STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

(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 149	Continued From page 22	W 149		
W9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.700a) 350.1060e) 350.3240a) 350.3240b) 350.3240d) 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 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 23 progress notes or nurse's notes of that resident 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 350.3240 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 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. (Section	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 24 3-612 of the Act) These requirements are not met as evidenced by: Based on interview, and record review, the facility failed to implement their policy to prevent neglect, when the facility failed to ensure an environment free of fear and abuse from a peer for 14 of 15 individuals in the facility (R2-R15), when: 1. R1's behaviors escalated, the facility failed to ensure adequate supervision of R1 and ensure safeguards are in place to ensure the other individuals in the facility are free from abuse and neglect. 2. Failed to ensure documentation is available which describes what events occurred including incidents of intimidation and physical and verbal aggression towards 14 clients by R1. 3. Failed to review and revise R1's plan to include sufficient interventions are in place to decrease and de-escalate her behaviors including, but not limited to, the use of an approved technique (CPI-Crisis Prevention Intervention). 4. Failed to implement their policy on reporting of abuse, neglect or mistreatment of individuals and failed to develop and implement a policy on peer to peer abuse. Findings include: 1. In review of the facility submitted roster, undated, that validates level of functioning, there are fifteen (15) individuals living in the facility. R's	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

(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
W9999	Continued From page 25	W9999		

1, 3, and 4 function in the mild range of mental retardation; R's 2, 5, 6, 8, 12, 13, and 14 function in the moderate range of mental retardation; R's 7, 9, 10, and 11 function in the severe range of mental retardation; R15 functions in the profound range of mental retardation.

In review of R1's Annual Interdisciplinary Team Evaluation (IDT) dated 2/24/12, R1 functions in the mild range of mental retardation and has additional diagnosis of Bipolar Disorder.

R1's 2/24/12 Annual IDT documents R1's overall age equivalent of 7 years and 10 months, and an IQ (Intelligence Quote) of 68. In further review of the IDT, R1 is her own guardian.

Per the 2/24/12 IDT, R1 is 5 feet 1 inch tall and weighs 176 pounds.

There is no evidence in R1's IDT of a supervision level for R1.

In an interview on 7/12/12 at 1:37 PM, when asked what R1's level of supervision is, E1 (Resident Services Director) stated, on the midnight shift, R1 is checked every 30 minutes. There is nothing specific during the daytime hours.

On 7/5/12 at 9:35 AM, R1 is observed to be ambulatory and verbal. R1 is walking around the facility talking with staff. R1 did talk with the surveyor.

R1's 7/3/12 revised INTERVENTION PROGRAM PLAN validates R1's behaviors of: Bossing, verbal aggression/meanness to others, physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	**307 EAST JEFFERSON SULLIVAN, IL 61951**

(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
W9999	Continued From page 26	W9999		

aggression, fixation on others, and telling untrue stories. Physical aggression is defined as hitting, smacking, pinching, biting, etc. Verbal aggression is defined as foul language, name calling, yelling, screaming, etc. Fixation on others is defined as following them around, demanding that they sit next to her, or R1 refusing to do activities unless that person is participating also. R1 receives the following medications for behaviors: Lithium 900 mg daily; Celexa 40 mg daily; and Invega 12 mg daily.

The facility's "Unusual Incident Reports" were reviewed from 1/1/12 to 7/8/12. These document R1's behaviors as the following:

1/29/12 - R1 was yelling at another resident for talking to someone else, when the other resident told R1 she could talk to her, R1 pinched her. Per R1's Universal Note (U-Note), dated 1/29/12, it is documented: R1 was "following another resident around, physically aggressive, and was mean to another resident. R1 pinched another resident because another resident was talking to someone she wanted to talk to."

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

1/30/12 - R1 was yelling at another resident, when staff intervened, R1 became physically aggressive to staff, pushing them and pulling their hair. Per R1's U-Note, dated 1/30/12, it is documented: R1 "got mad at another resident and was pushing her." R1 became physically aggressive to staff, spitting, pushing, pulling staff hair, slapping staff's face, kicking, and attempted to hit staff with her glasses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	**307 EAST JEFFERSON SULLIVAN, IL 61951**

(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
W9999	Continued From page 27 There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. 3/1/12 - R1 was yelling and cussing at staff, calling staff names. R1 pulled E3 (Food Service Supervisor - FSS) hair, jerking her over the coffee table, kicking and tried to bite staff. R1 shoved R12. Per R1's U-Note dated 3/1/12, it is documented: R1 began yelling and cussing at staff. R1 got up off couch and "attacked staff." R1 was calling staff names, R1 grabbed staff's hair and jerked her over the coffee table. R1 began kicking and trying to bite staff. R1 "attacked a resident for no reason." There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. 3/29/12 - At the Day Training (DT), R1 "grabbed staff at the throat on the side and called staff a b----." This report states that R1 was interfering with R3 going to work and the DT staff was blocking to allow R3 to go to work. Per R1's U-Note dated 3/29/12, it documents: Day Program reported R1 had an incident of verbal and physical aggression. R1 became upset when staff came to get another resident for work. Staff reported that they blocked R1 from getting to the resident so she could leave the area. R1 started to choke the DT staff. In an interview on 7/11/12 at 8:35 AM, when asked what happened regarding this choking incident on 3/29/12, Z1 (Day Training Program Administrator) stated, the staff person was not choked. R1 was grabbing at her neck, R1 did touch the staff with one of her hands on the side	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

(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
W9999	Continued From page 28	W9999		

of the staff's neck. The staff was trying to keep R1 away from R3, so R3 could go to work.

There is no evidence that this 3/29/12 incident of aggression by R1 was reported to IDPH.

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 3/29/12 was investigated and reported to IDPH, E2 (Administrator), stated, "no."

4/17/12 - R1 asked a peer to come with her and the peer refused. R1 returned to the kitchen, started yelling at the peer and grabbed her by the right wrist. Per R1's U-Note dated 4/17/12, it documents: R1 became physically aggressive before supper. R1 was upset because another resident was working in the kitchen and R1 wanted her someplace else. R1 returned to the kitchen yelling and grabbed the other resident by the wrist.

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

4/27/12 - After breakfast, R1 went to the living room, saw a peer sitting in a spot where R1 wanted to sit, so R1 hit her on the back shoulder. Per R1's U-Note dated 4/27/12, it documents: 4/27/12 - R1 hit another resident. R1 said it was because she was getting something R1 wanted. R1 was cussing at resident.

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

There is no evidence that this 4/27/12 incident of aggression by R1 was reported to IDPH.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 29	W9999		

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 4/27/12 was reported to IDPH, E2 (Administrator), stated, "no."

5/1/12 - R1 was verbally and physically aggressive to staff, slapping them twice in the face. Per R1's U-Note dated 5/1/12, it documents: R1 was verbally aggressive to staff. Slapped staff in the face twice.
5/21/12 - At DT, R1 grabbed a peer by the right shoulder, squeezing it hard. Per R1's U-Note dated 5/21/12, it documents: R1 was verbally aggressive. R1 was following a resident around and not letting her out of her site.
5/31/12 - While out of the facility playing Bingo, R1 became upset when a peer sat next to her. R1 began yelling at the peer to move and when she did not, R1 pinched her on the left arm and leg. R1 then began flipping chairs over and cussing staff. Per R1's U-Note dated 5/31/12, it documents: R1 became upset at Bingo when a resident sat beside her. R1 yelled at her to move, then began pinching her on the arms and legs. R1 then started flipping over chairs and cussing at staff.

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

6/2/12 - While on a picnic, R1 became upset because a certain resident would not sit by her. R1 became verbally aggressive to staff and residents, bossing people around. R1 shoved staff. Per R1's U-Note dated 6/2/12, it documents: R1 became upset at the picnic when a certain resident would not sit beside her. R1 started yelling, cussing, bossing everyone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

(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
W9999	Continued From page 30	W9999		

around, smacking and shoving staff.

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

6/15/12 - While waiting to get her medication, a peer moved in front of R1 and R1 hit her. Per R1's U-Note dated 6/15/12, it documents: R1 "was hitting other residents today."

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

There is no evidence that this 6/15/12 incident of aggression by R1 was reported to IDPH.

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 6/15/12 was reported to IDPH, E2 (Administrator), stated, "no."

6/16/12 - R1 "became upset due to wanting another client to tuck her into bed." R1 then started yelling and cussing at staff, hitting and kicking staff. R1 told staff she was going to get a knife.

There is no evidence that this 6/16/12 incident of aggression by R1 was investigated or reported to IDPH.

In an interview on 7/5/12 at 10:00 AM, R1 told surveyor that she took a knife to herself about a week ago because she was angry with staff. R1 stated that E4 (UA) would not let her be around R3. When asked if she had hurt herself, R1 stated "no, E4 took the knife away before I could." When asked if she had ever had this behavior before, R1 stated, "yeah, when I lived with my

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	**307 EAST JEFFERSON SULLIVAN, IL 61951**

(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
W9999	Continued From page 31	W9999		

mom. I got mad and got a knife. My mom took it away from me and talked to me. I was mad at my nephew."

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 6/16/12 was investigated and reported to IDPH, E2 (Administrator), stated, "no."

6/17/12 - R1 yelling at staff about the incident the prior night. R1 told staff she was going to pinch herself. R1 pinched herself on her left arm. Per R1's U-Note dated 6/17/12, it documents: R1 was hitting, kicking, and spitting at staff. R1 was yelling at other residents. Staff followed R1 into the kitchen. R1 "got a knife out and was trying to stab herself and staff tried to get her to stop then she tried to stab staff." R1 was saying mean things and bossing residents throughout the day.

There is no evidence that this 6/17/12 incident of aggression by R1 was investigated or reported to IDPH.

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 6/17/12 was investigated and reported to IDPH, E2 (Administrator), stated, "no."

6/23/12 - While on an outing to the zoo, R1 became upset when a peer with whom she was fixated held hands with another peer. R1 pinched a peer while at the zoo. R1 started yelling and tried to pull a tree limb down in the zoo almost hitting a small child. Per R1's U-Note dated 6/23/12, it documents: After arriving to the zoo, R1 became upset when another resident that she was fixated on held someone else's hand. R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

(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
W9999	Continued From page 32	W9999		

began yelling and bossing the other resident. R1 pinched another resident. R1 was non compliant and "tried pulling a tree limb down at the zoo almost hitting a child. Cussing staff.

There is no evidence that this 4/27/12 incident of aggression by R1 was investigated and reported to IDPH.

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 6/23/12 was investigated and reported to IDPH, E2 (Administrator), stated, "no."

7/6/12 - R1 reported to the DT staff that she was raped during a homevisit in May. R1 later recanted and said she told the story for attention.
7/7/12 - R1 admitted that she stole a cigarette from an employee's car, smoked the cigarette and put it out on a landscape timber. The facility was notified by the neighbor of the landscape timber smoking. The neighbor had called 911 and was putting water on the landscape timber with their water hose. Per R1's U-Note dated 7/7/12. it documents: Yelling at a resident for picking up a pitcher to pour herself a drink. R1 admitted to staff about stealing a cigarette and smoking at the back of the house. R1 told staff that she put the cigarette out in a crack of a landscape timber that started smoking and the neighbor found and put out with a water hose. R1 was constantly following another resident around and attempted to hit a resident that was sitting by another resident.
7/8/12 - R1 requested that a peer talk with her in private. After several requests, the peer consented to talk with R1. They started to walk down the hall, R1 began hitting, scratching her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

(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
W9999	Continued From page 33	W9999		

head, pulling her hair and biting her head. R1 calmed down, but told staff she wanted to kill herself. R1 was transported to the emergency room. Per R1's U-Note dated 7/8/12 it documents: R1 came into living room, became upset that staff was talking to a resident. R1 started to throw stuff that was on the coffee table at staff, then walked away. R1 returned to the living room and was throwing more stuff at staff. R1 was fixated on another resident, wanting to talk to her in private. R1 "became angry that the resident didn't want to talk to her. R1 started hitting the resident in the head. R1 pulled her hair, scratched her face, and bit her head." R1 then told staff she wanted to kill herself. R1 was sent to the emergency room (ER).

R1's Universal Notes from 1/1/12 to 7/9/12 were reviewed. R1's behaviors were documented as the following:

1/11/12 - R1 was following a female resident around the house. R1 would become upset if someone would talk to them. R1 would be mean by yelling at them not to talk to her. R1 was cussing at staff.

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

1/14/12 - R1 was verbally aggressive to residents. R1 was yelling, saying mean and hateful stuff to them, grabbing at the beads not allowing them to work with them.

There is no reproducible evidence that the facility is tracking R1's aggression toward her peers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	**307 EAST JEFFERSON SULLIVAN, IL 61951**

(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
W9999	Continued From page 34 1/28/12 - R1 was bossing other residents, being verbally aggressive to staff and residents. Yelling at a resident. There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. 1/31/12 - R1 was cussing and flipping people off. There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. 2/1/12 - R1 was calling staff and residents names. There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. 2/10/12 - While in the facility van, R1 became upset over someone visiting, she threw a CD player and took off her seatbelt. Staff had to pull the van over. There is no evidence that this 2/10/12 incident of aggression by R1 was investigated or reported to IDPH. 2/22/12 - R1 "seemed to be bullying residents around tonight. Calling names, cussing, being hateful, followed a resident around, became mad when she talked to someone else." There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. 2/23/12 - R1 became fixated on another resident. R1 then became verbally aggressive and hit staff in the head.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	**307 EAST JEFFERSON SULLIVAN, IL 61951**

(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
W9999	Continued From page 35 There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. 2/29/12 - R1 hit staff and was calling staff names. 3/20/12 - R1 was seen stealing another resident's cigarettes. R1 became upset when staff asked for her to give them back. R1 refused to give them back and went to her room, calling staff a B----. R1 came out of her room later and told staff that she had smoked all of the cigarettes. There is no evidence that this 3/20/12 incident of stealing by R1 was investigated or reported to IDPH. 3/26/12 - R1 started following a resident around and then flipped her off and staff. R1 proceeded to pinch staff and began hitting other staff to get to the resident. R1 slapped staff in the face, spit in her face, kicked and pinched staff. When getting on the workshop van, R1 threatened to hit the bus driver and ran off the van into the house. R1 did come back out, got on the van and went to work. There is no reproducible evidence that the facility is tracking R1's aggression toward her peers. There is no evidence that this 3/26/12 incident of aggression by R1 was investigated or reported to IDPH. In an interview on 7/11/12 at 8:35 AM, when asked if the facility notified the Day Training of this 3/26/12 incident, Z1 (Day Training Program Administrator), stated "no." Z1 further stated that "my staff report everything," and she was not	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 36	W9999		

aware of this incident. When asked how many staff are on the van during transport, Z1 stated, "one." Z1 further stated "to my knowledge there are no problems on the van. When asked if the same person always drives the van, Z1 stated, "typically yes."

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 3/26/12 was investigated and reported to IDPH, E2 (Administrator), stated, "no."

4/8/12 - R1 followed another resident around and would get upset if that resident was not paying attention to her. R1 was mean to staff and residents.
4/28/12 - R1 was constantly following another resident around. R1 began to be very mean and name call to another resident.
4/29/12 - R1 was following another resident around, cussing at them when they would not listen to her.
4/30/12 - R1 was verbally aggressive toward staff. Yelling and cussing at residents. R1 would follow a resident around, picking fights with others.
5/4/12 - R1 became verbally aggressive towards a resident, bossing residents around.
5/9/12 - R1 followed another resident constantly and if she did not listen to R1 or do what R1 wanted, R1 would start yelling and being mean to her and whoever else that resident was talking to. R1 was also being mean and hateful to staff.
5/20/12 - R1 was fixated on another resident, following them around, telling her where to sit, who she could or could not talk to, and cussing.
6/5/12 - R1 was cussing at staff, constantly following around another resident. R1 became very bossy to that resident and when they would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	**307 EAST JEFFERSON SULLIVAN, IL 61951**

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W9999	Continued From page 37	W9999		

not do what R1 wanted, R1 became mean and verbally aggressive to them.
6/18/12 - R1 was constantly being mean to staff and other residents. R1 was following a resident around all night and got upset when that resident would not do what R1 wanted.
6/19/12 - R1 was following a resident around the house. Bossy and telling residents what to do. R1 was yelling at staff.
6/24/12 - R1 was saying mean things to the residents, bossing them around. R1 was following a certain resident around.
6/25/12 - R1 was upset when a staff person sat next to a certain resident, making rude comments and flipping off staff. R1 threw a glass of water, hitting and trying to bite staff. R1 "was caught talking to a resident in an intimating way (saying, 'why you telling staff, you scared?')."

There is no evidence that this 6/25/12 incident of aggression by R1 was investigated or reported to IDPH.

In an interview on 7/10/12 at 2:00 PM, when asked if this incident of 6/25/12 was investigated and reported to IDPH, E2 (Administrator) stated, "no." E1 further stated that she was not aware of this incident until surveyor brought it to her attention.

6/26/12 - R1 was mean and highly agitated. Cussing and slamming doors. R1 was following a resident around until bedtime.
7/9/12 - R1 spoke with her mother. It was decided that R1 would go the sister facility until a visit could be scheduled for another home.

In an interview on 7/10/12 at 2:00 PM, when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 38	W9999		

asked if the above incidents were investigated and reported, E2 (Administrator) stated, "no." E2 further stated that she was not aware of some of these incidents that were documented in the universal notes. E2 stated that the staff are to document on an Incident report also.

In an interview on 7/11/12 at 1:35 PM, when asked who living in the facility cannot defend themselves, E1 (RSD), stated R's 7, 9, 10, and 15. E1 further stated that R1 usually does not target the men, it's the women that she pinches.

In an interview on 7/10/12 at 2:00 PM, when asked how the facility tracks who R1 targets with her behaviors, E1 stated that R1 is fixated or obsessed with R3. There is no system to track who R1's aggression is toward unless there is an injury report to go with it on the other person. When asked who was aggressed against in the above incidents, E1 and E2 (Administrator) were both unable to determine who was aggressed against.

In an interview on 7/5/12 at 4:33 PM, E7 (Unit Aide - UA), stated that R1 obsesses with R3 and targets her or whoever is near R3.

In an interview on 7/5/12 at 1:00 PM, E6 (UA), stated R1 is very controlling over R3.

In an interview on 7/6/12 at 10:00 AM, E2 (Administrator) stated, that R1, R3 and R13 are best buddies. They are very jealous of one another and are always trying to get one another in trouble.

In an interview on 7/10/12 at 9:45 AM, E1 (RSD)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 39	W9999		

told surveyor that R1 was returned home from the ER and placed on 1:1 supervision. E1 further stated that no one would admit R1 to the hospital. R1 is no longer living here. E1 stated that R1 is on a visit at a sister facility until a preplacement visit can be arranged at another home.

In an interview on 7/11/12 at 11:30 AM, when asked if R1 was discharged from this facility, E1 (RSD) stated, "No, she is not officially discharged. R1 is staying at a sister facility until placement can be found. All of R1's belongings are with her. R1 will not be coming back to this facility."

In an interview on 7/5/12 at 3:41 PM, when asked if she was afraid of anyone that lives here, R3 stated, yes. When asked who, R3 stated R1, because of her behaviors. R3 stated that R1 obsesses over her. R3 stated that R1 bosses her and wants to be with her constantly.

In an interview on 7/5/12 at 4:15 PM, when asked if he was afraid of anyone that lives here, R4 stated, "sometimes I am and sometimes I'm not." R4 stated that he is afraid of R1 when she has a behavior.

In an interview on 7/5/12 at 4:28 PM, when asked if she was afraid of anyone living here, R5 stated no, but R1 does hit her sometimes.

In an interview on 7/5/12 at 4:02 PM, when asked if he was afraid of anyone living here, R6 stated no. R1 then opened the office door, and R6 stated, "That's the one I'm afraid of, R1." When asked why, R6 stated, "because she chased me around the house and had her fist buckled up to hit me. I'm very scared of her. I haven't been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 40	W9999		

going on activities because of this, I stay in my room."

In an interview on 7/5/12 at 2:15 PM, when asked if she was afraid of anyone living here, R8 stated yes, R1 because she pinches me.

In an interview on 7/5/12 at 4:19 PM, when asked if she was afraid of anyone living here, R13 stated, kinda scared of R1 and R2 when they have behaviors. R1 has pinched me a few times. R13 stated, "sorta scared of them, I stay away from them."

In further review of R1's Intervention Program Plan, it is documented that the plan was revised on 5/7/12, 6/26/12, and 7/3/12.

There is no evidence of what part of or how R1's intervention program plan was revised.

In an interview on 7/6/12 at 11:30 AM, when asked how R1's intervention plan was revised, E1 (RSD) stated, when her medications were changed, her plan was revised to reflect her current medications.

In review of R1's record, the IDT has had a Med (Medication) IDT on 3/1/12, 5/7/12, and 6/20/12 for medication changes. In addition to medication changes on 6/20/12, the IDT documented that "staff have continued to give R1 more praise when she is being nice or helpful to others. Staff are giving her as much positive reinforcement to help deter her behaviors."

In an interview on 7/6/12 at 10:00 AM, when asked what safeguards are in place to protect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

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PATTERSON HOUSE	**307 EAST JEFFERSON SULLIVAN, IL 61951**

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W9999	Continued From page 41	W9999		

other residents from R1's aggression, E2 (Administrator) stated, we have had med (Medication) IDT's, staff are giving R1 more praise for positive things, R1 has seen her psychiatrist and had medication changes. We are having R1 go to a sister facility to visit friends to see if that helps with her behaviors. We have tried to see if it correlates with her menses.

R1's 7/3/12, most recent, revised INTERVENTION PROGRAM PLAN validates R1's behaviors of: Bossing, verbal aggression/meanness to others, physical aggression, fixation on others, and telling untrue stories. Physical aggression is defined as hitting, smacking, pinching, biting, etc. Verbal aggression is defined as foul language, name calling, yelling, screaming, etc. Fixation on others is defined as following them around, demanding that they sit next to her, or R1 refusing to do activities unless that person is participating also.

In review of R1's 7/3/12 Intervention Program Plan, R1 is receiving the following medication for behaviors: Lithium, Celexa, and Invega.

R1's intervention program plan states that when R1 exhibits Verbal Aggression/Meanness to others, "staff will redirect her to a private location and ask her to calm down and discuss what is bothering her. Staff will ask her what is bothering her and help her to develop a solution to her current problem." When R1 exhibits Physical Aggression to others, "staff will redirect her to her room to calm down and get away from the individual she is having a confrontation with. Staff will remind R1 that it is not acceptable to hurt others. If R1 does not calm down, staff will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 42	W9999		

redirect R1 to an activity on her own, such as calling a friend/family, reading a magazine, or listening to her CD player. Staff will allow her time to calm down and will talk with R1 about the problem. There is usually something that is most likely bothering R1 if she becomes verbally or physically aggressive. Staff will listen to what R1 has to say and talk with R1 about solving her problem appropriately." When R1 exhibits the behavior of Fixation on Others, "R1 will at times became fixated on certain individuals in the house. This is noted by her following them around, demanding that they sit next to her, or R1 refusing to do activities unless that individual is participating also. When staff notice R1 doing these things they will try to remind R1 to give others their own space or try to involve R1 in a larger group activity with others. Staff will verbally praise R1 for giving the other individual some space."

In an interview on 7/11/12 at 11:30 AM, when asked if all staff are trained in CPI techniques, E1 (Residential Services Director - RSD), stated "yes." When asked which techniques are staff trained to use, E1 stated, we are to verbally deescalate the behavior. We are taught the physical holds, but told not to use them . Only as a last resort are we to use physical holds on anyone. E1 stated that R1's behaviors are usually deescalated using verbal techniques.

In an interview on 7/6/12 at 10:00 AM, when asked what are staff to do if verbal esculation techniques do not work with R1, E2 (Administrator) stated staff are to call the RSD. If the situation warrants, staff can call 911 for assistance for physical aggression. When asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOUSE	307 EAST JEFFERSON SULLIVAN, IL 61951

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W9999	Continued From page 43	W9999		

if this is documented in R1's plan, E2 stated no.

In further review of R1's Intervention Program Plan, it is documented that the plan was revised on 5/7/12, 6/26/12, and 7/3/12.

There is no evidence of what part of or how R1's intervention program plan was revised.

In an interview on 7/6/12 at 11:30 AM, when asked how R1's intervention plan was revised, E1 (RSD) stated, when her medications were changed, her plan was revised to reflect her current medications.

The facility's policies regarding abuse, mistreatment and neglect of residents were reviewed. The facility policy titled "Policy on Abuse, Mistreatment, or Neglect of Residents," undated, states the following:

"It is the policy of this facility that all residents are to live free of abuse, mistreatment, or neglect. If a resident or employee suspect abuse, mistreatment, or neglect, they are to immediately notify the facility Resident Services Director, Administrator, or owners for investigation." This policy further states if the accused is an employee.

In review of another facility policy titled, "Resident Abuse, Neglect, and Mistreatment Policy, undated, defines Abuse as " the ill treatment, violation, revilement, malignment, exploitation and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator." This policy defines neglect as, "Failure to provide

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	14G290	A. BUILDING _____ B. WING _____	C 07/24/2012

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W9999	Continued From page 44 goods or services necessary to avoid physical or psychological harm." This policy further states, "All incidents of alleged abuse, neglect, and/or mistreatment shall be immediately reported to the RSD and Administrator. IDPH (Illinois Department of Public Health), shall be notified. An investigation shall be conducted and the conclusions reported to the Administrator, guardian and IDPH." These policies do not contain any reference as to if the perpetrator of the abuse is another resident. In an interview on 7/12/12 at 1:37 PM, when asked if the facility had a policy on peer to peer abuse, E1 (RSD), stated, "I don't think so." (A)	W9999		