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W 149	Continued From page 20 aggression had been investigated by the facility and reported to the Illinois Department of Public Health. E1 also stated, "No" when asked by the surveyor if R1 had a behavior program for physical aggression, if staff had been trained on the facility's policy for client to client abuse and if the facility maintains a system for monitoring trends and patterns of client to client aggression.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 350.620a) 350.1060e) 350.1230d)1)2) 350.3240a) 350.3240f) 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 available to administer these programs. Section 350.1230 Nursing Services	W9999		

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W9999	Continued From page 21 d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to protect clients from abuse and prevent neglect. Client to client abuse has occurred and the facility failed to take actions which protect the individuals and prevent reoccurrence for 2 of 14 current individuals of the facility (R3, R5), 1 of 1 prior resident of the facility (R2) and other unidentified individuals of the facility who have been subjected to abuse by R1. In addition the facility has failed to implement their policy and procedures prohibiting	W9999		

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mistreatment, neglect and/or abuse of the individuals for 2 of 14 current individuals of the facility (R3, R5), 1 of 1 prior resident of the facility (R2) and other unidentified individuals of the facility who have been subjected to abuse by R1.

This failure potentially affects 11 additional individuals of the facility (R4, R6-R15) as evidenced by the facility's failure to:

- Evaluate the appropriateness of R3 being R1's roommate after R1's continued aggressions against her (R3);
- Develop and implement a behavior intervention plan to address R1's physical aggression towards her peers and staff of the facility;
- Provide necessary supervision to prevent client to client abuse;
- Ensure that staff are aware of the facility's policy and procedures regarding client to client abuse;
- Document each incident of client to client abuse and identify the victim of the abuse; and
- Implement a system which assures that incidents of client to client abuse are reported and investigated and that safeguards and corrective actions are taken to prevent further incidents of abuse.

Findings include:

On 11/18/11 at 3:00 P.M. an Immediate Jeopardy was identified to have begun on 09/11/11 when the facility failed to provide necessary supervision to prevent R1 from physically aggressing towards peers of the facility. On 09/10/11 R1 was physically aggressive towards her roommate (R2). The facility removed R2 from the bedroom but on 09/11/11, R1 attacked R2 while she was

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sleeping on the couch. After this incident, R3 became R1's roommate and became the subject of R1's abuse as based on interview with staff and clients of the facility. There is no specific documentation of client to client abuse by R1 towards R3. R1 does not have a behavior intervention plan to address her aggression towards her peers. Upon interview, facility staff are not aware of the facility's policy and procedures regarding client to client abuse. Staff do not document each incident of client to client abuse nor specifically identify the victim(s) of R1's abuse. The facility does not investigate all reports of client to client abuse and ensure that safeguards and corrective actions are taken to prevent further incidents of abuse.

The facility's undated Abuse Prevention program states that it is the policy of the facility to, "...prohibit mistreatment, neglect or abuse of it's residents... and assure that the facility is doing all that is within it's control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by:
- identifying occurrences and patterns of potential mistreatment;
- immediately protecting residents involved in identified reports of possible abuse;
- implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making changes to prevent future occurrences; and
-filing accurate and timely investigative reports.

This policy goes on to state that the facility is committed to protecting their residents from abuse by anyone including, but not limited to

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W9999	Continued From page 24 other residents of the facility. The Physician's Order sheet dated 11/01/11 identifies that R1 is a 62 year old female who functions at a severe level of mental retardation and has diagnoses of Obsessive Compulsive Disorder, Anxiety, SIB (self injurious behaviors) and Expressive Aphasia. The Hab. (Habilitation) Notes dated 09/10/11 states, "Roommate (R2) walked in her room and R1 grabbed her breast and slapped R2 in the face. Staff (E6) interveind (intervened) to prevent R2 from further injury. R1 bit staff (E6) on the arm and slammed her (E6) in the door. Staff (E6) yelled for assistance from E8/R.N. (Registered Nurse and staff (unidentified). Staff (unidentified) was also bitten by res. (resident) R1. Staff (unidentified) had to physically redirect R1 to her bed to calm down to prevent further injury to herself or others. Res. (R1) is in her room content at this time." A facsimile notice was sent to the Illinois Department of Public Health on 09/15/11 regarding the 09/10/11 incident. This notice states, "Staff was instructed to keep both residents actively engaged and separated. Resident's room changes are being made. All staff will continue to monitor both residents." Per review of the Hab Note dated 09/11/11, documentation identifies that R1 was not closely monitored by staff after the 09/10/11 incident to ensure that she remained separated from R2. This note states, "When staff (E6) arrived for shift R2 was on the couch sleeping. R1 was sitting in the rocking chair in the corner. Staff (E6) asked	W9999		

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staff (E7) what was going on. E7 stated that about 11 P.M. or so, R2 was asleep on the couch and out of nowhere, R1 came out of her room, grabbed the blankets off of R2 and proceeded to try and pull her hair when staff (E7) stepped in to stop her. After that R1 sat in the rocking chair and refused to go back to her room. R1 finally listened about 12:45 A.M. and went to her bedroom where she stayed for the rest of the night. No more incidents at this time."

E1 (Administrator) was interviewed on 11/18/11 at 2:20 P.M. regarding the facility's investigation of R1's aggression towards her roommate (R2). E1 stated, "R2 was moved out of the bedroom she shared with R1 after the first incident (09/10/11)." When E1 was asked if the facility had investigated the incident of 09/11/11 to ensure that staff provided necessary supervision to prevent R1 from attacking R2 while she slept, E1 stated, "No." When E1 was asked who became R1's roommate after R2 was moved, she stated, "R3".

In review of R1's Behavior Tracking sheets, Hab. Notes and the RN (Registered Nurse) Consultant notes, there is no documentation identifying when R3 was moved into the bedroom shared with R1. These documents identify that no further incidents of aggression occurred after 09/11/11 until 10/05/11. Documentation of the incident written on 10/05/11 does not identify who was the victim of R1's aggression.

R1's Behavior Tracking sheet for October 2011 identifies the following aggressive incidents:

10/05/11 Two episodes of physical aggression.

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10/15/11 Physical Aggression, non-compliance hitting staff. Staff then documented that R1 was taken to her room to separate her from, "endangered staff".
10/20/11 Physical aggression and temper tantrums lasting fifteen minutes.

These documents do not identify the name(s) of the individuals and/or staff who were victims of R1's aggression.

The Hab. Notes for October 2011 identifies that on 10/11/11 R1 was seen by the Neurologist (Z5) who ordered Depakote 250 mgs (milligrams) to address her behaviors. The neurologist's (Z5's) Progress Notes dated 10/10/11 states, "Guardian thinks, "med (medication) for behavior" needs increased - has trouble getting along with Rm (room) mate... Has increased anger, fighting. Gets initiated easily... Reco (recommend) try Depakote 250 (one tablet) q (every) am for behavior..."

Z4 (R1's guardian) was interviewed by telephone on 11/18/11 at 8:45 A.M. and stated, "I did not go to the neurologist with R1, but I was aware that she is being aggressive towards her roommate. They (unidentified staff) told me that she is still having problems with aggression with her roommate and other individuals of the facility."

The Behavior Development Program dated 02/16/11 states that R1 has maladaptive behaviors of non-compliance related to ADL's (Activities of Daily Living) and anxiety which may lead to SIB (self injurious behaviors which occur at an average of 1-10 times per day. R1's Trazodone medication is identified within this

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W9999	Continued From page 27 plan, however this program does not include her Depakote which was added to her medication regime on 10/12/11. Further review of this program identifies methods of staff intervention for non-compliance, anxiety and SIB. No methods are contained within this plan to address R1's physical aggression towards her peers and staff and/or her Depakote medication which was ordered on 10/10/11 for physical aggression. R1's Qualified Mental Retardation Professional (QMRP) Monthly Review dated September 2011 identifies that she is monitored for incidents of anxiety which may lead to self injurious behaviors and non-compliance. No documentation is noted within this review regarding R1's physical aggression and/or how the facility and the day training site are monitoring R1's aggressive behavior. The Behavior Tracking sheet, Incident/Accident Reports, Hab. Notes and the RN (Registered Nurse) Consultant notes for November 2011 identifies that R1 had the following documented aggressive incidents during the month: 11/03/11 The Behavior Tracking sheet states that R1 was hitting and biting staff (unidentified) and residents (unidentified). It is also documented that this behavior lasted in excess of two hours. 11/07/11 The Behavior Tracking sheet states that R1 was hitting, biting and kicking staff (unidentified) and residents (unidentified). It is documented that this behavior lasted in excess of two hours. The Incident/Accident Report for 11/07/11 states, "3:30 P.M. Res. (R1) was going throw (through) a res (unidentified) closet and	W9999		

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staff (unidentified) told her that wasn't her closet and res (R1) flipped out." The RN Consultant noted for 11/07/11 states, "4 PM Res. (R1) in altercation with peer (unidentified). Staff (unidentified) redirected and res (R1) became agitated and scratched self above right eye on eyebrow. No bleeding or swelling noted upon assessment..."

11/11/11 The Behavior Tracking sheet states,"Hitting other peers (unidentified) and staff (unidentified) with items, kicking, hitting. Made her go to her room." This documentation states that this behavior lasted forty five minutes in duration. The Hab. Note dated 11/11/11 states, "R1 was in an (a) bad mood this morning. She was trying to take it out on R3 (R1's roommate)..."

The Behavior Tracking sheets for November 2011 do not consistently identify the name(s) of the individuals and/or staff who were victims of R1's aggression.

E2 (Direct Support Person/DSP) was interviewed on 11/17/11 at 3:55 P.M. and stated, "I was working on 11/07/11 but I did not see the incident and E10 (QMRP) was here and dealing with the behavior. R1 was in R4's and R5's closet. When she (R1) was asked to come out of their room, she became aggressive to her self and staff and hit her eye on the corner of the closet." When E2 was asked which peers were involved in the altercation(s) on 11/07/11 she stated, "I think she (R1) had been fighting with R3 (roommate) and had hit R5 when she was in the hallway going to her room." E2 (Direct Support Person/DSP) was again interviewed on 11/18/11 at 10:40 A.M. and stated, "We switched R3 from R1's room just last

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W9999	Continued From page 29 week. I think is was last Thursday or Friday (11/10 or 11/11/11). When E2 was asked why the facility had moved R3 out of the bedroom shared with R1, she stated, "They were fighting. E6 (DSP) was here. I came in on the end of it." The behavior documentation for R1 for 11/07/11 and 11/11/11 were reviewed with E2 on 11/18/11 at 10:40 A.M. When E2 was asked if the facility would be able to identify the unidentified individuals that were victims of R1's aggression, she stated, "No, you wouldn't know or be able to tell." When E2 was asked if she knew which peers were involved in the altercation(s) on 11/07/11, she stated, "I think she (R1) had been fighting with R3 (roommate) and had hit R5 when she was in the hallway going to her room." When E2 was asked what the facility's policy and procedures for client to client aggression was, she stated, "I'm not sure. I don't really know if we have a policy for client to client aggression." R5 was interviewed on 11/17/11 at 4:50 P.M. and stated, "R1 hit me in my head when she was coming out of my bedroom (11/11/11). Her (R1) and R3 got into it in the bedroom and they were fighting. When I came out of my bedroom R1 hit me." When R5 was asked how hard he was hit he stated, "She hit me hard enough to make me mad. Staff had to hold me back to keep me from hitting her." On 11/17/11 at 5:07 P.M., R3 was interviewed and stated, "I used to be R1's roommate. I'm not sure when they moved me out of her room. She's (R1's) a PEST! She hit me a lot and they didn't do anything." When R3 was asked who they were she stated, "Staff." When R3 was	W9999		

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asked what staff did when she told them that R1 was hitting her she said, "They didn't do nothing honey." R3 stated that she did not know how long she had been roommates with R1 but was glad that she no longer her (R1) roommate.

E3 (DSP) was interviewed on 11/18/11 at 10:30 A.M. and stated, "I started working here on November 1st, 2011. When I started R3 was R1's roommate. I'm not sure why they moved her but when I came back to work on the 13th (11/13/11) they had moved R3 to another room. They said that it was because of R1's aggression towards her (R3)."

E9 (DSP) was interviewed on 11/17/11 at 4:18 P.M. and stated, "R1 is in a room by herself." When E9 was asked why R1 is in a room by herself he stated, "She had difficulty with R3 as her roommate. She also had problems with R2. We just could not get her (R1) to understand she had to share her room."
In review of the facility's investigations from 09/10/11 to 11/18/11 there is no documentation showing that the facility evaluated the appropriateness of R3 being R1's roommate due to R1's physical aggression against her (R3).

Review of the clinical records for R1 and R3 did not identify when R3 became R1's roommate or when she (R3) was moved from the bedroom shared with R1 and/or why this move occurred. There is no documentation that R1's supervision was increased or that her behavior program was revised to address her physical aggression towards her roommate (R3) and other unidentified individuals of the facility.

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W9999	Continued From page 31 In review of the facility's investigations from 09/01/11 - 11/18/11, there is no documentation showing that the facility investigated incidents of R1's aggression towards R3 or other individuals of the facility after 09/10/11. There is no documentation showing that safeguards and/or corrective actions were taken by the facility to prevent further occurrences of client to client aggression by R1 after 09/10/11 until 11/11/11 when R3 was moved from the bedroom she shared with R1. E1 (Administrator) was interviewed on 11/18/11 at 2:20 P.M. and stated, "No" when asked if the facility had documentation showing that they had investigated incidents of R1's aggression towards her roommate (R3) and peers of the facility. E1 stated, "R2 had been moved out of the bedroom she shared with R1 after the first incident (09/10/11) and R3 then became her (R1's) roommate." When E1 was asked if the facility had documentation showing that other incidents of client to client abuse had been investigated by the facility and reported to the Illinois Department of Public Health, E1 stated, "No, but I know we should have investigated these incidents." E1 also stated, "No" when asked by the surveyor if R1 had a behavior program for physical aggression, if staff had been trained on the facility's policy for client to client abuse and if the facility maintains a system for monitoring trends and patterns of client to client aggression. A	W9999		