STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G102	A. BUILDING ______ B. WING ______	C 12/01/2011

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W 240	Continued From page 15 period of time but they shouldn't be doing that." E7, Qualified Support Personnel (QSP), was interviewed on 11/16/11 at 2:21pm. E7 stated, "I saw the Physical Therapy evaluation in July when she (E4) created it." E7 then verified that she did not implement the suggestions in the evaluation completed by E4. E7 added, "I felt R1 was supported well here. He had been on a decline for some time but still did not have any drastic change. R1 is pretty stable but needs assistance with all his ADLs (activities of daily living)".	W 240		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.3240a) 350.3240b) 350.3240e) 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 350.3240 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	W9999		

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administrator. (Section 3-610 of the Act)
e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These Regulations were not met as evidenced by the following:

Based on record review and interview, the facility failed to ensure 1 of 1 client (R2) who was allegedly slapped by a staff person, was protected from further potential abuse when the facility failed to ensure:
1. The allegation of physical abuse was immediately reported to the Administrator or designee.
2. The incident and accident investigation policy was implemented.
3. The alleged perpetrator was immediately removed from contact from all clients.
4. The allegation of physical abuse was thoroughly investigated.
5. The facility staff were retrained related to policies and procedures related to an allegation of physical abuse.

Findings include:

R2, per the Client Admission memo dated 2/24/10, is a 27 year old female whose diagnoses

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W9999	Continued From page 17 includes Profound Mental Retardation, Pervasive Developmental Disorders and Epilepsy. The undated Incident and Accident Investigation Policy was reviewed. Under general policy it includes, "...Acts of client to client aggression or aggression that results in an injury, allegations of abuse and neglect, injuries that require outside medical treatment and injuries of unknown origins...Additionally, it is the policy of the facility that the Administrator or a management staff designated by the Administrator is immediately notified of any of these type of incidents. The managerial designee assigned must have the authority to immediately place staff on administrative leave pending a thorough investigation in cases of suspected or alleged abuse or neglect." An undated incident investigation was reviewed. Under summary of allegation it includes, "On October 13, 2011, E8, Housekeeping staff, reported to E9 (Housekeeping Manager), that he saw Habilitation Aide, E10, slap R2 twice, once on each side of her face. E8 and E9 then reported this to E2, Residential Services Director at 10:30am. Under the following information was gathered, it includes, :"...A body check was completed at R2's day program at approximately 10:40am; the nurse noted that there was a small 3 centimeter scratch on the right side of her face and two 1/2 cm abrasions on right side of upper neck. The two 1/2 cm abrasions were previously noted. On her upper left cheek, R2 had reddened skin...QAF (Quality Assurance Facilitator) E11, reviewed the security cameras and observed the	W9999		

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following: E8 enters Plum hallway at 9am and goes into the first and second room on the left hand side. At approximately 9:10am, E10 enters R2's room, then leaves and enters another person's room. E10 re-enters R2's room at approximately 9:12am. At approximately 9:12am, E8 leaves R3's room and enters the hallway. At approximately 9:15am, E8 stops outside of R2's room and is facing in the direction of R2's doorway. He then moves towards the nursing station. At approximately 9:19am, E10 leaves the room with R2 and heads towards the front lobby. At approximately 9:20am, R2 gets on the bus for DT (day training)...."

Under Conclusion/Summary , it includes , "Based on information gathered, it is inconclusive as to whether the allegation of physical abuse occurred. E10 was put on administrative leave immediately following the allegation. As there are no cameras in the room and no additional witnesses to support E8's statement, the allegation is based only on the report of E8. Due to her disability, R2 is unable to relate the details of that morning. There is a possibility that the injuries noted are from R2 as she is on a behavior program for self injurious behavior including biting, hitting and punching herself."

Under follow up it includes, "An IDT (Interdisciplinary Team) meeting will be held for R2's QSP(Qualified Support Personnel) with the behavior department."

E8, was interviewed on 11/18/11 at 9:50am. E8 stated, "I saw the staff (E10) hit R2 with an open hand to both sides of her face." E8 added, "I came to the office to tell E9."

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E9 was interviewed on 11/18/11 at 9:56am via phone. E9 stated, "I got in the facility I believe a little after 10:30am. I got to the building. I paged someone and E8 heard my voice and came to my office and that's when he reported to me what he observed. I then went to E2's office and reported it to her." Surveyor asked if E8 reported the allegation immediately. E9 answered, "He (E8) is more fluent in Spanish so he waited because he knew I was coming, so he can explained himself fully. He knows the severity and seriousness and he knows he has to report it in details so that's why he waited." Surveyor asked if there was anybody else that E8 can talk to. E9 answered, "The dietary manager is bilingual though I don't know if he was in the building at that time. I also don't know if E8 was comfortable with talking with another supervisor from another department."

E11, was interviewed on 11/18/11 at 12:10pm. Surveyor asked what is the facility's policy on reporting allegations of abuse. E11 answered, "Allegations of abuse/neglect - staff report it to their supervisor and if they are not on site, staff have the numbers of their supervisors to report it to." Surveyor asked if E8 called E9. E11 answered, "It does not appear that E8 tried to call E9. Surveyor asked if the allegation was reported immediately. E11 then verified that E8 did not report it immediately and that E10 continued to work her shift from the time E8 allegedly saw her slapped R2 at around 9:15am until E10 left at 10:29am. E11 stated, "The investigation is inconclusive because it is one's staff report versus another staff's word. There are no other witnesses. R2 also has self injurious behaviors and she could have potentially done it when she

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W9999	Continued From page 20 was by herself." Surveyor asked if R2 was ever alone or out of range of vision from the cameras since leaving her room with E10. E11 stated, no, staff was with her when she got on the bus, while on the bus and when she got to day training . Surveyor asked if the staff with R2 saw her having a behavior. E11 answered, "No." Surveyor then asked when could R2 probably injure herself if staff did not observe any behaviors. E11 answered, "R2's injuries could have been before E10 re-entered the room at approximately 9:12am." Surveyor asked if E10 reported any injuries on R2. E11 answered, "No." Further review of the investigation showed that the delay in reporting was not identified as a problem in need of further staff training. E2, Residential Services Director, was interviewed on 11/18/11 at 1:10pm. E2 stated, "No re-training was done with any staff." Surveyor asked if E8 reported the allegation late. E2 answered, "E8 did report it immediately. He reported it to his supervisor." Surveyor told E2 about the timelines. E2 then verified that there was at least a 40-45 minute delay in reporting. E2 further stated that staff were not retrained on immediately reporting allegations of abuse, neglect and mistreatment after this incident. E1, Administrator, was interviewed on 11/18/11 at 12:55pm. E1 stated, "For instances of abuse/neglect/mistreatment, staff should report it to any of the four supervisors (Administrator, Director of Nursing, and any of the two Resident Services Directors) immediately."	W9999		

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