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APOSTOLIC CHRISTIAN TIMBER RIDGE	2125 VETERANS ROAD MORTON, IL 61550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 29 device] pole (used to raise the [mechanical lifting device] fork) out of the manual [mechanical lifting device], and went towards [R2]. He hit the back of [R2's] head before staff could get to both of them. He was not saying anything." Under the section titled "Resident Status, Injuries Mental Status, Review Of Incident" it states, R2 "was bleeding and received emergency treatment. She was taken to the ER [emergency room]. See following nurses notes: '10:15am Left with staff, in stable condition, for [hospital ER] for evaluation of laceration posterior head. 12:40pm Returned to [facility] in stable condition.'" It continues, "Complains of headache and agrees to eating lunch. Dressing intact to top of head over laceration. Removed dressing to observe 2-3cm laceration with 6 staples intact." That section of the Resident Incident Report of 1/29/12 continues, R1 "has had 1:1 intervention at [the facility] since the incident, and has not been agitated. He went to work today as usual without incident. The 1:1 staff intervention has continued in order to insure protection of the others [sic] residents." This section was signed by E2 (Resident Services Director). In interviews with Z1 (Day Training Qualified Support Professional, Educational Services) on 3/27/12 at 2:50pm., and E3 (QMRP) on 3/30/12 at 9:35am., both identified R2, R3 and R4 as individuals who would be considered as targeted peers by R1. The facility was unable to provide evidence that corrective action had been initiated regarding a pattern of R1 targeting particular peers for acts of aggression.	W 127		
W9999	FINAL OBSERVATIONS	W9999		

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W9999	Continued From page 30 LICENSURE VIOLATONS 350.1060e) 350.1230b)6)7) 350.3240a) 350.3240f) 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 b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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	W9999		

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W9999	Continued From page 31 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 are NOT MET as evidenced by: Based on interview and record review, the facility failed to set up a structure which protected individuals and prevented reoccurrence of peer to peer abuse for 3 of 4 individuals in the sample [R2, R3, and R4] and 6 individuals outside the sample [R5, R6, R7, R8, R9 and R10] when they failed to: 1) ensure the receipt of and implementation of revisions to R1's behavior program and increased supervision needs, through follow up site visits and observations to ensure that safety measures were implemented by the day training site after the incident of peer to peer abuse by R1 to R2 on 1/29/12 which resulted in 6 staples to R2. 2) take corrective action regarding a pattern of R1 abusing his peers to prevent further abuse. 3) take corrective action regarding a pattern of R1 targeting particular peers for acts of aggression. Findings include: 1) A "Resident Incident Report" dated 1/29/12 states, R1 "got up and pulled a [mechanical lifting device] pole (used to raise the [mechanical lifting device] fork) out of the manual [mechanical lifting device], and went towards [R2]. He hit the back	W9999		

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of [R2's] head before staff could get to both of them. He was not saying anything."

Under the section titled "Resident Status, Injuries, Mental Status, Review Of Incident" it states, R2 "was bleeding and received emergency treatment. She was taken to the ER [emergency room]. See following nurses notes: '10:15am Left with staff, in stable condition, for [hospital ER] for evaluation of laceration posterior head. 12:40pm Returned to [facility] in stable condition.'" It continues, "Complains of headache and agrees to eating lunch. Dressing intact to top of head over laceration. Removed dressing to observe 2-3cm laceration with 6 staples intact."

That section of the Resident Incident Report of 1/29/12 continues, R1 "has had 1:1 intervention at [the facility] since the incident, and has not been agitated. He went to work today as usual without incident. The 1:1 staff intervention has continued in order to insure protection of the others [sic] residents." This section was signed by E2 (Resident Services Director).

E2 was interviewed on 3/23/12 at 9:33am. E2 stated that R1 has had 1 on 1 supervision at the facility since the incident of 1/29/12. E2 stated that the 1 on 1 staff meets R1 at the bus and is with him until bed time around 8:00pm. E2 also stated that at the day training R1 is "1 on 1 in the hallway." E2 stated that R1 had "never had an incident with no antecedent. It was a weekend. He was sitting on the mat table. He got up and went toward the [mechanical lifting device]. Thought nothing of it. He pulled out the pole and hit her on the back of the head."

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R1, per current Individualized Service Plan [ISP] dated 7/21/11 is a 41 year old male with diagnoses of Moderate Mental Retardation, Epilepsy, Obsessive-Compulsive Disorder and Organic Affective Disorder. The ISP lists R1's IQ as below 25 and states that his overall functional level is "Severe." It states that R1 "is verbal with a severe speech impairment."

R2, per current ISP dated 6/16/11 is a 48 year old female with diagnoses of Spastic Cerebral Palsy with quadriplegia and Severe Mental Retardation. The ISP states that R2 "is independent with her power wheelchair. Her transfer protocol remains a 1 person stand-pivot with a gait belt. Her posture is characterized as having severe scoliosis."

Per review of facility incident reports, a "Resident Incident Report" dated 2/17/12, under the section titled, "Detailed Account Of The Occurrence as reported by [day training] staff" states, R1 "was in the hallway by the restroom. He had an angry look on his face. He was alone. [R3] came out of her classroom in her wheelchair. She was going to another class. [R1] saw [R3] and stomped his foot, and then snapped his fingers. He started coming toward [R3]. Several staff were in the hall at this time, and began talking with [R1], coming toward him." It continues, R1 "swung his hand toward [R3], and hit the head rest on her wheelchair."

Day training "Incident Report" dated 2/17/12 describes the incident as follows; R1 "was in hallway by restroom unattended with an angry look on his face. [R3] came out of room 156 to go to her next class. [R1] started moving towards

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[R3]. Staff intervened + tried to redirect [R3] away from area. [R1] became more agitated + swung at [R3's] head + hit the back of her headrest."

Z1 (Day Training Qualified Support Professional, Educational Services) was interviewed on 3/27/12 at 2:50pm. When asked if day training was notified of the incident of 1/29/12 which resulted in staples to R2, Z1 stated, yes. When asked when they were notified, Z1 stated, "The following day" which was the first working day. When asked what the plan was for protecting the other individuals at day training who are around R1, Z1 stated staff are to monitor him at all times.

Z1 was asked about the incident of 2/17/12 when R1 was "alone" in the hallway. Z1 stated that there are 2 bathrooms in the suite where R1 is in class. Z1 stated that both were occupied. Z1 stated that two staff were assisting individuals at the table in the classroom. Z1 stated that R1 "walked out of the classroom. There is a bathroom next door. One individual who he has targeted in the past was out there. Staff realized he left but the incident was already starting to occur. I was not available."

Z1 was asked if there were any changes since the incident of 2/17/12. Z1 stated that R1 is to be 1 on 1 outside the classroom. Z1 stated that he is to be monitored when walking in the hallway, staff are with him in the food line and assisting him with his tray. R1 sits at a table with staff for lunch. Z1 stated that anytime R1 is out of the classroom staff are to be with him. When asked when this was implemented, Z1 stated it was when he moved up to his new classroom around

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W9999	Continued From page 35 2/02/12. Z1 was interviewed on 3/27/12 at 3:05pm. When asked if she had copies of the new behavior program revisions dated 2/09/12 and 3/19/12, Z1 checked in R1's day training file and stated, "I don't have a copy of that one." The day training file contained a copy of the behavior program dated 7/11. This is the program which had revisions made to it 2/09/12, but the revised copy was not available in the day training record. Z1 was interviewed on 3/30/12 at 2:55pm. Z1 stated that she had received the material from the facility revised 2/09/12 but it was not in the file. Z1 stated that the revision of 3/19/12 was not received until after the interview of 3/27/12. E3 (Qualified Mental Retardation Professional, QMRP) was interviewed on 3/30/12 at 9:35am. When asked when day training was notified about the incident of 1/29/12 with R1 and R2, E3 stated, 1/30/12. When asked who was notified, E3 stated, Z1. When asked what their expectations were for supervision for R1 at day training, E3 stated that they hoped he would be monitored to "maintain the safety of the ladies." E3 stated that he did not remember if the expectation was for 1 on 1. When asked if a copy of the new behavior techniques were provided to the day training, E3 stated, "Yes, the techniques are not really that different. The addition of the positives." E3 was asked if that was provided, and E3 stated yes. E3 was asked if after the incident of 2/17/12 at the day training site, if he had communication with the day training site. E3 stated, "I know I have talked with them, I can't say where or when.	W9999		

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I also E-mailed them. I routinely sent E-mails." When asked if he ever visited the day training site after the incident of 1/29/12 to see if the expectations for supervision of R1 were being met, E3 stated, "I was not there, no." E3 added that he was there twice to pick up R1 when he had difficulty and had to be picked up. When asked he was there after the incident of 2/17/12, E3 stated he had been there once to pick up R1 but, "No, not to observe, no formal observation."

E3 provided copies of several E-mails. An E-mail dated 2/09/12 at 1:30pm to Z1 states, "Here is an addition to [R1's] behavior program dealing with Physical Aggression." After describing the intervention the E-mail states, "This has been added to his program in [the facility computer system]. Please start doing this, along with the other things the program says to do." Another E-mail from E3 to Z1 on 2/09/12 at 3:21pm., states, "please give me a call early next week... We need to discuss a couple of things concerning [R1]."

An E-mail from E3 to Z1 on 2/13/12 states, R1 "had 3 incidents in the last week, fortunately intercepted by the 1:1 staff...We need to talk this week sometime." An E-mail from E3 to Z1 on 2/20/12 at 10:40am states R1 " is going to [an outside agency review team] on Thursday. We are finalizing what we are saying to them, and want your input. Particularly in light of the incident with [R3] last week."

An E-mail from Z1 to E3 on 3/27/12 at 3:54pm. states, "Can I get a copy of [R1's] most recent behavior program, if he has one newer than 7/11." This was after Z1 was interviewed on

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3/27/12 at 3:05pm., by the surveyor regarding the availability of the newest revisions of R1's behavior programs and techniques. E3 E-mailed back to Z1 on 3/27/12 at 3:57pm., stating "Here's what we have. The positive one is all new; the other is as before except for the bit in red on the PA [Physical Aggression] program." Hand written on this form regarding the Physical Aggression program, "was sent in E-mail 2/09/12."

An E-mail from Z1 to E3 on 3/27/12 at 11:08am states, R1 "had an incident while I was teaching a class today. His nemesis [Z2 day training peer not residing at the facility] was yelling about wanting a staff person 'to die'. This staff is a favorite person to [R1]. He got up walked over to her, hit her in the back, and then went back to his previous activity." The incident report from day training of this incident of 3/27/12, under the section titled "Description of Incident" states, Z2 "was talking loudly and not very nice. [R1] was stringing beads and got up walked about 3 feet and hit [Z2] in the back. [Z2] was speaking badly of [R1's] favorite staff." The incident report, under the section titled "Administrative Follow-up" states, R1 "is very fond of this staff + has a history of hitting [Z2] when she is negative. He was monitored by staff the remainder of the morning with no further issues." This section was written by Z1.

The facility failed to ensure the receipt of and implementation of revisions to R1's behavior program and increased supervision needs While R1 is at the day training site, through follow up site visits and observations to ensure that safety measures were implemented by the day training site after the incident of peer to peer abuse by R1

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to R2 on 1/29/12 which resulted in 6 staples to R2. R1 had incidents of peer to peer abuse at the day training site on 2/17/12 and 3/27/12.

2) R1's incidents of peer to peer abuse were reviewed back to 9/11. Per review of facility incident report forms, R1 had incident reports for the following incidents of peer to peer abuse from 9/11 through 12/11:

9/17/11-R1 hit R5 on the head as he passed by him.
10/08/11-R1 kicked R6 with his left leg. R1 struck R6 lightly on the left shoulder area.
11/01/11-R1 took R4's hand and squeezed her hand. R1 looked upset.
11/01/11-R1 put his hand on R7's chin and tried to turn her face towards him. Staff told him he needed to let go, which he did, then he grabbed at her shirtsleeve.
11/14/11-R1 hit R8 on the shoulder.

These were the only incidents where R1 was able to aggress against peers from 9/11 through 12/11. Starting in 1/12, R1 had the following incidents:

01/01/12-R1 reached out and put his hand on R9's shoulder which caused her to fall over.
01/05/12-R1 kicked R4's wheelchair, grabbed and pulled her hair. This incident occurred at day training.
01/06/12-R1 hit R6 on his back with a magazine.
01/14/12-R10 hit R1 with her wheelchair. R1 hit R10 on the left shoulder.
01/16/12-R1 swung his arms around staff resulting in a hit to the back of R4's head as she was in her wheelchair, R1 then took ahold of R4's pony tail.

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W9999	Continued From page 39 01/29/12-R1 hit R2 in the back of the head with a pole from a mechanical lift causing 6 staples. E3 (QMRP) was interviewed on 3/30/12 at 9:35am. When asked if it was noticed that there was an increase in behavior in 1/12 for R1, E3 stated that there was an apparent increase in the number of incidents, but compared to October and November there was not an increase. When asked if there had been an increase in physical aggression for R1 in 1/12, E3 stated, "Not really, seems about like normal. Might have been looking at intensity, aggression toward staff is not reportable." E3 was asked regarding the incident of 1/05/12 at day training, the incident report stated, the facility "staff was alerted to monitor when [R1] is near [R4] at home, too." E3 was asked what form this alert took. E3 stated, "Normal, E-mail." E3 provided an E-mail addressed to all staff which stated, "This afternoon at [day training] [R1] walked over to [R4], struck her, and grasped her hair. While this seems to be an isolated incident, it reminds us to watch out and take extra care when they are near each other." It continues, "Please be extra vigilant when [R1] and [R4] are in the same areas at [the facility], and redirect them apart as needed. The closer they are to each other, the nearer staff should be, to ensure safety." E3 was asked, what were the expectations after the incident of 1/05/12 with R4. E3 stated, "To keep an eye on [R1]. Specially when in the area of other residents, particularly ones he's had problems with in the past."	W9999		

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E3 was asked, regarding the incident of 1/06/12 with R6 being the third incident in one week, was there any increase in supervision. E3 stated, no.

E3 was asked if a change in R1's behavior had been noticed since December 2011. E3 stated, "Subjectively, seems more times out of it, not himself, had a decrease in movements."

E3 was asked if after the incident on 1/14/12 when R10 hit R1 with her wheelchair and R1 hit R10 in the shoulder if there was an increase in supervision. E3 stated that was a provoked incident and they were kept away from each other. E3 stated, "His reaction didn't look like part of a pattern."

E3 was asked if there was a facility response to R1's increase in physical aggression. E3 stated, "At this point, no. Around this time E1 (Director of Nursing) sent his information to Z3 [Psychiatrist]."

E3 was asked regarding the incident of 1/16/12 where R1 hit R4 and pulled her hair, since this was the second time R1 had aggressed against R4 in January and the fifth incident of physical aggression by R1 in January, the incident report states, facility staff "is coordinating appropriate redirection interventions with [R1] and [R4] not only at [the facility] but at [day training] as well", what was the facility doing for prevention instead of redirection after the fact. E3 stated, "Good question. Still don't see this as unusual. It's an increase since December. We were looking at factors involved."

The next incident was the incident of 1/29/12 with R2 when per a "Resident Incident Report" dated

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1/29/12, R1 "got up and pulled a [mechanical lifting device] pole (used to raise the [mechanical lifting device] fork) out of the manual [mechanical lifting device], and went towards [R2]. He hit the back of [R2's] head before staff could get to both of them."

Under the section titled "Resident Status, Injuries Mental Status, Review Of Incident" it states, R2 "was bleeding and received emergency treatment. She was taken to the ER [emergency room]." It states R2 returned with a 2-3cm laceration with 6 staples.

3) Z1 (Day Training Qualified Support Professional, Educational Services) was interviewed on 3/27/12 at 2:50pm. Z1 was asked if there were certain individuals that R1 targeted. Z1 stated, R4, R2, and R3. E3 (QMRP) was interviewed on 3/30/12 at 9:35am. When asked who he would consider targeted peers by R1, E3 stated, "Mostly younger females that are non-ambulatory." E3 mentioned R3, R2, and R4. E3 stated that "those are the three main ones."

R2, per current ISP dated 6/16/11 is a 48 year old female with diagnoses of Spastic Cerebral Palsy with quadriplegia and Severe Mental Retardation. The ISP states that R2 "is independent with her power wheelchair. Her transfer protocol remains a 1 person stand-pivot with a gait belt. Her posture is characterized as having severe scoliosis." Per "Adaptive Devices" list dated 3/30/12, R2 uses, "Manual Wheelchair Power Wheelchair Left Splint Bilateral AFO's Foot Pedals Chest Strap (for Transportation Only)."

R3, per current ISP dated 10/06/11 is a 38 year

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old female with diagnoses of Cerebral Palsy with Quadriplegia and Moderate Mental Retardation. The ISP states that R3 is non-ambulatory. Per Adaptive Devices list dated 3/30/12, R3 uses, "Manual Wheelchair Power Wheelchair Left Splint Foot Cups Foot Pedals Chest Strap Headrest."

R4, per current ISP dated 8/04/11 is a 29 year old female with diagnoses of Cerebral Palsy with Spastic Quadriplegia and Visual Impairment (low vision both eyes). The ISP states that R4 is non-ambulatory. Per Adaptive Devices list dated 3/30/12, R4 uses, "Manual Wheelchair Power Wheelchair Left Splint Foot Cups Foot Pedals Headrest."

R1's incidents with R2, R3 and R4 from 10/11 up to current were reviewed. They are as follows:

10/08/11-R1 "made an unusually mild negative statement in [R4's] direction while walking up the hallway. (Human Rights Meeting Report 10/03 through 10/10/11)
10/12/11-R1 "raised his fist and pointed his finger towards peer [R4] and said 'I don't want [R4] here'." Incident Report dated 10/12/11
11/01/11-R1 took R4's hand and squeezed her hand. R1 looked upset. Incident Report that was dated 11/01/11
11/08/11-R1 "asked repeatedly to have [R4] removed from the MPR [Multi Purpose Room]." (Human Rights Meeting Report 11/07/11 through 11/13/11)
11/13/11-R1 gave R2 a gentle hug. (Human Rights Meeting Report 11/07/11 through 11/13/11)
01/05/12-R1 "Kicked [R4's] wheelchair. [R1] grabbed and pulled [R4's] hair. After several

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times of staff telling [R1] to let go he did. [R4] was anxious, and her face was red." Occurred at day training. Incident Report dated 01/05/12.
01/11/12-R1 "walked up to [R4] with a friendly smile and touched her shoulder. Staff redirected him before he could give her a hug." Incident Report dated 01/11/12
01/13/12-R1 "raised his hand and his voice. He yelled at [R3] and gestured angrily. [R3] startled and became frightened....[R1] stood still and looked wildly around....[R3] remained frightened and upset. She asked staff if they had a gun to protect her." Incident Report dated 01/13/12
01/16/12-R1 "proceeded to walk by a staff and swung his arms around the staff, resulting in a hit to the back of [R4's] head as she was in her wheel chair next to the staff member. [R1] then took hold of [R4's] pony tail." The incident report continues, R4 "was upset but was not injured." Incident Report 01/16/12
01/22/12-R1 "went over to [R2] and 'touched her shoulders with a smile on his face'." (Human Rights Meeting Report 1/20/12 through 2/05/12)
01/22/12-R1 "started pointing his fingers at [R3] with an angry look on his face." Incident Report dated 01/22/12
01/28/12-"When peer [R4] drove her wheelchair into the dining room, [R1] raised his hand in the air and calmly stated 'I hate you [R4]'." Incident Report dated 1/28/12
01/29/12-R1 hit R2 in the back of the head with a pole from a mechanical lift causing 6 staples. Incident Report dated 01/29/12
02/12/12-R1 "glared at [R2] with what appeared to be a 'threatening stare', and began to stomp his foot toward her repeatedly. 1:1 staff stepped in front of [R1] so he could not see her." (Human Rights Meeting Report 2/06/12 through 2/12/12)

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W9999	Continued From page 44 02/14/12-R1 "looked at peer, [R2] who was in the living room and snapped his fingers." Incident Report dated 02/14/12 02/14/12-R1 "raised his arm, called out resident's name [R4], then lowered arm and muttered an obscenity, as if to use that obscenity as a descriptive noun." Incident Report dated 02/14/12 02/17/12-R1 "was in the hallway by the restroom. He had an angry look on his face. He was alone. [R3] came out of her classroom in her wheelchair. She was going to another class. [R1] saw [R3] and stomped his foot, and then snapped his fingers. He started coming toward [R3]. Several staff were in the hall at this time, and began talking with [R1], coming toward him." It continues, R1 "swung his hand toward [R3], and hit the head rest on her wheelchair." Incident Report dated 02/17/12 For the incident of 10/12/11 with R4, the incident report of that date under the section titled "Follow up" states, "Noted. Review at HRC (Human Rights Committee) meeting." This was signed by E3. It also states, "Review at HRC meeting" and this was signed by E2 (Residential Services Director, RSD). For the incident of 11/01/11 with R4, the incident report of that date under the section titled "Resident Status, Injuries, Mental Status, Review Of Incident" it states, R4 "was not injured. She was counseled. [R1] aggressed toward [R4] (hugged her) in October of last year and in May of this year." For the incident of 11/08/11 with R4, the Human Rights Meeting Report for 11/7/11 through	W9999		

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11/13/11 under the section titled "Antecedent(s)" it states, "focusing on a targeted peer across the MPR [Multipurpose Room]." Under the section titled "Summary & Follow-up" it states, 11/8 asked repeatedly to have [R4] removed from the MPR." There are no recommendations regarding preventing incidents between R1 and R4.

For the incident of 01/05/12 with R4, the incident report of that date under the section titled "Detailed Account Of The Occurrence" it states, "Kicked [R4's] wheelchair. [R1] grabbed and pulled [R4's] hair. After several times of staff telling [R1] to let go he did. [R4] was anxious, and her face was red." Under the section titled Resident Status, Injuries, Mental Status, Review Of Incident it states, R4 "did not complain of discomfort and received staff support. [R4] and [R1] ride different busses back to [the facility], so did not have contact with each other on the trip home. In the past [R4] has been counseled concerning ways to protect herself and seek staff assistance. She is aware of ways to alert staff if she needs help for any reason. Recently [R4] has chosen to seek [R1] out, or go near him at times. She has been counseled that [R1] has aggressed toward her in the past. [R1] has not aggressed toward [R4] at [the day training site] since April 2010. [Day training] staff indicated that [R4] and [R1] are monitored thorough [sic] the day. [Day training site] has indicated their staff will continue to check on [R1] and [R4's] whereabouts, and their proximity to each other. [The facility] staff was alerted to monitor when [R1] is near [R4] at home, too. [R1's] psychiatrist evaluated his medications last week, and is available for consultation at any time. The [facility] HRC will review this incident and status

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as well." This was signed by E2.

E3 (QMRP) was interviewed on 3/30/12 at 9:45am. E3 was asked, since the incident report states that facility staff were alerted to monitor when R1 is near R4, what form did the alert take. E3 stated "Normal, E-mail." E3 provided an E-mail addressed to all staff which stated, "This afternoon at [day training] [R1] walked over to [R4], struck her, and grasped her hair. While this seems to be an isolated incident, it reminds us to watch out and take extra care when they are near each other." It continues, "Please be extra vigilant when [R1] and [R4] are in the same areas at [the facility], and redirect them apart as needed. The closer they are to each other, the nearer staff should be, to ensure safety." E3 was asked what were the expectations after the incident of 1/05/12 with R4. E3 stated, "To keep an eye on [R1]. Specially when in the area of other residents, particularly ones he's had problems with in the past."

For the incident of 01/11/12 with R4, the incident report of that date, under the section titled Follow-Up states, "Noted. Review at HRC meeting." This is signed by E3. It also states, "Review at HRC meeting" and this was signed by E2 (RSD).

E3 (QMRP) was interviewed on 3/30/12 at 9:45am. Regarding the incident of 01/11/12 where R1 "walked up to [R4] with a friendly smile and touched her shoulder. Staff redirected him before he could give her a hug," E3 was asked, when R1 approached R4 how could staff have prevented aggression by R1 to R4 had that been his intent. E3 stated that it would depend on

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where the staff were positioned.

For the incident of 01/13/12 with R3, the incident report of that date, under the section titled "Describe the incident" states, R1 "raised his hand and his voice. He yelled at [R3] and gestured angrily. [R3] startled and became frightened....[R1] stood still and looked wildly around....[R3] remained frightened and upset. She asked staff if they had a gun to protect her." Under the section titled Follow-Up it states, "Noted. Review at HRC meeting." This is signed by E3. It also states, "Review at HRC meeting" and this was signed by R2 (RSD).

E3 was interviewed on 3/30/12 at 9:45am. E3 was asked, since the incident report states that R1 stood and looked wildly around and frightened R3 was there any recommendation to increase the supervision of R1. E3 stated, no. When asked if it was noticed any change in behavior since 12/11, E3 stated, "Subjectively, it seem like there was more times when he was out of it. Not himself."

For the incident of 01/16/12 with R4, the incident report of that date, under the section titled "Detailed Account Of The Occurrences" states, R1 "proceeded to walk by a staff and swung his arms around the staff, resulting in a hit to the back of [R4's] head as she was in her wheel chair next to the staff member. [R1] then took hold of [R4's] pony tail." The incident report under the section titled "Resident Status, Injuries, Mental Status, Review Of Incident" states, R4 "was upset but was not injured, per nurse report. [R1] has aggressed toward [R4] in the past. [R1] is being followed by a Psychiatrist and was last seen by

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her on October 28, 2011 and a fax follow-up occurred three weeks ago. There were no changes recommended due to his overall progress. [Facility] staff is coordinating appropriate redirection interventions with [R1] and [R4] not only at [the facility] but at [the day training site] as well. The facility HRC will review this incident."

E3 (QMRP) was interviewed on 03/30/12 at 9:45am. E3 was asked regarding the incident of 1/16/12 where R1 hit R4 and pulled her hair, since this was the second time R1 had aggressed against R4 in January and the fifth incident of physical aggression by R1 in January, the incident report states, facility staff "is coordinating appropriate redirection interventions with [R1] and [R4] not only at [the facility] but at [day training] as well", what was the facility doing for prevention instead of redirection after the fact. E3 stated, "Good question. Still don't see this as unusual. It's an increase since December, not other months. We were looking at factors involved."

E3 was asked, what was being coordinated with the day training site. E3 stated that they were to continue to monitor specially in areas with targeted residents, also to keep an eye on him in the hallway.

For the incident of 01/22/12 with R3, the incident report of that date states, R1 "started pointing his fingers at [R3] with an angry look on his face." Under the section titled Follow-Up it states, "Noted. Review at HRC meeting." This is signed by E3.

E3 was interviewed on 03/30/12 at 9:45am.

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Regarding the incident of 01/22/12 with R3 was there any response to the increase in behaviors. E3 stated to, "continue what we're doing."

For the incident of 01/28/12 with R4, the incident report of that date states, "When peer [R4] drove her wheelchair into the dining room, [R1] raised his hand in the air and calmly stated 'I hate you [R4]'." Under the section titled Follow-Up it states, "Noted. Review at HRC meeting." This is signed by E3.

E3 was interviewed on 03/30/12 at 9:45am. Regarding the incident of 01/28/12 with R4, E3 was asked if there was any programmatic response to the incident. E3 stated, no.

A "Resident Incident Report" dated 1/29/12 states, R1 "got up and pulled a [mechanical lifting device] pole (used to raise the [mechanical lifting device] fork) out of the manual [mechanical lifting device], and went towards [R2]. He hit the back of [R2's] head before staff could get to both of them. He was not saying anything."

Under the section titled "Resident Status, Injuries Mental Status, Review Of Incident" it states, R2 "was bleeding and received emergency treatment. She was taken to the ER [emergency room]. See following nurses notes: '10:15am Left with staff, in stable condition, for [hospital ER] for evaluation of laceration posterior head. 12:40pm Returned to [facility] in stable condition.'" It continues, "Complains of headache and agrees to eating lunch. Dressing intact to top of head over laceration. Removed dressing to observe 2-3cm laceration with 6 staples intact."

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W9999	Continued From page 50 That section of the Resident Incident Report of 1/29/12 continues, R1 "has had 1:1 intervention at [the facility] since the incident, and has not been agitated. He went to work today as usual without incident. The 1:1 staff intervention has continued in order to insure protection of the others [sic] residents." This section was signed by E2 (Resident Services Director). In interviews with Z1 (Day Training Qualified Support Professional, Educational Services) on 3/27/12 at 2:50pm., and E3 (QMRP) on 3/30/12 at 9:35am., both identified R2, R3 and R4 as individuals who would be considered as targeted peers by R1. The facility was unable to provide evidence that corrective action had been initiated regarding a pattern of R1 targeting particular peers for acts of aggression. (B)	W9999		