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(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 340	Continued From page 31 a wet paper towel and wiped the hands of the clients. Z4 was asked if any soap or sanitizer was used. Z4 stated that it was paper towels that were wet with water. 2. At 11:52am Z1 (Day Training direct care) was observed feeding R35 her lunch (puree). Z1 stopped feeding R35 momentarily and wiped R39's mouth. Z1 then went back to feeding R35 her lunch. Z1 did not wash her hands in-between feeding R35 and wiping R39's mouth and then again feeding R35.	W 340		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall	W9999		

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W9999	Continued From page 32 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) These requirements are not met as evidenced by: Based on interview and record review, the facility failed to prevent abuse of 2 of 2 clients in the sample (R66 and R57) that were physically abused by a peer (R1). On 6/8/13 R1 pushed R66 resulting in R66 sustaining a fractured femur. On 6/16/13 R1 pushed R57 resulting in R57 receiving 9 sutures to the forehead. The facility failed to: 1) Identify and address in the IPP (Individual Program Plan) R1's physically aggressive behavior of pushing others. 2) Provide R1 with necessary staff supervision to ensure 2 of 2 clients (R66 and R57) injured by R1 are free from further potential abuse. 3) Ensure a complete and accurate tracking system is in place to ensure clients are free from abuse from their peers. Findings include: - Review of the facility's Injury / Illness Reports noted that on 6/8/13 R1 pushed R66 at 5:30pm.	W9999		

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R66 was sent to the hospital and diagnosed with a right fractured femur. On 6/11/13 R66 had surgery, ORIF (Open Reduction Internal Fixation), to repair the right femur fracture.

- Review of the facility Injury / Illness Reports noted that on 6/16/13 at 12:45pm R1 pushed R57 to the floor. R57 was sent to the Emergency Room and received 9 sutures to his upper forehead.

The facility's policy titled, "Abuse Prevention Program - Facility Policy, - Facility Procedures, - Abuse Reporting", dated 11/23/12 was reviewed. The policy includes the following:
"Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. ..."
"Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. ...
Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment."

1. E10 (direct care) documented the following regarding R1 pushing R66 on 6/8/13, resulting in

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R66 sustaining a fracture to her right femur:
On 6/8/13 at 5:30pm R66 was sitting in her chair in the Family Room during dinner. R66 opened a can of pop, removed the tab, and offered it to R1. For some reason R1 did not want the tab today and stated, "No." R66 stood up with her walker and moved toward R1 and made an inappropriate gesture (using the middle fingers of both hands). R66 turned around to return to her seat. R1 began to speak and R66 turned around a second time and approached R1. R66 then told R1 to "shut up."
R1 became upset and walked towards R66. R1 then pushed R66 forward, R66 immediately lost her balance. R66 tried to catch herself, using her walker, but instead began to spin as she fell. R66 landed on her back and hit her head on the floor. R66 looked like she was in pain so E10 left the area to get the nurse.
R66 was transferred into a chair, where she stayed until about 8pm. At 8pm R66 refused to stand up and cried for the first time. R66 was then placed in her bed. Around 9pm E10 noticed swelling around R66's knee. The nurse was notified and R66 went to the hospital for an evaluation.

E11 (Registered Nurse) documented the following in R66's nursing notes:
6/8/13 5:30pm - Staff told me another client pushed this one (R66) down in the Family Room after (R66) gave the other client the finger. Client hit her head, no visible injury, no bumps, no c/o (complaint of) pain. ... C/O pain to her (right) knee - thigh and refused to bear weight to her right side with out flinching in pain to her face and closing eyes as if to cry. The physician was called and said to watch client until the AM but monitor her and send out if need be and to

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medicate for pain.
6/8/13 9:40pm - Client now c/o (complains of) pain radiating up her right thigh to her hip area ... Nurse Practitioner notified and said to send R66 to the Emergency Room. At 10:45pm R66 left, via ambulance, with staff to a local hospital.

E3 (LPN / Assistant Director of Nursing) documented, on 6/12/13 at 3:30pm that the hospital where R66 was taken was contacted. E3 documented that R66 had surgery on 6/11/13 (ORIF) to repair her right fractured femur. (Which was the result of the 6/8/13 incident when R1 pushed R66 to the floor.)
E3 documented, on 6/18/13, that R66 was discharged, from the hospital, to a nursing home for therapy.

E5 (Coordinator / Incident Investigator) was interviewed on 7/1/13 at 2:15pm. E5 stated that on 6/8/13 at approximately 5:30pm R66 wanted to give R1 a tab from a can of pop. R1 did not want the tab, R66 offered R1 the tab twice and both times R1 refused the tab. R66 gave R1 the finger and then R1 pushed R66 to the floor.

E1 (Administrator) prepared a final report regarding R1 pushing R66 on 6/8/13. E1 documented that on 6/8/13 at 5:30pm R1 pushed R66 after R66 made an obscene gesture.
E1 documented, "Without intent and due to her (R1)diagnoses, abuse cannot be established."

However, according to the report submitted by the witness to the incident E10, "R1 became upset and walked towards R66. R1 then pushed R66 forward, R66 immediately lost her balance ... R6 landed on her back and hit her head on the floor ..."

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E1 was interviewed on 7/17/13 at 11:13am. E1 stated that no changes to R1's behavior program have been implemented after R1 pushed R66 on 6/8/13.

2. An Injury / Illness Report, dated 6/16/13 at 12:45pm, noted that R57 was pushed to the floor by another resident. R57 sustained a laceration to the upper middle forehead near the right eye.

Nursing documentation for 6/16/13 at 1pm noted that R57 was pushed to the floor by another resident. R57 was noted with a large laceration to the upper middle forehead. R57 was sent out to the hospital, via a 911 call.
R57 returned to the facility on 6/16/13 at 7:40pm with 9 sutures to the anterior frontal scalp. R57 returned with orders for an antibiotic to be taken twice a day.

E5 (Coordinator / Incident Investigator) was interviewed on 7/16/13 at 2:05pm. E5 stated that she investigated the incident dated 6/16/13.
E5 stated that E12 (Activity Staff) actually witnessed the incident of 6/16/13.
E5 stated that on 6/16/13 at approximately 12:45pm R57 (who was in his wheelchair) was coming out of R1's bedroom. E12 observed R1 behind R57. R1 was tilting R57's wheelchair forward, R1 then pushed R57's wheelchair and stated, "Go (R57)." E5 stated that R1 was observed pushing R57's wheelchair with some force and pushed it forward and over. R57 hit his head on the floor. E5 stated that E12 was the only witness to the incident.

E1 (Administrator) was interviewed on 7/16/13 at 1:40pm. E1 stated that R1 was hospitalized at a

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psychiatric hospital for 5 days due to physically aggressive behaviors and the injuries that R1 caused to R66 (fractured femur) and R57 (9 sutures to forehead).

R1's IDT (Inter Disciplinary Team) meeting on 6/28/13 to discuss R1's readiness to return to workshop.
"Following a behavior incident she (R1) had been hospitalized at (name of hospital) for 5 days for psychiatric observation."
The IDT noted that R1 had been hospitalized for 5 days for psychiatric observation (6/16/13 - returning to facility on 6/21/13). The IDT noted that R1 was observed for one week upon her return to the facility and it was determined that R1 did not require any changes to her care plan or medications. R1's behavior program was determined to be appropriate.

Review of R1's psychiatric hospital records note the reason for R1's hospitalization "aggressive behavior at group home - pushing residents."
"Main Problems Treated - Danger to others."
R1 was diagnosed with "Intermittent Explosive Disorder."

On 7/17/13 surveyor obtained the following information, dated 9/18/12 from the Mayo Clinic: Intermittent Explosive Disorder - involves repeated episodes of impulsive, aggressive violent behavior or angry outbursts in which you react grossly out of proportion to the situation. Symptoms - Explosive eruptions, usually lasting less that 30 minutes, often result in verbal assaults, injuries and the deliberate destruction of property. These episodes may occur in clusters or be separated by weeks or months of nonaggression. In between explosive outbursts,

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the person may be irritable, impulsive, aggressive or angry.

R1's Behavior Enrichment Program, with an implementation date of 7/1/13 was reviewed. The behavior plan identifies 3 targeted maladaptive behaviors.
- Attendance - R1 will attend at least 40% of scheduled day programming each month.
- Physical Aggression - Hitting, biting, scratching, or throwing objects at others.
- Leaving the Building - Leaving programming area or exiting the facility or Day Training program unsupervised (generally when angry).

R1's behavior program was not revised to address her behavior of pushing others after 2 incidents (6/8/13 and 6/16/13) in which R1 caused injuries to R66 (fractured femur) and R57 (9 sutures to forehead).

E4 (direct care) was interviewed on 7/17/13 at 11:22am. E4 explained R1's behaviors that include pushing other residents, that are in wheelchair, away from a table if R1 does not want them at the table. E4 stated that if R1 gets upset she will pull someone or push them away. E4 stated she observed R1 try and pull R37 out of a seat because she wanted the seat that R37 was occupying.

On 7/17/13 R1's behavioral data for July 2013, dated 7/1/13 thru 7/12/13 was reviewed. R1 is noted to have had 14 incidents of physical aggression during this time period.
- 8 of the 14 incidents of physical aggression are identified as "Very Serious."
- 6 of the 14 incidents of physical aggression are identified as "Moderately Serious."

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The data tracking form identifies that if an incident of physical aggression is identified as "Very Serious" only then an Incident Report will be generated.
No Incident Report is generated when R1 is physically aggressive, unless the injury is very serious.

E2 (QIDP - Qualified Intellectual Disability Professional) was interviewed on 7/17/13 at 10:50am. E2 stated that if a behavioral incident is identified as "Very Serious" then an Incident Report should be written.
E2 was asked how or who determines if an incident of physical aggression is "very serious" or "moderately serious?" E2 stated that it is the direct care staff's decision how serious R1's behavior should be classified. E2 verified that R1's behavior program does not define the varying levels of "serious."

E1 (Administrator) was interviewed on 7/17/13 at 11:13am. E1 stated that no Incident Reports regarding R1's 14 incidents of physical aggression in July 2013 have been generated (8 of which were identified as "Very Serious".) E1 stated that staff need to be trained on data tracking of behavioral incidents.
Without an effective data collection system, the facility is unable to determine how often, the extent of and who is being abused by their peers.

E11 (Registered Nurse) documented the following in R1's nurses notes:
- 6/12/13 825 (8:25pm) "Behavior very inappropriate today she was observed telling another client "shut up" and cursing at the client. Redirected from inappropriate behavior but she was very hostile yelling and refusing to stop

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W9999	Continued From page 40 harassing the other FM (female) client. Will continue to monitor behavior so she does not lash out at the other client." - 6/12/13 "Late Entry note for 6/8/13 4:30pm Client pushed another FM (female) client using a walker down on the floor. Upset because the other client put a finger up at her." Nursing progress note entry - 6/16/13 12:45pm "Resident pushed another resident to floor in w/c (wheelchair) having aggressive action. Had done to another resident on last week, both pt (patients) were sent out to hosp. (hospital) for medical tx. (treatment). ... " Nursing progress note entry - 6/24/13 9:45pm. Returned from visit with sister. Resident appears easily agitated - observed following other residents and tell them what they should do. Staff intervened several times - redirected resident away from peers. ... E1 was interviewed on 7/16/13 at 1:40pm. E1 verified that R1 pushed R66 on 6/8/13 and R66 sustained a fractured femur that required surgery. E1 verified that R1 pushed R57 on 6/16/13 and R57 received 9 sutures as a result of that injury. E1 stated that R1 was hospitalized at a psychiatric hospital for approximately 5 days. E1 stated the IDT (Inter Disciplinary Team) met to discuss R1's behavior and no changes to R1's behavior program were recommended by the IDT. (B) 350.620a) 350.3240a)	W9999		

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W9999	Continued From page 41 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 350.3240 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) These requirements are not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to prevent abuse when the facility failed to remove an employee from resident contact immediately after an allegation was reported to the Administrator. The Administrator was notified that 1 of 1 client (R52) was physically abused by an employee on 7/11/13. The facility failed to ensure R52 is free from potential abuse until the facility concludes their investigation. Findings include: The facility's policy titled, "Abuse Prevention Program - Facility Policy, - Facility Procedures, -	W9999		

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Abuse Reporting", dated 11/23/12 was reviewed. The policy includes the following:
"Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. ..."
"Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. ...
Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment."
"V. Protection of Residents
The facility will take steps to prevent mistreatment while the investigation is underway. ...
Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents."

On 7/12/13 at 2pm E1 (Administrator) was interviewed and asked if the facility had any current (July 2013) allegations of abuse. E1 stated the facility has had no allegations (other than resident to resident) since December 2012.

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E1 was asked if any allegation of abuse was reported to him on 7/11/13. E1 stated that (an outside agency) reported to him an allegation of inappropriate redirection. E1 explained that the outside agency told him that E13 (direct care) was observed to inappropriately redirect R52. E1 stated that it was reported that E13 tapped R52 on the shoulder to get him to sit down.
On 7/12/13 at 3:55pm E1 stated that he had no written report from the outside agency. E1 stated that he did not document what he was told by the outside agency. E1 stated that he was told that R52 was "tapped on shoulder repeatedly" by E13. E1 verified that E13 worked on 7/11/13 and on 7/12/13.
E1 stated, 7/12/13 at 3:35pm, that he did conduct an in-service with the morning staff on 7/12/13. E1 stated he discussed that staff should not tap clients on the shoulder to get their attention. E1 stated that he also discussed more appropriate ways to talk to clients and the use of gentle touch.

Z6 (Employee of an outside agency) was interviewed on 7/12/13 at 3:45pm. Z6 stated that it was reported to E1 that E13 was observed to slap (or whack) R52 on the upper arm / shoulder area. Z6 stated that E1 was told that Z7 could not tell how hard R52 was hit, however, E1 was told that E13 hit R52. Z6 stated that the phrase "inappropriate redirection" was also used in discussing the incident with E1.

Z7 (Employee of an outside agency) was interviewed on 7/18/13 at 11:43am. Z7 stated that on 7/11/13 E13 was observed to hit /slap R52 on the shoulder. Z7 stated this was reported to E1 (Administrator) on 7/11/13. Z7 stated that E1 stated that he would take care of this right now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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 44 E1, verified on 7/12/12 at 3:35pm, that he did not initiate an investigation regarding an allegation that R52 was alleged to be abused by E13. E1 did not put safeguards in place to ensure E13 did not have the opportunity to have direct contact with R52. The facility failed to implement its Abuse Prevention Program Policy. The facility's policy states that an employee of the facility who has been accused of mistreatment will be removed from resident contact immediately. (B)	W9999		