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W 257	Continued From page 33 red. E4 stated that R4 "was really screaming loud." E2 (QMRP) and E5 (Group Home Manager) were interviewed on 2/09/11 at 9:55am. When asked if R3 had any explanation as to why he did that to R4, E2 stated that R3 "said I have to listen to that. How would you like to listen to that." E2 stated that she explained to R3 that R4 was not doing anything then, E2 stated that R3 stated, "Oh he does that all day long." The facility failed to ensure that R4's behavior program was revised to prevent a a pattern of R4 abusing R3.	W 257		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.810a) 350.810c)2) 350.1060e) 350.1060h) 350.3240a) 350.3240b) 350.3240f) Section 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. At a minimum, there shall be at least one staff member awake dressed and on duty at all times. c) The number and categories of personnel to be	W9999		

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W9999	Continued From page 34 provided shall be based on the following: 2) Amount and kind of program content, supervision, and personal care needed to meet the particular needs of the residents at all times. 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. 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) 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) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a	W9999		

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W9999	Continued From page 35 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 set up a structure which protected individuals by preventing reoccurrence of resident to resident abuse and preventing potential further occurrences of resident to resident abuse for 2 of the 4 individuals residing in the facility (R3 and R4) when they failed to: 1) take corrective action regarding a pattern of R4 abusing R3, 2) ensure adequate supervision to prevent further potential resident to resident abuse after an incident on 2/01/11 when R3 allegedly placed a pillow over R4's face. In addition, facility staff failed to follow facility policies and procedures by failing to immediately notifiy the administrator regarding the allegation of abuse by R3 to R4. Findings Include:	W9999		

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A facility "Incident Report" form dated 2/01/11 at 8:30pm. states, "(E3, direct care) and (E4, direct care) heard (R4) screaming. This was right after (E3) had done a 15 minute check. It had been about 5 minutes. We both ran to the back. (R3) was leaving (R4's) room with pillow (sic). We asked (R4) what happened. He said (R3) put the pillow over his face. (R4's) face was red." The form was filled out by E4.

R3, per Physicians Order Sheet (POS) of 12/10, is a 55 year old male with diagnoses of Mild Mental Retardation, History of Depression, and History of Anxiety. Undated facility roster provided at the start of the survey lists R3 as functioning in the Moderate range of Mental Retardation. R3 has a behavior program dated 1/7/11 which addresses the behavior of "Elopement." The behavior program includes "when (R3) is in his room with the door shut, staff will do 15 minute checks on him to make sure his (sic) is in his room." The program continues, "Third shift staff will continue doing hourly checks on (R3) when he is sleeping."

R4, per POS of 12/10, is a 64 year old male with diagnoses of Mental Retardation, Anxiety, and Depression. Undated facility roster provided at the start of the survey lists R4 as functioning in the Severe range of Mental Retardation. R4 has a behavior program dated 8/6/10 which addresses the behaviors of "Physical Aggression: Hits & kicks others, grabs onto peers, touches peers/staff" and "Verbal Aggression: Teases peers, calls staff names, yells at staff/peers and bosses peers."

1) Facility Incident Reports were reviewed. The

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behavioral incident reports showed a pattern of resident to resident aggression between R4 and R3.

A facility "Incident Report" form dated 10/11/10 states, "I asked (R4) to pick up his room." The incident report continues, R4 "then leaned out his doorway + yelled '(R3) leave me alone,' R3 was in his room asleep." The incident report of 10/11/10 goes on to state that when asked to get on the bus, R4 yelled, R3 "get out of my room" even though R3 was "in the doorway between the dining room/hallway." Under the section titled "Administrative Follow-up" it states, (R4) is on a level III Behavior Program for Verbal Aggression to peers. Continue to follow (R4's) Behavior Program as written." This section was signed by E2 (Qualified Mental Retardation Professional, QMRP).

A facility Incident Report form dated 11/05/10 states, "heard (R4) in bedroom yelling at (R3)." The incident report continues, "(R4) still yelling tried to hit (R3)." The incident report goes on to say that E5 (Group Home Manager) had to "stop (R4) from hitting (R3)." Under the section titled Administrative Follow-up it states, "(R4) is on a level III Behavior Program for Physical Aggression + Verbal Aggression. Staff to continue following (R4's) Behavior Program as written."

A facility Incident Report form dated 11/15/10 states, "(R3) was looking at his housemates (R4) new toy book that he just got at 6:30am that morning. When (R4) came into the L (living) room after brushing his teeth...(R4) said 'he's got my book.' The report continues, "(R4) tapped

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(R3) on the back (with) his hand. (R3) kept looking at the book. (R4) then took his ball hat off + hit (R3) in the left arm. (R3) still kept looking at the book. (R4) then hit (R3) in the left arm with his hand." Under the section titled Administrative Follow-up it states, "(R3) suffered no injury from (R4's) physical aggression. (R3) should not have been looking at (R4's) book without (R4's) permission. GMH (Group Home Manager, E5) will address with staff."

Per "Program Services Summary" for "Nov. 2010" it states, "(R4) displayed incidents of physical aggression to peer(s) in am & pm this month (4X in am on 15th with favorite 3rd shift staff, & 1X in pm on 24th with sub staff)." It states that an "Incident Report not completed on 24th." This form was signed by E2 on 12/28/10. E2 (QMRP) and E5 (Group Home Manager) were interviewed on 2/09/11 at 10:00am. When asked what happened on 11/24/10, E5 stated that she would have to pull the communication book notes. Per "Daily Communication Log" sheet dated 11/24/10, under the section titled "2nd Shift Report" it states, "(R4) was yelling at (R3) today. He tried to pour milk on (R3)."

A facility Incident Report form dated 12/27/10 states, "(R4) came out of the kitchen after yelling 'Shut up (R3) get out of my room' and kicked (R3) on the right leg. I used VP (verbal prompts) to stop (R4) from kicking (R3). (R4) then sat next to (R3) + hit him on his right arm." The report continues that R3 had no visible injuries. This form was signed by E5. Under the section titled Administrative Follow-up it states, "Staff to continue to try to keep (R3) and (R4) away from each other when (R4) gets upset as (R3) is

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(R4's) target person." This section was signed by E2. E5 and E2 were interviewed on 2/08/10 at 2:10pm. When asked whether R3 was in R4's room at the time R4 yelled "get out of my room," E5 stated, "No, (R3) was on the couch I believe." E2 stated that it was not until around Christmas time when R4 got upset because he could not go home for the holidays.

A facility Incident Report form dated 12/28/10 states, "(R3) was sitting on couch waiting for bus when (R4) sat directly next to him. (R4) kicked at (R3's) feet when he sat down. When I corrected (R4) he started yelling at the top of his voice 'stop it (R4)' then hit (R3) with his glove." Staff redirected R4 to his room. The report continues, "(R4) came back + yelled at (R3) + kicked him again." Under the section titled Administrative Follow-up it states, "Staff to continue to try to separate (R3) and (R4) when (R4) becomes upset." This section was signed by E2 (QMRP).

A facility Incident Report form dated 1/18/11 states, "(R3) was in the kitchen. (R4) came in the kitchen kick (sic) (R3) in the right lower leg." Under the section titled Administrative Follow-up it states, "No injury to (R3). Staff to continue to try to keep (R3) separated from (R4) when (R4) becomes upset as (R4) targets (R3)." This section is signed by E2.

A facility Incident Report form dated 1/31/11 states that R4 was redirected from taking a dirty shirt out of the laundry. The report states, "he began yelling 'Shut up (R3), go to your room (R3).'" After being redirected to his room, R4 "came back out of his room and went directly to (R3) (who was sitting on the couch) and tried to

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kick (R3) but was blocked by staff. (R4) tried several times but was blocked by staff."

E2 (QMRP) was interviewed on 2/08/11 at 2:25pm. When asked whether R4 was on a behavior program, E2 stated, yes. When asked if R4's behavior program has been revised due to continuing aggressive behavior and targeting R3, E2 stated that his new program was to be reviewed on Friday (2/11/11). E2 stated that his new program had been reviewed by Professional Review. When asked if the new program was in effect yet, E2 stated no. Per review of R4's current behavior program it was initiated on 8/06/10.

A "Professional Review Committee Behavior Program Review" form dated 1/28/11 was reviewed. It stated that a behavior program for R4 was approved and to be submitted to the "Human Rights Review Board" on 2/11/11. It also stated that the last review was for the program dated 8/6/10.

A "Psychotropic Medication Monitoring Form Consult" dated 1/13/11, under the section titled QMRP comments states, "(R4) has been targeting a housemate since Christmas. He did not get to go to his sister's house for Christmas & (R4) was very upset about it. He has been yelling at his housemate & kicking him/hitting him with his cap for no reason at all."

A facility "Incident Report" form dated 2/01/11 at 8:30pm. states, "(E3, direct care) and (E4, direct care) heard (R4) screaming. This was right after (E3) had done a 15 minute check. It had been about 5 minutes. We both ran to the back. (R3)

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W9999	Continued From page 41 was leaving (R4's) room with pillow (sic). We asked (R4) what happened. He said (R3) put the pillow over his face. (R4's) face was red." The form was filled out by E4. E2 (QMRP) and E5 (Group Home Manager) were interviewed on 2/09/11 at 9:55am. When asked whether R3 had any explanation as to why he did that to R4, E2 stated that R3 "said I have to listen to that. How would you like to listen to that." E2 stated that she explained to R3 that R4 was not doing anything then. E2 stated that R3 stated, "Oh he does that all day long." The facility failed to take corrective action regarding a pattern of R4 abusing R3. 2) Per the facility Incident Report from 2/01/11 involving R3 placing the pillow over R4's face, it states that the incident took place at 8:30pm. E3 (direct care) was interviewed on 2/08/11 at 3:00pm. E3 stated that she heard R4 scream. She ran down the hall and saw R3 walking out of R4's bedroom. E3 stated that R3 was carrying a blue dotted pillow. E3 stated that R4 claimed that R3 had placed the pillow over his face. E3 stated that R4's face was red and that she had "never heard him scream like that before." E3 stated she asked R3 if he put the pillow over R4's face. E3 stated that R3 stated that he was tired of R4 "bugging him." E4 (direct care) was interviewed on 2/08/11 at 3:06pm. E4 stated that she heard R4 scream "real loud." E4 stated that she had never heard him scream like that before. E4 stated that R4's face was "beet red." When she asked R3 if he	W9999		

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did this he said no but later admitted it but said he just tapped him. E4 stated if R3 had just tapped him, R4's face would not have been that red. E4 stated that R4 "was really screaming loud."

E3 was asked if she notified anyone. E3 stated that E4 said she would chart it. E4 was asked if she notified anyone. E4 stated no, that she told E5 (Group Home Manager) the next day. When asked when she notified E5, E4 stated "When she came in. I think that's when I was here third and first" (due to a severe snow storm). E4 stated it was about 8:30am.

E1 (Administrator), E2 (QMRP) and E5 (Group Home Manager) were interviewed on 2/09/11 at 9:15am. E1 was asked when she was first notified of the incident. E2 stated, "I'm the one who called her (E1)." E2 stated she got the call at 8:27am. and notified the administrator (E1) at 8:36am. per her cell phone records. E5 stated that she called E2 the next morning. E5 stated, "I didn't find out until the next morning." When asked whether R3 held the pillow over R4's face or just hit him with it, E2 stated, "He (R3) says he just hit him." E1 stated, "(R4) said he held it over his face."

E3 stated, during her interview at 3:00pm on 2/08/11, that she left the building the night of the incident (02/01/11) at 9:00pm. E4 stated, during her interview at 3:06pm on 2/08/11, that E3 left the building at 9:00pm. E4 verified that she was alone in the building from 9:00pm. until the next morning. When asked if there have been any changes in supervision since the incident, E4 stated "One of us should sit by the hallway and

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watch." E4 was interviewed again on 2/8/11 at 3:30pm. When asked what she did to ensure that R3 and R4 would have no contact during that first night, E4 stated that she would walk back every 15 minutes. E4 stated that R3 did not wake up that night and that R4 only got up once to go to the bathroom. E4 stated that R4 was up early that morning around 5:30am. E4 stated that R4 only woke up one time on third shift and did not get up to use the bathroom that night.

Per observation done 2/08/11 at 2:50pm., R3 and R4's bedrooms are at the far end of the hallway across the hall from each other.

R2, per POS of 12/10, is a 77 year old male with diagnoses of Mental Retardation and Cerebral Palsy. The POS states that he transfers independently with stand by contact guard assistance and is to always use a gait belt. The undated facility roster provided at the start of the survey states that R2 functions in the Severe range of Mental Retardation. Physical Therapy Screening Summary form dated 10/07/10 states that R2 requires stand by assistance/contact guard assistance during ambulation. It also recommends stand by assistance at all times in bathroom.

R1, per Psychological Evaluation of 10/16/06, is currently a 40 year old male who functions in the Profound range of Mental Retardation. It includes the statement that his "computed IQ would be less than 20." R1's Annual Nursing Assessment of 8/05/10 states that R1 is incontinent and wears adult incontinence briefs. R1's current Individualized Service Plan of 8/04/10, under the section titled "Staff-Directed

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Services" states, "Staff will assist me as needed with toileting, bathing, dressing, grooming, etc. I need to be assisted with toileting every 2 hours due to me wearing an adult incontinence brief."

E3 (direct care) was interviewed on 2/08/11 at 3:00pm. E3 was asked if since the incident she had worked at this house. E3 stated that this was her first day back. When asked if there were any new instructions on what to do differently to ensure R4's safety, E3 stated, "No, I need to check the communication book."

E4 (direct care) was interviewed on 2/08/11 at 3:06pm. When asked if there have been any changes to ensure safety, E4 stated, "One of us should sit by the hallway and watch."

Per "Daily Communication Log" form dated 2/02/11 on first shift it states, "(R3) is very concerned about someone telling his sister about last night - we need to keep a very good eye on him - (check) him every 15 mins. to make sure he stays away from (R4)." Per R3's behavior plan of 1/07/11, 15 minute checks were already a part of his level of supervision.

Per Daily Communication Log form dated 2/03/11, it states, "Please keep an eye on (R3) + make sure he is not left alone (with R4)." Under the section for 3rd shift it states, "Voided at night - (R1) inct. (incontinent) X3"...(R2) inct. X1." That section also includes the statement, "Please (check) on (R3) every 15 mins. tonight and make sure he stays away from (R4) - If you have any incident call me immediately." However per incident report of 2/01/11 and interviews with E3 and E4 conducted on 2/08/11, a 15 minute check

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W9999	Continued From page 45 was completed just prior to the incident of 2/01/11. Per Daily Communication Log form dated 2/04/11, under the section for 3rd shift it states, "R2 started his shower at 11:00pm. then bed at midnight." It also states R1 was incontinent three times. Under the section titled 2nd shift it states, "Continue to watch (R3) every 15 minutes - make sure if (R4) + (R3) are both in their room, staff is checking frequently to ensure safety of clients." Per Daily Communication Log form dated 2/05/11 it states, "Keep a very close eye on (R3) + (R4) - If they are both in their rooms - please keep an eye on the hall to avoid issues." E2 (QMRP) and E5 (Group Home Manager) were interviewed on 2/08/11 at 1:50pm. When asked about ensuring safety, E2 stated that they were doing 15 minute checks when R3 is in his room and that an "at risk" meeting was held. E2 stated that the meeting was to "make sure we are doing everything we can to ensure his safety and others." E2 stated that there was to be an addendum to R3's behavior program. E5 stated that in between the 15 minute checks, when both are back in their rooms, staff are to observe the hall. When asked if there are always two staff in the afternoon, E5 stated, yes. When asked if one staff is in showering someone and the other is in the kitchen, how are they to ensure safety. E5 stated, "Listen really hard." When asked again about prevention strategies, E2 stated, "Other than have staff watch down the hallway, adding an addendum to (R3's) behavior	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G301	A. BUILDING _____ B. WING _____	C 02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER	4636 WEST ANDOVER PEORIA, IL 61615

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W9999	Continued From page 46 program." E2 stated the behavior addendum is to be to Human Rights Friday (2/11/11). E2 and E5 were interviewed on 2/09/11 at 9:35am. When asked if R1 needs assistance with toileting, E2 stated, yes, and E5 stated that R1 wears adult incontinent briefs. When asked what assistance R2 needs in the bathroom, E5 stated that he needs someone in the bathroom to assist him getting started and getting finished, that he sits on a shower bench to bathe. When asked, during the time there is only one staff and they are in the shower room or attending R1 to change his incontinence brief, there is no one to watch the hallway, both E2 and E5 stated, "correct." Staff schedules were reviewed. Per interview with E4 on 2/08/11 at 3:06pm., due to weather E4 was the only staff in the building from 9:00pm. on 2/01/11, until the next morning on 2/02/11. On 2/03/11 there was only one staff on second shift from 9:00pm to 10:30pm., and one staff on third shift. On 2/04/11 there was only one staff on second shift from 9:00pm to 10:30pm., and one staff on third shift. On 2/05/11 there was only one staff on third shift. On 2/06/11 there was only one staff on third shift. On 2/07/11 there was only one staff on third shift. E2 (QMRP) was interviewed on 2/08/11 at 3:55pm. When asked if there were intermittent times on second shift after 9:00pm. that there is only one staff, E2 after looking at the schedule stated, "There sure is." When asked if third shift has had only one staff since the incident of 2/01/11, E2 stated that there is one staff until 4:30am or 5:30am.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G301	A. BUILDING _____ B. WING _____	C 02/25/2011

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W9999	Continued From page 47 The facility failed to develop a structure which ensures the safety of individuals by providing adequate supervision to R3 and R4 while meeting the physical needs of R1 and R2, in order to prevent further potential resident to resident abuse after the incident on 2/01/11 when R3 allegedly placed a pillow over R4's face. 3) The facility "Instruction Sheet" dated 4/07/10, for the form titled "Incident Report," under the section titled "Investigation and Follow-up For Incidents And Injuries Occurring In ICF/DD Group Homes," states the following: "1. By regulation, the following incidents require that the Administrator or Administrator Designee of (the facility's) ICF/DD homes be notified: a. Any injury b. Self Injurious Behavior (SIB) c. Resident to Resident abuse, including Mental Injury 2. Upon discovery of any of the above listed scenarios, the employee will notify the Administrator or Designee and document the date and time of notification on the form." The facility policy 101.56 titled "Reporting and Investigating Abuse/Neglect and Death of persons served" and dated 4/02/98 with a revised date of 3/19/07, under section V states the following: "1. Any employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Administrator of Administrator Designee."	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W9999	Continued From page 48 Per interview with E1 (Administrator), E2 (QMRP) and E5 (Group Home Manager) at 9:15am on 2/09/11, E1 was not notified of the 2/01/11 incident between R3 and R4 until approximately 12 hours after it had occurred. (A)	W9999		