

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

PRINTED: 04/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RANDOLPH HOUSE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 SOUTH FIRST STREET</b> <b>VANDALIA, IL 62471</b>		
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W 331	Continued From page 42 In interviews with E2/ Residential Service Director on 12/19/12 at 3:10 PM and 12/20/12 at 2:45 PM, E2 confirmed that there was no additional evidence that nursing thoroughly assessed R2 after the allegation of inappropriate sexual behavior by R1 towards R2 reported to the facility on 11/8/12. E2 confirmed that Z9/ Guardian called on 12/17/12 expressing concerns over changes in R2's behavior. E2 confirmed R2 was seen by physician on 12/17/12. E2 confirmed the facility could not provide reproducible evidence that R2 was seen in a timely manner to be assessed after an allegation of sexual abuse had been made.	W 331			
W9999	FINAL OBSERVATIONS  Licensure Violations:  350.620a) 350.1060e) 350.1060f) 350.1060j) 350.1210 350.3240a) 350.3240b) 350.3240c) 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	W9999			

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W9999	<p>Continued From page 43</p> <p>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, properly trained and supervised staff shall be available to administer these programs.</p> <p>f) There shall be a functional training and habilitation record for each resident, maintained by and available to the training and habilitation staff.</p> <p>j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p>	W9999			

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W9999	Continued From page 44  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)  c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (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 3-612 of the Act)	W9999			

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W9999	Continued From page 45  These regulations were not met as evidenced by:  Based on observation, interview and record review, the facility has failed to ensure that individuals are not subjected to abuse, when the facility failed to protect individuals, prevent reoccurrence and intervene with timely corrective action, for R1's known possible non-consensual sexual inappropriateness, and his known verbal and psychological abuse towards peers, failed to implement their own policies and procedures for abuse, when the facility failed to:  1) Investigate 3 known allegations of non-consensual sexual inappropriateness; and, report 4 known allegations of non-consensual sexual inappropriateness, for individual with known allegations of non-consensual inappropriateness towards peers (R1).  2) Prevent further potential reoccurrence of non-consensual sexual inappropriateness, for 1 with known allegations of non-consensual inappropriateness towards peers (R1).  3) Ensure a method for accurate and timely data collection from the day training site to the facility, for 1 individual with known threatening and stealing behaviors towards peers, and non-consensual sexual inappropriateness towards peers (R1).	W9999			

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W9999	<p>Continued From page 46</p> <p>4) Ensure a method for accurate behavioral data collection across all environments, regarding R1's maladaptive behaviors, for 1 individual with known threatening and stealing behaviors towards peers, and non-consensual sexual inappropriateness towards peers (R1).</p> <p>5) Ensure timely modifications to R1's Behavior Development Program, for 1, for whom there are no interventions for his known maladaptive behaviors of stealing peers personal property, entering peers rooms without permission, misuse and/or destruction of peers property, and keeping peers up at night with loud noise (R1).</p> <p>6) Ensure that R1's Behavior Development Program designates behavioral interventions on a clear hierarchy from the least to the most restrictive interventions, for 1 individual of the facility who has a past conviction for battery against staff (R1). R1 was charged with battery against staff on 10/7/12. As a result of the incident which occurred on 10/7/12, the court system found R1 guilty of battery and was sentenced to two years court supervision, which R1 is currently serving.</p> <p>Findings include:</p> <p>1. In review of R1's 4/4/12 Individual Program Plan (IPP), R1 functions in the mild range of mental retardation, with an additional diagnosis of Schizoaffective Disorder. R1's birthday is 6/14/85 (27 years of age). R1 has a legal guardian. His 4/3/12 Inventory for Client and Agency Planning (ICAP), documents that R1's overall age equivalent is 8 years and 9 months. His 3/7/05</p>	W9999			

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W9999	<p>Continued From page 47</p> <p>psychological documents an intelligence quotient (IQ) of 59, utilizing the Stanford Binet Intelligence, 5th Edition. Per this psychological, R1 has a history of explosive and aggressive behavior, towards himself and others. He has had several hospitalizations for psychotic episodes in the past four years (prior to 2005). His 4/5/12 Behavior Development Plan documents an additional diagnosis of Intermittent Explosive Disorder.</p> <p>Physician's orders of 11/1/12 document Haloperidol, Trazodone and Carbamazepine to assist in behavior control.</p> <p>During observations at the facility on 11/7/12, at 3:30 p.m., R1 was observed to be verbal and independently ambulatory.</p> <p>R1's personal file contains a 6/27/08 court order of supervision for a period of one year, for a battery offense. Per the 6/3/08 notification to the Illinois Department of Public Health (IDPH), R1 was aggressive with a staff member. The staff member was seen in the emergency room and required shoulder immobilization due to a sprained shoulder.</p> <p>A 9/17/12 report to IDPH documents that on 9/16/12, facility staff called the police when R1 pushed a staff backwards. The police came to the facility and spoke with R1.</p> <p>On 10/07/12 a police department report documents that R1 was arrested for a battery charge, and was taken to jail on that evening, with facility staff (E1 - Habilitation Aide -HA), wishing to pursue charges. R1 has a court appearance scheduled for 11/19/12.</p>	W9999			

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W9999	<p>Continued From page 48</p> <p>State's Attorney letter (dated 11/19/12) addressed to R1's public defender states, "My offer for your client is as follows: Plead to Battery, 2 years Court Supervision and \$100.00 fine plus court costs. Please let me know if your client is interested in this offer."</p> <p>In an interview with E3/ Administrator on 1/3/13 at 9:30 AM, E3 confirmed that R1 pleaded guilty to the charge of battery against staff that occurred on 10/7/12. E3 further confirmed that R1 is currently on two years court supervision for battery.</p> <p>In review of R1's 4/5/12 Behavior Development Plan, R1 displays physical aggression, defined as shoving or putting hands on staff. R1 also displays disruptive behavior, defined as yelling, screaming, verbally threatening peers and staff, refusing daily tasks, interrupting and demanding excessive staff attention, and taking or accepting items from others.</p> <p>1a) R3's 11/12 physician's orders document that R3 functions in the mild range of mental retardation.</p> <p>During observations at the facility on 11/7/12, at 3:30 p.m., R3 is verbal and independently ambulatory.</p> <p>On 11/8/12, at 12:32 p.m., R3 was interviewed at the day training site. Z2 (day training staff), was also present for the interview.</p> <p>R3 stated, "(R1) gets wild with me...scares me a little bit...spanks my butt...I'm not gay...came into</p>	W9999			

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W9999	<p>Continued From page 49</p> <p>my room and showed me his parts...scared to tell staff." When asked, R3 stated that this occurred while residents were on vacation in another town.</p> <p>On 11/8/12, at 2:30 p.m., surveyor informed E2 (RSD) and E3 (Administrator), of R3's allegation. E2 and E3 stated, at this time, that they were unaware of this allegation prior to surveyor notification.</p> <p>On 11/14/12, at 11:37 a.m., surveyor asked E3 (Administrator), if this allegation had been investigated. E3 stated that it had, and presented a typed investigation report. When asked, E3 confirmed that she had not notified IDPH of this allegation and the follow-up investigation.</p> <p>1b) On 11/8/12, behavioral notes were reviewed for R1, at R1's day training site. A 7/31/12, day training document, entitled "Observational Notes", states the following: "(R3) came up to me &amp; (and) said that (R1) pulled down (R3's) pants in the bathroom. I took (R3) to (Z1)."</p> <p>On 10/26/12, at entry to the facility, surveyor had requested 6 months of behavioral data for R1, for behaviors occurring at the facility and at the day training site, including non-reportables, and reportables to IDPH.</p> <p>During surveyor review of the facility's behavioral review notes for R1, no reproducible documentation of the 7/31/12 behavioral note was found.</p> <p>On 11/8/12, surveyor presented the 7/31/12 day training behavioral note to E3 (Administrator), and</p>	W9999			

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W9999	<p>Continued From page 50</p> <p>E2 (RSD). E2 and E3 both stated that they had never seen this document prior to this date and time (11/8/12, 2:30 p.m.).</p> <p>In a 11/13/12, 3:30 p.m., phone interview with E3, when asked, E3 stated that the facility had not investigated the above incident. E3 further stated, "That was months ago."</p> <p>In a 11/14/12, 11:56 a.m., interview with E3, E3 further confirmed that the 7/31/12 incident has not been reported to IDPH as of this date.</p> <p>1c) In review of R2's ICAP, R2 functions in the profound range of mental retardation, with an overall age equivalent of 1 year and 3 months. His 5/15/08 Stanford-Binet 5th and Stanford-Binet L-M, documents that R2 was unable to complete any test items. His estimated IQ is less than 20, and further validates that R2 is non-verbal. Per this psychological, R2 has difficulty making his wants and needs known to staff, as R2 does not use sign language. R2 uses the bathroom at scheduled times when taken by staff, and holds out hands and arms while being dressed. R2 is difficult to engage in specific activities, has no concept of time and requires constant supervision in the community.</p> <p>Per a 11/9/12 facility diagram of rooms and roommates, presented by E2 (RSD), R1 and R2 are current roommates.</p> <p>In a 11/14/12, 2:40 p.m., interview with E2, E2 stated that R1 and R2 have been roommates for at least a year.</p>	W9999			

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W9999	<p>Continued From page 51</p> <p>An 11/11/12, 6:00 p.m. phone interview was conducted with E4 (HA). E4 stated that during nightly bed checks, she came upon R1 and R2's bedroom door, which was shut. When E4 opened the door, R1 was standing at the head of R2's bed, facing R2. R1 was pulling up his pajama pants. When asked what he was doing, R1 stated he was changing his underwear. E4 stated that she reported this to E2 (RSD) and E3 (Administrator), but was told it was not necessary to document this incident. E4 stated that she is worried because R2 and R1 were roommates, that R2 "doesn't have a voice", that she is worried about R1, "messaging with him sexually."</p> <p>In a 11/13/12, 3:30 p.m. phone interview with E3 (Administrator), E3 confirmed that E4 had told her about the incident regarding R1 standing by R2's bed. E3 stated that the bedroom door is to be open and that R2 is to receive 15 minute bed checks due to his seizure diagnosis, "so that's all that's needed...what else can we do?" When asked, E3 stated that she had no further information on this incident and had not investigated the incident.</p> <p>In a 11/14/12, 11:45 a.m., interview with E3 (Administrator), when asked, E3 confirmed that IDPH had not been notified of this incident.</p> <p>1d) In review of an undated facility roster that validates level of functioning, R4 functions in the moderate range of mental retardation. His 3/11/12 ICAP documents an overall functioning age equivalent of 4 years and 8 months. His 4/19/04 Stanford Binet 5th documents an IQ of</p>	W9999			

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W9999	<p>Continued From page 52 40.</p> <p>In an 11/09/12, 9:00 a.m., interview with E1 (HA), E1 stated that within the past two months (exact date not sure), while working the night shift, E1 heard R4 say, "get out of my bed." E1 thought this was around 10:00-11:00 p.m. As E1 went down the hallway, R1 was coming out of R4's bedroom. (R1's roommate is R2. R4 and R9 are roommates - per an undated document provided by the facility). E1 stated that she documented this incident, and did so in the facility office before her work shift was over. When asked, E1 stated that no further interviews were conducted with her by facility administrative staff regarding this incident.</p> <p>In a 11/13/12, 10:25 a.m., phone interview with E7 (HA), E7 stated that she worked with E1 on the night shift a couple of months ago, not sure of the exact date. E7 stated that she and E1 witnessed R1 coming out of R4's room. E7 heard R4 say, "no, no stop." When E7 and E1 entered R4's room, R1 was on R4's bed. E7 stated that E1 documented this incident for E2 and E3, further stating, "I was there when she wrote it up." When asked, E7 stated that no further interviews were conducted with her by facility administrative staff regarding this incident.</p> <p>On 11/13/12, at 2:15 p.m., surveyor notified E2 (RSD) about the above incident. E2 stated that she knew nothing about the incident, prior to this conversation.</p> <p>In a 11/13/12, 3:00 p.m. phone interview with E3 (Administrator), surveyor notified E3 of the above incident, who also denied knowledge of the</p>	W9999			

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W9999	<p>Continued From page 53 incident.</p> <p>On 11/14/12, at 11:56 a.m., surveyor asked E3 (Administrator), if an investigation had been initiated regarding the incident with R4 and R1. E3 confined at this time that an investigation has not been initiated and IDPH has not been notified.</p> <p>2. On 11/8/12, at 2:30 p.m., surveyor informed E2 (RSD), and E3 (Administrator) of R3's (11/8/12, 12:32 p.m. interview), allegations of sexual inappropriate behavior from R1, as well as the 7/31/12 day training behavioral note alleging that R1 had pulled down R3's pants while in the bathroom at the day training site.</p> <p>In a 11/13/12, 3:30 p.m. phone interview with E3 (Administrator), E3 confirmed that E4 (HA), had told her about the incident regarding R1 standing by R2's bed. E3 stated that the bedroom door is to be open and that R2 is to receive 15 minute bed checks due to his seizure diagnosis, "so that's all that's needed...what else can we do?" When asked, E3 stated that she had no further information on this incident and had not investigated the allegation of sexually inappropriate behavior by R1 towards R2.</p> <p>In a 11/13/12, 3:00 p.m. phone interview with E3 (Administrator), surveyor notified E3 of the incident regarding R1 being in R4's bedroom, with R4 telling R1 "no, no" and "get out of my bed."</p> <p>In a 11/13/12, 10:25 a.m., phone interview with E7 (HA), E7 stated that within the past 6 months. R1 has been in R3's room multiple times, unwanted by R3. E7 stated that R3 related to her</p>	W9999			

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W9999	<p>Continued From page 54</p> <p>that R1 "thrusts" his hips toward him, "slaps my butt" and "groped" him. E7 stated that she reported this to E2 (RSD). E7 stated that E2 stated that they (R1 and R3) were just "playing." When asked, E7 stated that no follow-up interviews or investigations were conducted by any administrative staff.</p> <p>In a 11/14/12 10:12 a.m. interview with E3 (Administrator), E3 stated that the facility does conduct sexuality assessments and that they are updated annually in preparation for each individual's annual program review.</p> <p>However, per review R2's personal chart, there was no reproducible evidence of a sexuality assessment.</p> <p>E3, on 11/14/12, at 10:45 a.m., stating that no sexuality assessments could be found for R2.</p> <p>E3 (Administrator), when asked (11/14/12, at 11:56 a.m.), confirmed that of this date and time, the facility has not implemented a plan to prevent possible further potential abuse until the above documented allegations can be resolved.</p> <p>3. On 11/8/12, Day training "observational notes" were reviewed for R1, at the day training site.</p> <p>5/2/12 - "(R1)" was working...taking the rods from the job and holding them to his groin &amp; (and) gesturing it as a penis."</p> <p>5/2/12 - "...I noticed (R1) and another female client joking around and (R1) took one of the parts of a metal rod and put it in the area of his</p>	W9999			

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W9999	<p>Continued From page 55 penis and wiggled it at her...".</p> <p>Neither observational note from day training documents the time of the incident, so it is unclear whether the incidents are the same or two separate incidents on the same day. In an interview with Z2 (day training staff), on 11/8/12, at 12:15 p.m., Z2 was unsure whether there was one or two occurrences of the same behavior on 5/12/12, agreeing that there was no documentation of time on either of the reports.</p> <p>7/31/12 - "(R3)" came up to me &amp; (and) said that (R1) pulled down (R3's) pants in the bathroom. I took (R3) to (Z1 - day training staff).</p> <p>In a 11/9/12, 12:10 p.m., interview with Z1 (day training staff), Z1 stated that the day training site sends documentation of behaviors/incidents from the day training site to the facility. Sometimes the documents are placed in an envelope and sent to the facility on the van that transports individuals from day training back to the facility. Sometimes the facility is notified by fax and sometimes by phone.</p> <p>At entry to this survey on 10/26/12, surveyor requested six months of incident reports, reportables, non-reportables and day training reports, including behavior incidents. On 10/26/12, at 12:45 p.m., E2 (RSD), presented the above requests to surveyor, verifying that this was all of the above information requested for a six month period. During review of the presented information, no reproducible documentation was found for the two 5/2/12 incidents and the 7/31/12 incident.</p>	W9999			

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W9999	<p>Continued From page 56</p> <p>On 11/14/12, at 11:33 a.m., E3 (Administrator), stated that facility administration was not aware of the 5/12/12 and 7/31/12 behavioral incidents that occurred at the day training site, until informed by the surveyor. When asked, E3 stated that accurate data and information from the day training site is necessary for program planning and revision. E3 further agreed that the current method of data collection exchange between the facility and the day training site, has not been accurate and complete.</p> <p>4. R1's 4/5/12 Behavior Develop Plan (BDP), defines "Physical Aggression" and "Disruptive Behavior" as the maladaptive behaviors to be reduced/eliminated. Physical Aggression is defined as "Shoving, putting hands on staff". Disruptive Behaviors are defined as "Yelling, screaming, verbally threatening peers and staff, refusing daily tasks, interrupting and demanding excessive staff attention, taking or accepting items from others."</p> <p>R1's "QMRP - (Qualified Mental Retardation Professional) Review of IPP" was reviewed for behavioral data. Per this section it states: "(R1) will not take other clients belongings with zero incidents of physical aggression toward himself or others per month for 6 cons (consecutive) months. The 9/12 QMRP review notes document 15 incidents.</p> <p>In a 11/16/12, 11:15 a.m., phone interview with E2, E2 stated that the data regarding taking others possessions, physical aggression to others and self could not be differentiated per individual behavior for this 9/12 summary and prior QMRP</p>	W9999			

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W9999	<p>Continued From page 57</p> <p>summary notes. E2 further confirmed that the methodology of collecting R1's behavioral data was not modified until after surveyor entered the survey on 10/26/12, and after surveyor interviews regarding accurate behavioral data collection for R1.</p> <p>On 11/8/12, day training behavioral tracking sheets (Behavior Data Sheet), for R1, for the months of July/12-October 8/12) were reviewed at the day training. One of the data sheets is for the targeted behaviors of physical aggression toward himself (R1) and others. The other data sheet is for disruptive behaviors (defined as yelling, screaming, verbally threatening peers and staff, refusing daily tasks, interrupting and demanding excessive staff attention). There was no reproducible documentation for tracking R1's stealing behavior.</p> <p>In an 11/8/12, 12:15 p.m., interview with Z2 (day training staff), Z2 stated that food stealing, money stealing and stealing peers possessions are current behaviors that R1 exhibits at the day training site.</p> <p>Z2 agreed that the physical aggression tracking sheet does not specify whether R1's physical aggression is against himself, staff or other consumers. Z2 further agreed that the disruptive behaviors tracking sheet does not provide for actual tracking of specific disruptive behaviors, including R1's stealing behaviors.</p> <p>5. In review of R1's 4/5/12 Behavior Development Plan (BDP), R1 displays physical aggression , defined as shoving or putting hands on staff. R1 also displays disruptive behavior, defined as</p>	W9999			

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W9999	<p>Continued From page 58</p> <p>yelling, screaming, verbally threatening peers and staff, refusing daily tasks, interrupting and demanding excessive staff attention, and taking or accepting items from others.</p> <p>"Objective #2" within the BDP states that "(R1) will not take other clients belongings with 0 incidents of physical aggression toward himself or others per month for 6 consecutive months."</p> <p>Pro-active strategies for all behaviors above include staff making requests of R1 using a calm voice and offering choices. When R1 appears agitated, staff will back off and monitor R1 from a distance, without placing additional demands on him. When R1 appears nervous or agitated, staff are to suggest that R1 go to his room or go outside or to another quiet area of the facility. Once calm, staff will repeat their request and will receive verbal praise for compliance. If these strategies do not work, and if R1's behavior becomes disturbing to his peers, staff will direct R1 to his room. If his agitation continues, R1 will be physically escorted to his room. Per the program, staff can hold his hands to his side or across his chest, escort him to his room and stay with him until he is calm.</p> <p>In an 11/8/12, 12:15 p.m., interview with Z2 (day training staff), Z2 stated that within the last 6 months R1 has gone up to other individuals and taken food from their plates, as well as getting into consumers' packed lunches. R1 engages in purposeful spitting on other consumers, knows, "who he can target," and does so. R1 will follow consumers into the bathroom, in order to obtain money from them. Z2 stated that, regarding his physical aggression, she is, "a little nervous"</p>	W9999			

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W9999	<p>Continued From page 59 around him, and that consumers in general, "just keep their distance from him."</p> <p>A review of R1's more significant behaviors (stealing, entering peers rooms without permission, misuse and/or destruction of peers' property, and keeping peers up at night with loud noise), at the facility between 5/1/12 and 11/10/12 are summarized below (per review of "Staff Statement To Incidents" forms):</p> <p>5/1/12 - threw R15's walker (86 years old, and requires walker for mobility - per observation and R15's 11/12 physician's orders),</p> <p>In a 11/8/12, 3:10 p.m., interview with R15, R15 stated that R1 makes my cry. No one scares me except R1. He threw my walker.</p> <p>7/11/12 (E1 -Hab Aide) - playing cd in room, playing around in room and in and out of living room - he slept from maybe five a.m. - 5:45 a.m. In a 11/9/12, 9:00 a.m. interview, with E1, E1 stated that R1 turns his television up 'really loud' at night. Other individuals stay awake and can't sleep. This occurs a couple of times a week, keeps his roommate and others awake.</p> <p>In a 11/13/12, 10:25 a.m., phone interview with E7 (HA), E7 stated that R4 will stay up late and have his television at a loud volume. This noise bothers his roommate (R2), who is non-verbal, and he cannot sleep. R's 6, 7, 8 and 14 complain about the noise, as they can hear the television all the way down the hall, even with doors closed.</p>	W9999			

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W9999	<p>Continued From page 60</p> <p>7/17/12 - 10:45 p.m. - in living room gathering up video materials to take back to his room - R12 from her room hollered out, "good night (R1) good night." R1 proceeded to throw his stuff down and threaten staff and use vulgar language - another staff member took him outside to calm down.</p> <p>In a 11/10/12, 11:00 a.m., interview with E5 (HA), E5 stated that she was on duty during this incident. R1 was playing his video cassette recorder tapes loudly in the living room, and was beginning to unhook everything. R12 woke up from the noise, and saying "good night" to R1 as a way to get him to be quiet and go to bed.</p> <p>8/6/12 - E7 (HA) - R1 stated that R3 told him he didn't want to be friends with him anymore, as R3 didn't like the way R1 treats staff. R3 also told R1 that he didn't want R1 in his room, because he steals stuff.</p> <p>9/3/12 - (E8 - HA) R1 upset - throwing things in his room, broke door latch and the molding that keeps the door shut, punching walls.</p> <p>9/19/12 - (E1 - HA) -R1's roommate (R2 - non verbal and profound mental retardation - 5/15/08 Stanford-Binet 5th and undated facility roster that validates level of functioning), tried to enter their shared bedroom. R1 jumped off the bed and shut the door in roommates face. "This is a reoccurring event with (R1) trying to shut roommate out of their room."</p> <p>In a 11/13/12, 9:41 a.m., interview with E11 (HA),</p>	W9999			

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W9999	<p>Continued From page 61</p> <p>E11 stated that she has witnessed R1 slamming the door in his roommates face within the last six months, and that this is a common occurrence.</p> <p>9/26/12 - (E7 (HA) - R1 teasing R12 about her incontinence -R12 asked R1 to stop at least twice.</p> <p>10/7/12 - staff went into another clients room to "see why she was crying." R1 was in R15 and R11's room, picking up papers she (R15) had dropped. As he walked out, he "took personal items off R11's nightstand."</p> <p>In a 11/7/12, 9:00 a.m., interview with E1 (HA), E1 confirmed that she was on duty 10/7/12 and witnessed R15 crying. As R1 left R15 and R11's room, R15's papers were strewn on the floor. R11 told E1 that R1 took her stuff..."my birthday present." E1 stated that R11's lotion was lying on the floor by the bedroom door.</p> <p>11/10/12 - R1 and R3 were downstairs - R1 took R3's hat and would not return it; rubbed the hat down the front of his jeans over his genital area. R3 stated that when he tried to get his hat back, R1 shoved him away and he fell into the activity table.</p> <p>In a 11/13/12, 12:19 p.m., phone interview with E10 (HA), E10 stated that she did not witness R1 rubbing R3's hat over his genital area, but that R3 did tell her that R1 grabbed his hat and rubbed it over the outside of his jeans, over his buttocks and genital area. R3 also told E10 that he was fearful of R1. E10 stated she did not witness R1 throwing R3's hat out into the rain, but did see</p>	W9999			

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W9999	<p>Continued From page 62</p> <p>R3's hat outside in the rain.</p> <p>In a 10/13/12, 10:25 a.m., phone interview with E7 (HA), E7 stated that within the last six months (could not provide exact date), R1 tore R4's cat posters off of his door. E7 stated that R4's door was entirely covered with cat pictures taped to his bedroom door. E7 stated she was on duty, that R4 was crying. E7 did not see R1 remove the cat pictures, but R4 related the information to her. When she went to R1's room and found the cat pictures, only 2 or 3 of the cat pictures remained on his door. E7 stated that she did not document this incident, but did inform E2 (RSD).</p> <p>In a 11/13/12, 2:30 p.m., interview with E2 (RSD), E2 confirmed that she was aware of this incident.</p> <p>In a 11/13/12, 9:44 a.m. interview, with E11 (HA), E11 stated that within the last six months, sometime in the summer (could not provide exact date), R8 came to me and was "very upset" and "emotional." R8 told E11 that R1 had taken some of his ties. E11 stated that she wrote this information in the communication book, which is reviewed by administrative staff (E2 and E3). E11 stated that the ties were found in R1's room.</p> <p>In a 11/13/12, 2:30 p.m., interview with E2 (RSD), E2 confirmed that she was aware of this incident.</p> <p>In a 11/13/12, 9:44 a.m., interview with E11, E11 stated that within the last six months (could not provide exact date), R6 told her that R1 takes his razor, and that this was documented in the</p>	W9999			

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W9999	<p>Continued From page 63</p> <p>communication book, which is reviewed by administrative staff (E2 and E3).</p> <p>In a 11/13/12, 2:30 p.m., interview with E2 (RSD), E2 confirmed that she was aware of this behavior. E2 stated that R2 and R4's electric razors are locked in the medication room (within the facility office), to protect their property. E2 further stated that R's 4, 13 &amp; 14's money is locked in the medication room, to protect their money from being stolen by R1.</p> <p>In a 11/9/12, 9:00 a.m., interview with E1 (HA), E1 stated that R1 is R2's roommate (non-verbal -5/15/08 Stanford-Binet 5th). R1 takes R2's belts, wears them or hides them, and takes his ankle socks. His mother bought him cologne. It had to be kept locked in the medication room, so R1 wouldn't take it. E1 stated there have been various occasions of these behaviors in the past six months, but could not provide exact dates.</p> <p>In an 11/8/12, 1:23 p.m., interview with R13, R13 was asked if anything bothered her or upset her at her home. R13 stated, "(R1) does." At this time, R13 began to cry. R13 stated that sometimes R1 takes my money (could not provide specific dates). R1 also gets in her jewelry box. Now R13 keeps her money in the office where it is locked up, and also keeps things in her "popcorn thing" to hide things from R1. R13 also stated that R1 is loud at night, calls people names and cusses. "I can't sleep."</p> <p>In a 11/13/12, 2:30 p.m., interview with E2 (RSD,</p>	W9999			

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W9999	<p>Continued From page 64</p> <p>E2 confirmed that she was aware of R1's behaviors of taking his roommates personal possessions.</p> <p>In a 11/8/12, 12:32 p.m., interview with R3, R3 stated that R1 takes his rechargeable batteries from his room.</p> <p>In a 11/8/12, 10:30 a.m., interview with R6, R6 stated that R1, "bothers me more than anyone else...hit me in the stomach...took my cologne and poured it out..."</p> <p>In review of the 4/5/12 BDP, there is no reproducible evidence of a specific methodology and intervention strategy for staff to implement when R1 steals, enters others rooms without permission, destroys the property of peers, and/or uses peers property without their permission and keeps individuals awake at night.</p> <p>Per a 9/20/12 Special Interdisciplinary Team meeting (IDT), it states that this review is being held regarding R1's "Continued aggressive outbursts." It was explained to R1 at this meeting that if R1's behavior continued the way it has been, at some point she (E3 - Administrator), may have to say that the facility cannot meet his needs and refer R1 for placement elsewhere. This meeting also documents R1's taking food from his peers at day training during lunch and breaks.</p> <p>The BDP was revised on 9/20/12. Per the revised plan, possible antecedents of his maladaptive behaviors are described as "...when he is found doing something he is not supposed to. Ex:</p>	W9999			

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W9999	<p>Continued From page 65</p> <p>Going into peers rooms, taking food or money from others, etc..."</p> <p>Per this BDP, there is no reproducible documentation of specific methodologies and intervention strategies for staff to implement when R1 engages in stealing, entering peers rooms without permission, destroys property of peers, uses peers property without their permission, and keeping peers awake at night with loud noise.</p> <p>In an 11/7/12, 9:57 a.m., interview with E2 (RSD), when asked, E2 stated that R1's stealing and using other individuals property without permission, destruction of other individuals property, entering other individuals rooms without permission and keeping peers awake at night with loud noise is informally addressed, confirming that R1's BDP does not provide specific intervention strategies to address these behaviors.</p> <p>On 11/13/12, E2 presented surveyor with a revised BDP, dated 11/12/12. E2(RSD), stated (11/13/12 at 2:30 p.m.), that the interdisciplinary team had met on 11/12/12 to revise R1's BDP, confirming that R1's program had not been modified regarding the above concerns, until after the surveyor interview.</p> <p>In a 11/13/12, 2:15 p.m., interview with E2 (RSD), E2 stated that there is only an informal plan regarding R1's noise disturbance during sleeping hours, confirming that his BDP does not address this. R1 is to turn down his video or audio equipment to a certain decibel level at 10:00 p.m.</p>	W9999			

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W9999	Continued From page 66  At a 9/20/12 Special Interdisciplinary Team Meeting (IDT), E3 (Administrator), explained that based on R1's recent inappropriate behaviors at home and at the day training site, changes were necessary. R1 had undergone a reduction and discontinuation of his Depakote due to severe side effects related to a blood disorder. The team agreed that this is when the change (increase), in R1's behaviors occurred. At the time all agreed that the best avenue to reducing/eliminating R1's aggression is through medication adjustments that mimic the effects of the Depakote. E3 stated that due to R1's behavior toward staff, two staff at the facility had resigned. At this meeting E3 (Administrator), explained to R1 that if his behavior continued the way it has been, at some point she may have to say that the facility cannot meet his needs and refer him for placement elsewhere. Per this report, "Sometimes (R1's) anger comes out of nowhere."  A 10/16/12 facility document entitled "CHRONOLOGICAL SUMMARY OF EVENTS", was provided to the surveyor by E3 (Administrator), on 11/8/12, stating at this time (9:45 a.m.), that this was an accurate documentation of actions taken by the facility to date.  This report documents that on 4/5/12 R1's physician recommended in writing that the psychiatrist stop the Depakote and other drugs that can cause a decrease in white blood cells, as the biopsy results did not indicate an underlying blood disorder. R1's Depakote was discontinued over a 4 week period. Per this same document	W9999			

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W9999	<p>Continued From page 67</p> <p>between 6/4/12 and 10/11/12 R1's psychiatrist ordered fourteen (14) medication changes (increases, decreases, discontinuation and starts of medications).</p> <p>There is no evidence of any other interventions regarding R1's behaviors other than drug intervention, until 9/17/12. This same document validates the following:</p> <p>9/17/12 - R1 had his initial appointment for counseling, with regards to his anger management.</p> <p>9/18/12 - referral form was completed for the Support Services Team (SST), through the Illinois Department of Human Services.</p> <p>9/20/12 - Special Interdisciplinary Team Meeting to address R1's behaviors and revision of his Behavior Development Plan (BDP), which removed staff's ability to use any physical redirection.</p> <p>Per the summary of the special 9/20/12 IDT -</p> <ul style="list-style-type: none"> <li>-R1 should continue to go to counseling</li> <li>-The SST recommendations will be incorporated into R1's Individual Program Plan (IPP)</li> <li>-R1 will continue to see his psychiatrist for monitoring and adjustment of his psychotropic medications.</li> <li>-R1 will have to work whenever there is work offered at the day training site Monday through Thursday to be offered a material handling job on Friday. If he sleeps when there is work available or refuses to sit at his work station to do work Monday through Thursday, he will not be offered a material handling job at the end of the week.</li> </ul>	W9999			

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W9999	<p>Continued From page 68</p> <p>-R1's behavior plan will remove any use of physical redirection.</p> <p>On 10/1/12 there is an addendum to the special IDT. Per this addendum, the day training site will implement a "plus" system for positive behavior. This system will include a + for each half day that R1 displays no aggressive outbursts and will replace the one that was proposed at his recent meeting. Once R1 was 3 +'s he will earn the material handling job.</p> <p>On 11/7/12, at 12:15 p.m. E2 (RSD), stated that there have been no further revisions or update to R1's programs since 10/1/12, even though R1's inappropriate behaviors have continued.</p> <p>6. R1/s 4/4/12 BDP provides pro-active strategies for all behaviors above include staff making requests of R1 using a calm voice and R1 offering choices. If his agitation continues, R1 will be physically escorted to his room. Per the program, staff can hold his hands to his side or across his chest, escort him to his room and stay with him until he is calm.</p> <p>Per the 9/20/12 special IDT, E3 (Administrator), again explained to R1, that if his behavior continued the way it has been, at some point she may have to say that the facility cannot meet his needs and refer him for placement elsewhere.</p> <p>However, his revised 9/20/12 BDP removes any use of physical redirection by staff when R1 is agitated. If R1 will not go to his room with verbal cues, other individuals will be moved from the area. This plan does not provide for the least</p>	W9999			

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W9999	<p>Continued From page 69</p> <p>restrictive to the most restrictive interventions that staff may need to implement.</p> <p>In an 11/7/12, 9:57 a.m., interview with E2 (RSD), when asked, E2 confirmed that the revised 9/20/12 BDP does not provide interventions for staff should R1 require physical restrictions for his maladaptive behaviors.</p> <p>R1 has a documented history of physical aggression towards staff : (6/27/08 court order for supervision, "Staff Statements To Incidents" forms, and 10/7/12 police report):</p> <p>R1's personal file contains a 6/27/08 order of supervision for a period of one year, for a battery offense. Per the 6/3/8 notification to IDPH, R1 was aggressive with a staff member. The staff member was seen in the emergency room and required shoulder immobilization due to a sprained shoulder.</p> <p>6/4/12 - E8 and E9 (HA's) -R1 threatened to punch E9 in the face, followed staff, yelling and cursing, and punched staff in arm to knock phone out of her hand, while E9 was trying to call Administrator for assistance. R1 remained on phone with Administrator for approximately 1 and 1/2 hours, then calmed down.</p> <p>7/16/12 -R1 slammed office door up against the wall 8-9 times, "accidentally" ran into E2 - picked up office chair and threw it - threaten to punch E2 (RSD) in face.</p> <p>7/17/12 - E5 (HA) asked R1 to go to bed, at 10:45 p.m., as another individuals was saying "Good night R1, Good night R1," in an angry voice. (Per</p>	W9999			

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W9999	<p>Continued From page 70</p> <p>E5, on 11/10/12, at 11:00 a.m.), the individual was R12, who was angry because she was trying to sleep. Per the report, R1 used vulgar words with this staff, picked up a wooden television tray and threatened this staff with physical harm.</p> <p>8/1/12 - R1 had fist in staff's face, yelling curse words, threatening to punch staff in face, and lunging towards this staff. In a 11/10/12, 11:00 a.m., interview with E5 (HA), , E5 stated that the staff aggressed on was E7, and that R1 pushed E7 also.</p> <p>9/8/12 - 5:30 p.m. R1 threw computer chair in office which hit E7's right leg - stood in front of the office door and would not let E7 leave - took phone from E7, pushed E7 out of the office, and locked himself in the office, and proceeded to throw things in office - prior to this verbally aggressive to R15, R4 and R13.</p> <p>In a 11/13/12, 10:25 a.m., phone interview with E7, E7 stated that her leg bruised, was swollen, with a lump under the bruised area, that lasted for 2 weeks.</p> <p>A 9/17/12 report to IDPH documents that on 9/16/12, facility staff called the police when R1 pushed a staff backwards. The police came to the facility and spoke with R1.</p> <p>9/16/12 - 2:30 p.m. -documented by E8 (HA) regarding R1 -upset with staff, yelling and cussing - went to room and throwing things and breaking stuff - told staff better be hiding from him -pushed this same staff (this staff not identified in this</p>	W9999			

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W9999	<p>Continued From page 71 report, written by E8) - police called - talked to R1 and R1 calmed.</p> <p>On 10/07/12 a police department report documents that R1 was arrested for a battery charge, and was taken to jail on that evening, with facility staff E1 (HA), wishing to pursue charges. R1 has a court appearance scheduled for 11/19/12. Per the 10/7/12 "Staff Statement To Incidents"- while dealing with R1's misuse of others property while being in their room (R's 15 and 11) - R1 cursed staff, threatened staff, so close that his saliva hit her in the face (E1) - cornered E1 in the office, grabbed my arm (E1) , trying to get phone - then hit and shoved E1 with his shoulder/forearm -asked other staff to call Administration and RSD while I called police - grabbed my arm and tried to take phone away.</p> <p>State's Attorney letter (dated 11/19/12) addressed to R1's public defender states, "My offer for your client is as follows: Plead to Battery, 2 years Court Supervision and \$100.00 fine plus court costs. Please let me know if your client is interested in this offer."</p> <p>In an interview with E3/ Administrator on 1/3/13 at 9:30 AM, E3 confirmed that R1 pleaded guilty to the charge of battery against staff that occurred on 10/7/12. E3 further confirmed that R1 is currently on two years court supervision for battery.</p> <p>In a 11/3/12, 2:30 p.m., interview with E2 (RSD), when asked, E2 stated that she had removed a baseball bat from the facility premises, confirming that R1 had been swinging it out on the front porch when exhibiting his aggressive behaviors.</p>	W9999			

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W9999	<p>Continued From page 72</p> <p>E2 stated that this has happened within the last 6 months, but could not recall the exact date. E2 stated she removed the bat, so that R1 would not be able to use it as a weapon.</p> <p>On 11/13 12, E2 presented surveyor with a revised BDP, dated 11/12/12. E2(RSD), stated (11/13/12 at 2:30 p.m.), that the interdisciplinary team had met on 11/12/12 to revise R1's BDP, confirming that R1's program had not been modified regarding the above concern, until after the surveyor interview. Per review of this revised program, it now addresses R1's physically aggressive behaviors on a least to most restrictive hierarchy.</p> <p>The facility's undated "CLIENT PROTECTIONS" policy was reviewed. Abuse refers to ill treatment; violation, revilement, malignment or exploitation of an individual whether purposeful or due to carelessness, inattentiveness or omission of the perpetrator.</p> <p>Verbal abuse includes any spoken, written or gestural language and psychological abuse includes humiliation, harassment and threats of punishment or deprivation, sexual coercion and intimidation.</p> <p>Neglect refers to any failures by facility to carry out required/appropriate services, habilitation or treatment as ordered by authorized personnel. Neglect means failure to provide goods or services necessary to avoid physical or psychological harm.</p>	W9999			

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W9999	<p>Continued From page 73</p> <p>The facility will ensure that residents are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on chemical and physical restraints.</p> <p>A facility employee or agent who becomes aware of abuse or neglect of a resident shall inform the Administrator/Resident Services Director. The Administrator/Designee is responsible to notify the resident's representative (guardian/family) and the Illinois Department of Public Health. The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse/neglect while the investigation is in process.</p> <p>All residents shall be permitted to receive, possess, and use personal property...A reasonable effort to prevent loss and theft of resident's property appropriate to a particular facility will be made. Complaints regarding the theft of resident's property will be promptly investigated.</p> <p>"THE FACILITY SHALL BE RESPONSIBLE TO INSURE THAT NO RESIDENT IS SUBJECTED TO PHYSICAL, VERBAL, SEXUAL, NEGLECT, EXPLOITATION, OR PSYCHOLOGICAL ABUSE..."</p> <p>The facility's undated "CLIENT BEHAVIOR &amp; FACILITY PRACTICES" was reviewed.</p> <p>The facility will:... "If a specific behavioral need is identified, the Interdisciplinary Team must develop a specific program addressing the behavioral need which is incorporated into the</p>	W9999			

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NAME OF PROVIDER OR SUPPLIER  <b>RANDOLPH HOUSE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 SOUTH FIRST STREET</b> <b>VANDALIA, IL 62471</b>		
(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	<p>Continued From page 74 resident's Individual Program Plan."</p> <p>Regarding procedure for the behavior program: "Designate the interventions on a hierarchy from the most positive to most intrusive."</p> <p>The facility's undated "ACTIVE TREATMENT SERVICES' policy was reviewed.</p> <p>It is the policy of this facility to ensure that data relative to accomplishment of the criteria specified in resident IPP objectives are documented in measurable terms. The facility will utilize data which is relevant to accurate measurement of the criteria stated in the IPP. Data will be concise, accurate and will yield information relevant to making program decisions. The facility will document significant events that are related to the residents IPP and assessments and that contribute to an overall understanding of residents on-going level and quality of functioning.</p> <p>It is the policy of this facility to conduct IPP reviews that are sufficiently responsive to ensure that the necessary revisions occur to the IPP. The IPP must be reviewed when the resident is regressing or losing skills previously gained.</p> <p>(A)</p>	W9999			