

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012272	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/17/2013
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NAME OF PROVIDER OR SUPPLIER STUART ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 13 NORTHBROOK DRIVE MCLEANSBORO, IL 62859
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Z9999	<p>FINDINGS</p> <p>Statement of Licensure Violations:</p> <p>350.620a) 350.1060c)1) 350.1060c)2) 350.1060d) 350.1060e) 350.1210 350.3240a) 350.3240f)</p> <p>Section 350.620 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1060 Training and Habilitation Services</p> <p>c) There shall be written training and habilitation objectives for each resident that are:</p> <p>1) Based upon complete and relevant diagnostic and prognostic data.</p> <p>2) Stated in specific behavioral terms that permit the progress of the individual to be assessed.</p>	Z9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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Z9999	<p>Continued From page 1</p> <p>d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.</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>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>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.</p>	Z9999		

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Z9999	<p>Continued From page 2 (Section 3-612 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interviews and record review of facility failed to put adequate safeguards in place to prevent the increasing frequency of mental and physical abuse to peers for 1 of 1 residents with documented peer to peer aggression (R1) from the sample of 3. with the potential to affect 13 of 13 residents in the facility R2 thru R13. The facility failed to:</p> <ul style="list-style-type: none"> - Provide necessary monitoring and supervision to prevent peer to peer abuse. - Develop and implement a system to ensure peer to peer abuse did not continue. - Revise R1's behavior program based on her continued aggression toward others. - Develop program interventions that were proactive to prevent behavior versus reacting to the behavior when it occurred. - Thoroughly investigate each allegation of peer to peer abuse and put sufficient safeguards in place impacting 13 residents in the facility. <p>These failures to put safeguards in place to prevent peer to peer abuse ultimately resulted in R1 becoming more frequently abusive to peers without sufficient safeguards.</p> <p>Findings Include:</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>The facility failed to put effective safeguards in place to prevent additional peer to peer abuse after R1 became physically abusive and struck R2 on the forearm causing bruises and R5 on the shoulder. The facility failed to develop and implement an effective system to protect all residents and prevent additional abuse. Per review of the facility admission sheet, R1 is a 29 year old female that was admitted to the facility on 02-13-13 with a diagnoses that includes Intellectual Disability at a moderate level, Impulse Control disorder and Oppositional Defiant Disorder.</p> <p>Per review of a behavior summary log completed by the facility dated from 03-04-13 to 08-20-13, R1 displayed the following behaviors toward peers: There were no times documented identifying when the behavioral incidents occurred.</p> <p>a) 03-04-13 R1 was yelling and cursing at her roommate (R3). No staff interventions documented.</p> <p>b) On 03-14-13 A peer (R7) was yelling, R1 began yelling that she was going to tape R7's mouth shut. No staff intervention documented</p> <p>c) R1 was yelling at a peer (unknown) and refusing to leave area. No staff intervention documented.</p> <p>d) On 04-14-13, R1 was throwing items that belonged to other residents (unknown) on to the floor. No staff intervention documented.</p> <p>e) On 04-23-13, R1 repeatedly entered a</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>restroom that was occupied by a female peer (R2). Staff tried to redirect R1 away from the area, then stood between R1 and R2 with R1 yelling that she "was going to go off on the peer." Crisis Prevention Intervention (CPI) was done by staff to prevent R1 from getting to the other resident (R2)..</p> <p>f) On 04-25-13, R1 was irritating peer (R6), telling her that she had no friends, staff asked R1 to leave R6 alone and R1 responded by becoming combative with staff.</p> <p>g) On 04-28-13, R1 took a phone away from R6 while the R6 was talking on it. Staff intervened and R1 slapped the staff in the face.</p> <p>h) On 06-06-13, R1 was having a dispute with staff then ran to R8 who was seated in a wheel chair R1 shoved R8 across the floor in the wheelchair. CPI was used by staff to help calm R1.</p> <p>i) On 06-25-13, R1 was in a verbal argument with R9, staff attempted to redirect, R1 hit staff and CPI was done to calm her.</p> <p>j) On 07-02-13, R1 attempted to trip R9 as they were leaving the facility to board the bus to workshop. Staff attempted CPI, but R1 continued to fight with staff and yell at other residents.</p> <p>k) On 07-14-13, R1 was yelling at R2 in the hallway, R6 propelled her wheelchair around R1, and R1 grabbed the wheelchair that R6 was in and shoved it. Staff removed all other residents from the area and applied CPI for 35 minutes then released R1, after 5 minutes R1 came out of room and ran toward staff attempting to hit them. CPI was done again for another 20 minutes when</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>R1 was calm.</p> <p>l) On 07-24-13, R1 was seated on the bus with peers (most from a sister facility) returning from workshop, R1 was irritating the other residents, causing several to be upset, act afraid and were crying by the time they got home. The bus driver reported the behavior to R1's facility staff when they got home. The other residents were not identified. As the bus was unloaded at the sister facility R1 tried to grab other residents as they walked by. R1 was very combative with staff hitting, kicking and biting when they attempted to stop her from grabbing the other residents.. R1 went into her room and punched a mirror on the wall causing it to break. R1 was not injured but said that she "wanted to hurt herself." R1 was transported to a local hospital for evaluation and returned.</p> <p>m) On 07-26-13, R1 left the facility (staff were aware) R1 walked across the street to a sister facility. Staff there redirected R1 back to Stuart Estates and R1 complied. R1 was gone for approximately 15 minutes. About 40 minutes after R1 returned, R1 got on her bicycle and rode it to the Dairy Queen. Staff followed her but R1 refused to return to the facility with them. An off duty staff happened to present and was able to talk R1 into going back to the facility with her. .After R1 returned to the facility R1 became combative with staff then picked up R10's walker that was sitting in the hallway and threw it. The other 12 residents were seated in the dining room as it was diner time. No staff intervention documented.</p> <p>n) 08-05-13, R1 was shoving the back of R2's head down, when R2 raised her arm to stop the shoving, R1 started to twist R2's arm. Staff</p>	Z9999		

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Z9999	<p>Continued From page 6</p> <p>separated them and R1 went to her room, then came back out into the living room and said that she was going to hit another peer but returned to her room. No staff interventions were documented.</p> <p>The behavioral summary shows many instances of R1 being combative with staff, leaving the facility (with staff being aware), self injurious behaviors and destruction of property. Per interview with Z3, (Chief of Police) done on 12-03-13 at 11:30AM, Z3 said that the police have been to called to R1's facility at least 10 times, and probably more since R1 was admitted (9 months ago) because of the severity of her behaviors and staffs inability to control them. Z3 expressed concern that R1 was going to cause harm to another resident in the facility.</p> <p>Per interview done with E1 (Qualified Intellectual Disabilities Professional/QIDP) on 12-03-13 at 2:00PM.. E1 stated that R1 is not on a one to one behavior program. Per E1, if R1 "goes off" that other residents in the facility that could, would remove themselves from the area around R1 and staff would remove anyone that could not remove themselves to protect them. E1 said that R1's behavior outbursts caused the other residents to be upset and agitated. E1 said that the facility would have to call in extra staff when R1 was having an explosive behavior to stay with R1 until she has calmed down. this was done to ensure the safety of the other residents.. E1 said that staff have to use CPI with R1 frequently to prevent her from causing harm to herself or other residents. E1 said that a new behavior program was established for R1 on 09-24-13 that contained staff interventions for the displayed behaviors of hitting, kicking, biting, shoving and self injurious behaviors such as butting her head</p>	Z9999		

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Z9999	<p>Continued From page 7</p> <p>on things. Per E1, the facility calls in extra staff when R1 is having an explosive anger episode to ensure other residents are protected from R1. The behavioral summary completed by the facility, from 03-04-13 to 08-20-13 documents R1's behaviors and use of CPI, but does not document when or, if extra staff were called in to protect the other residents</p> <p>Per review of the behavior intervention program that was established on 09-24-13, R1's behaviors were identified as being physical aggression, property destruction, self injurious behaviors, verbal aggression, and lying. The interventions developed for the behaviors were identified as being proactive (what to do before behaviors occur) they are as follows:</p> <ol style="list-style-type: none"> 1. Provide R1 with high levels of quality attention non-contingently on an hourly basis regardless of whether or not R1 is engaging in problem behavior or appropriate behavior. 2. For example, have at least one staff member check in with R1 each hour to talk with her or to engage in an activity for a few minutes. If possible, keep R1 engaged in conversation or activities (games, watching TV, with her etc.) for longer periods of time. 3. Each hour do something enjoyable with R1 such as playing a game with her, going on an outing to get a Pepsi, sitting and talking with her during a snack or mealtime, etc. 4. Attempt to make the interactions positive. 5. Continue to establish yourself as a social reinforcer (make your positive attention enjoyable for R1. 	Z9999		

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Z9999	<p>Continued From page 8</p> <p>6. Allow R1 to access food from the kitchen according to her own preferences (do not deny access, especially given the fact that R1 has no rights restrictions dealing with food).</p> <p>7. Offer to make a phone call for R1 once each hour (or comply with her request to make phone calls each hour).</p> <p>8. Provide praise and positive attention for any appropriate behavior R1 engages in, no matter how small or trivial.</p> <p>Per record review, none of the listed interventions were documented as being attempted to prevent behavior episodes.</p> <p>Reactive Procedures (what to do when precursor behavior occurs)</p> <p>If you see R1 engaging in precursor (lower-level) behaviors (crying, complaining, constantly requesting access to outings, items or phone calls). Do this:</p> <ol style="list-style-type: none"> 1. Go over to R1 using neutral body language and facial expressions and provide validating statements concerning the situation: 2. For example, "I understand that you want to go see your boyfriend and you seem sad that you can't see him right now." 3. "It makes sense to be mad when you can't have cigarettes. If there was something I really wanted., I'd be mad too, if I couldn't have it." 4. R1 I know you really want to go to work today, and I can tell you're upset that you didn't get to 	Z9999		

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Z9999	<p>Continued From page 9</p> <p>go. I'm sorry you weren't able to go today.</p> <p>5. Continue validating R1's expression of her thoughts, her actions, and her emotions constantly until she appears calm. If R1 escalates, switch to the "support, Prompt, Pause techniques" described below.</p> <p>Use Support, Prompt, Pause Strategies.</p> <p>1. while R1 is still displaying lower level signs of distress and you've delivered multiple validating statements. Use the support strategy.</p> <p>2. Ask R1 if there's anything you can do to help her or if there's anything you can get her.</p> <p>3. If possible honor her requests. If it's not possible, provide a validating statement prior to letting her know that it's not possible to grant her request.</p> <p>If R1 becomes physically aggressive or engages in property destruction:</p> <p>1. Move others out of the way, move yourself out of the way but make sure R1 and the other residents are safe.</p> <p>2. Wait for a lower level behavior, e.g. crying or agitation. While you wait, do not talk to R1. Provide minimal attention while assuring her safety.</p> <p>3. Prompt R1 to engage in an alternative or incompatible behavior.</p> <p>Per interview with E1 on 12-03-13 at 2:00PM, staff have not documented using any of the interventions in this plan and verified that the plan</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>has not been reviewed since it was established.</p> <p>E1 said that the facility gave R1 a 30 day involuntary discharge notice on 08-12-13 because of her severe outbursts of combative behavior. E1 went on to say that the facility has not been able to find another facility that would accept R1 as a resident but they are still trying to find one that is capable of dealing with her outbursts.</p> <p>E1 restated that facility staff were not documenting the behavior program interventions that were developed on 09-24-13 to address R1's increasing episodes of peer to peer abuse, property destruction, combative behaviors and self injurious behaviors. E1 said that there was no reproducible documentation to indicate the facility was monitoring the behavior plan interventions for use or effectiveness. The facility staff document the behaviors and the use of CPI, but fail to document the specific interventions developed to address specific behaviors before they resort to the use of CPI. E1 also said that the behavior plan established for R1 on 09-24-13 had not been sent to the workshop because R1 was not combative at the day training site. E1 said that you cannot predict when R1's explosive behaviors would occur or the intensity of the outbursts.</p> <p>An interview was completed with Z1 (Qualified Intellectual Disabilities Professional/QIDP) on 12-04-13 at 10:00AM at the day training site. Per Z1, R1 has days when she is verbally argumentive with staff but has not been physically combative while there or been overly aggressive with her peers. Z1 said that workshop staff were dealing with a behavior program for R1 that identified inappropriate social skills as the problem area. The program does not identify or</p>	Z9999		

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Z9999	<p>Continued From page 11</p> <p>address any of the combative behaviors displayed by R1 in the facility such as hitting, kicking, biting, shoving, property destruction or self injurious behaviors. The program at workshop states that "she can become argumentive with staff when asked to follow rules and will often blame others for her inappropriate actions."</p> <p>Per interview with R2 at the day training site on 12-04-13 at 9:30AM. R1 has twisted her wrist before and it hurt. R2 said "I am afraid of R1." R2 also said that she is afraid that R1 will hurt her friend,(R4) because her friend cannot speak or protect herself from R1. R2 stated again "she (R1) hurt me."</p> <p>Per review of a facility investigative summary dated 11-11-13, R1 and R6 had been arguing for a while about laundry and clothing. They escalated to yelling and cursing at each other, staff redirected them to other areas. R6 went to the dining area and sat beside the kitchen door. R1 had went to the kitchen to make her lunch for the next day. Staff asked R6 to go to the living room, which she did. Staff went to answer the phone and R1 came out of the kitchen and approached R6 in the living room. Staff then heard screams and loud yelling. R6 told staff that R1 had bitten her on her arm. R1 immediately verified that she had bit R6 on her arm. Staff directed all other residents to their rooms as a precaution and removed R6 from the area. No visible injury was found on R6's arm. Per the summary, staff are not sure that R1 actually bit R6.</p> <p>Per interview with R6, done 12-03-13 at 4:15PM. in the facility, R1 did bite her arm and it hurt. R6 pointed to her left upper arm and said there!</p>	Z9999		

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Z9999	<p>Continued From page 12</p> <p>there!. When asked if she was afraid of R1, R6 did not answer verbally but nodded her head yes and looked across room toward R1.</p> <p>Per review of a facility investigative summary form dated 11-17-13. R1 had just returned from a home visit and wanted to do her laundry. Other laundry was already in the machine being done and that caused R1 to become angry. R1 started to hit staff and was redirected to her room, R1 came out of her room and went into R5's bedroom and hit her on the right shoulder. R1 then went into the hallway and took a large picture off the wall and threw it on the floor causing it to break, then picked up a residents walker and threw it on the floor. R1 then went to R2 who was sitting in a motorized wheelchair and hit her on the left forearm. This caused a bruise that was 1 and 1/2 centimeter wide by 1 and 1/2 centimeter long. R1 then went to the living room and started taking pictures and a mirror off the walls and began throwing them on the floor. At that point staff documented that the other residents were taken to the mens hall with the hall doors closed to isolate them from R1. The summary did not include if extra staff were called in to ensure the safety of the residents and supervise R1 until she had calmed down.</p> <p>The facility documented a brief investigation after each incident of behavior but did not address possible precipitating factors or possible interventions to prevent the behavior. The staff completed the section titled "Future Interventions To Prevent Incidents" on one of the incident reports, dated 08-05-13. The incident report shows that staff observed R1 attempting to shove R2's head down. R2 raised her arm to defend herself and R1 grabbed it and twisted it causing</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012272	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/17/2013
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NAME OF PROVIDER OR SUPPLIER STUART ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 13 NORTHBROOK DRIVE MCLEANSBORO, IL 62859
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Z9999	Continued From page 13 R2 pain. Under future Interventions to Prevent Incidents, staff wrote " More staff on shift so residents name (R1) can have one to one." A one to one program was not developed for R1. The other incident reports were not completed under the Future Interventions to Prevent Incidents." section. A Trend/Pattern assessment was completed by facility staff after a behavioral incident that involved R1 striking 2 peer (R2 and R5) on 11-17-13 that documents that the Interdisciplinary Team made recommendations for enhanced staffing increase on 11-18-13, after the Peer to peer abuse occurred. Per review of the facility staffing schedule for November and interview with E1, there was no staffing increase made after the recommendation was given. (B)	Z9999		