><br>R2's 8/17/10 IHP and 8/17/10 behavior support plan, and R12's 5/5/10 IHP do not provide for any restrictions regarding R2 and R12 being in the same room alone, nor any restrictions regarding holding hands, and the "no touch" rule.<br><br>Additionally, there is no evidence of guardian consent/s or human rights review/approval regarding these restrictions.<br><br>In an interview with E1, on 10/6/10, at 2:45 p.m., E1 stated that the above described restrictions regarding R2 and R12's relationship are not documented in their respective IHP's, that there are no guardian consents and no human rights review/approval for the above described restrictions.<br><br>3) Facility policies were reviewed. All policies were undated.<br>Regarding "CLIENT PROTECTIONS', it states, "The facility shall be responsible to ensure that no resident is subjected to physical, verbal, sexual, neglect, or psychological abuse...Abuse refers to ill treatment..whether due to carelessnes, inattentiveness or ommission of the perpetrator...Neglect refers to any failures by the facility to carry out required/appropriate | W9999 | | |

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| W9999 | Continued From page 81<br>services...failure to provide goods or services necessary to avoid physical or psychological harm...psychological abuse includes...sexual coercion and intimidation."<br><br>Regarding abuse or neglect of a resident,..."shall inform the Illinois Department of Public Health. The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse/neglect while the investigation is in process."<br><br>"The facility shall also inform each resident, guardian...of the resident's...behavioral status...shall immediately notify the Guardian or resident's next of kin or representative of any significant incidents or changes in the client's condition...including abuse...In case of peer on peer aggression, the facility shall notify the guardian...Administrator...An Administrative Summary shall be completed and sent to the Illinois Department of Public Health...."<br><br>"Residents making informed consent shall be permitted free exercise of sexual expression with respect to theirs and others privacy. If it is determined that a restriction of rights is necessary to protect the individual, the Behavior Management Committe/Human Rights Committee, Interdisciplinary Team and resident/guardian shall all approve such a restriction."<br><br>"A written consent will be obtained for all procedures/treatment/service that are other than routine."<br><br>Under "ACTIVE TREATMENT SERVICES', "The Individual Program Plan shall identify residents | W9999 | | |