

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER PARK PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 205 PARK AVENUE PANA, IL 62557		
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W 455	Continued From page 29 done."	W 455			
W9999	<p>Facility "Policy Name: Standard Precautions, dated March 2007," under "Procedure" F. Resident care Equipment ...Ensure that all single use items are discarded properly. I. Occupational Health and Bloodborne Pathogens ...Place all used ...sharp items in appropriate puncture resistant containers ...</p> <p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS</p> <p>350.620a) 350.1060e) 350.3240a)</p> <p>Section 350.620 Resident Care Policies</p> <p>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.</p> <p>Section 350.1060 Training and Habilitation Services</p> <p>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,</p>	W9999			

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W9999	<p>Continued From page 30</p> <p>properly trained and supervised staff shall be available to administer these programs.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements are not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure their system to prevent, abuse, neglect or mistreatment was in place when the facility failed ensure individuals are not subject to peer to peer abuse one resident (R8), who has been issued a 21 day discharge notice, however remains a client who has not been discharged from this facility as of 2/22/12. The facility failed to ensure:</p> <p>1) R8's behavior management plan includes interventions for physical aggression to address current behaviors with revisions as indicated.</p> <p>2) Supervision level For R8 meets this clients needs and provides protection for the other client's in the facility.</p> <p>3) R8's behavior management plan addresses suicidal ideas (with safeguards), property destruction, hallucinating or delusional behaviors, and self abusive behaviors (SIB).</p> <p>4) The facility policy for self injurious behaviors was implemented.</p> <p>5) Facility staff are aware of any changes to R8's</p>	W9999			

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W9999	<p>Continued From page 31</p> <p>BMP including supervision level as this client has not been discharged.</p> <p>6) Implement their policy to prevent abuse/neglect from their peers.</p> <p>Findings Include:</p> <p>Per review of R8's ISP (Individual Support Plan) of 12/21/11, R8 is a 22 year old ambulatory verbal male who functions in the mild range of mental retardation with additional diagnoses of Bi-Polar Disorder and Attention Deficit Hyperactive Disorder. R8's mother is his current legal guardian.</p> <p>Per review of R8's Behavior Management Program (BMP), undated, R8 displays non-compliance, inappropriate social interaction, physical aggression and hallucinatory/delusional behavior. The plan does not address self abuse, property destruction, withdrawal and unusual habits.</p> <p>Review of peer to peer altercations:</p> <p>-7/30/11, R8 grabbed R2's right elbow with redness.</p> <p>-8/4/11, R8 hit R2 in the right knee with an umbrella there was redness noted.</p> <p>-8/9/11, R8 was having some behavioral issues and walked up to R2 and spit in his face. Will have a special staffing for R8 on 8/18.</p> <p>Per interview with E1, Resident Service Director (RSD), on 2/23/12 at 8:49 AM, E1 stated that the</p>	W9999			

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W9999	<p>Continued From page 32</p> <p>facility had a special staffing 8/18/11 due to R8's maladaptive behaviors. The meeting was for R8 and his family to inform them that if R8's maladaptive behaviors continue the facility would seek a involuntary discharge. This meeting did not include any revision to R8' BMP or changes in R8's supervision level.</p> <p>-8/20/11, R8 walked up to R12 and pulled him from the computer chair that R12 was sitting in. R12 had no injury noted.</p> <p>-8/26/11, R8 struck R9, R12, and R1 with no injury noted. R9 and R1 struck R8 back. R8 had a small abrasion on the right side of neck from R1. R8 was admitted the next day to a hospital for psychiatric evaluation for a 7 day period. R8 displayed no behaviors while at the hospital and was returned to facility. The hospital made no new recommendations upon readmission to the facility. The facility did not review or revise R8's BMP upon his return to the facility. There was no evidence R8's supervision level was reviewed or revised.</p> <p>R8 did not display any peer to peer altercations in the month of September.</p> <p>- On 10/1/11, R8 displayed physical aggression toward R2 by slapping him in the face. No injury was noted or sign of mental distress. R8's BMP was implemented and he continued to display aggression toward staff members and expressed suicidal ideations.</p> <p>- 10/2/11, R8 again displayed physical aggression toward a resident. R8 pushed R12. R8 again displayed physical aggression toward staff as well</p>	W9999			

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W9999	<p>Continued From page 33</p> <p>as property destruction and suicidal ideations.</p> <p>- 11/7/11, E5 (Direct Support Staff) notified E1 (Residential Service Director) that R8 was having behavioral issues and making suicidal ideations staff implemented his BMP without success, 911 (emergency services) was called.</p> <p>- 11/8/11, R8 was having behavioral issues and was becoming physically aggressive with staff.</p> <p>-11/12/11, R8 slapped R10 in the face, no injury noted.</p> <p>-11/14/11, R8 hit R12 in the face no injuries were noted at this time.</p> <p>-11/22/11, R8 was having some behavioral issues and walked up to R12 and hit him in the head, there were no injuries noted at this time.</p> <p>On 10/3/11, R8 was seen by the local mental health center and was referred to a hospital for a psychiatric evaluation. A special staffing was held on 10/4/11 to follow up recommendations for R8. The facility special staffing consisted of a discharge notice.</p> <p>Per interview with E1 (Residential Service Director) on 2/22/12, a discharge staffing was held on 10/4/11 concerning R8. R8 was to be discharged from the facility to a Mental Health Center. E1 stated the Mental Health Center would not accept R8 as a patient. R8 returned to the facility on 10/20/11.</p> <p>Per review of BMP, undated, the operational definition of hallucinatory/delusional behavior as</p>	W9999			

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W9999	<p>Continued From page 34</p> <p>one or a combination of the following: hearing voices telling him to hurt himself, self injurious behavior, somatic complaints of illnesses or over exaggerating of sickness or injury.</p> <p>Interview with E1 on 2/22/12 states that R8's intervention of suicidal ideations would be included under the operational definition of hallucinatory/delusional behavior.</p> <p>Review of the facility policy of Suicidal Ideations (dated 3/07) states: It is the policy that all suicidal statements or actions shall be taken seriously and will be considered an unusual incident. The procedure states that</p> <p>a) upon becoming aware of suicidal statement/action, staff should immediately place the individual on documented 24 hour visual monitoring, or until no statements or action has taken place for 24 hours.</p> <p>b) During visual monitoring, remove all potentially hazardous items from the individuals immediate environment.</p> <p>Review of the BMP, undated, Method for Hallucinatory/Delusional Behaviors: There is a history of SIB (Self -Injurious Behavior) in the form of R8 attempting to burn his hand with a lighter, light a lighter in his mouth and making superficial cuts on his arm. No actual physical injury has occurred since his admission. Staff will continue to monitor, if this SIB should occur, staff will document on an General Accident Report. Staff will ask R8 to stop participating in his SIB and redirect him to an activity.</p> <p>The BMP, undated, does not instruct staff to visually monitor R8 for 24 hours, or until no</p>	W9999			

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W9999	<p>Continued From page 35</p> <p>statements or actions of self abuse have taken place for 24 hours. Nor does it refer to removing hazardous items from R8's immediate environment.</p> <p>Per review of R8's Behavior Management Program (BMP), undated, R8 displays non-compliance, inappropriate social interaction, physical aggression and hallucinatory/delusional behavior. The plan does not address self abuse, property destruction, withdrawal and unusual habits.</p> <p>Per review of a Special Interdisciplinary Team Meeting for R8, dated 11/17/11, R8 was issued a 21 day involuntary discharge notice on 10/17/11 with a formal hearing held on 11/17/11. The team discussed the increase in R8's behaviors and his becoming more aggressive with his peers and staff.</p> <p>Revisions, dated 11/17/11, that were made for R8 include:</p> <ul style="list-style-type: none"> -Increase staffing with 2 staff from the hours from 4p-12a. - Revise BMP to add positive reinforcements and interactions to encourage positive behavior. -Increase general supervision to close monitoring during waking hours with staff documenting every 30 minutes. <p>Interview with E1 on 2/16/12, E1 stated that R8's BMP did not change, the only modification to R8's program was the medication up-dates. E1 also stated that the last staff meeting to discuss R8 was held on 10/19/11, and staff were not re-trained after the Special Meeting for R8 on 11/1711. R8 continued to have peer to peer</p>	W9999			

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W9999	<p>Continued From page 36 behaviors after the Special Meeting of 11/17/11.</p> <p>Review of incident reports dated after 11/17//11 includes: R8 was having behavioral issues on 11/22/11 and walked up to R12 and hit him in the head. There no injuries. 11/22/11-R8 hit R2 in the head, no injury noted.</p> <p>Interview with E3, Administrator, on 2/16/12 at 2:20 PM, R8 left the facility on 11/22/11 for a home visit and has been visiting a CILA (Community Integrated Living Arrangement) since 11/29/11. E3 stated R8 is still resident of the facility and has not been formally discharged.</p> <p>Per review of Abuse and Neglect Policy (Dated 12/09) It is the policy of the facility that incidents of peer to peer physical, verbal or sexual abuse will be addressed by the IDT of the persons involved. Persons living at the facility have the right to expect that they will not be abused by a peer.</p> <p>Procedure: The staff of the facility will document the incident each time there is an incident of peer to peer physical contact, verbal abuse that was volitional and not accidental or sexual abuse.</p> <p>In either case, an abbreviated IDT meeting may be held to review the BMP for the person and determine if the current intervention strategies remain appropriate.</p> <p>These meeting and reviews will be documented and any changes in interventions or treatment plan will be noted.</p>	W9999			

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W9999	Continued From page 37 R8 may be placed back at this facility pending the court hearing without any changes to R8's BMP in place and staff trained on R8's new BMP. (B)	W9999			