

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2014
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NAME OF PROVIDER OR SUPPLIER ELLNER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 MARKET STREET EVANSVILLE, IL 62242
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Z9999	<p>FINDINGS</p> <p>Statement of Licensure Violations:</p> <p>350.620a) 350.1060f) 350.3240a) 350.3240d) 350.3240e)</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>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>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>	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) 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)</p> <p>e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interviews and record review the facility failed to put safeguards in place to prevent staff to peer abuse which affected all 15 in the facility (R1-15). When they failed to:</p> <p>1) Implement safeguards which ensure individuals are not subject to abuse when 1 of 1 individual outside of the sample (R5) had her hair burn by a staff member with a lighter, 2) to prevent ingestion of inedible objects for 1 of 1 who have a diagnosis of PICA (R3).</p> <p>2) Ensure allegations of abuse were investigated according to policy to prevent further and ongoing abuse of 15 residents who reside in the facility (R1-R15).</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>The facility also failed:</p> <ul style="list-style-type: none"> -Provide necessary monitoring and supervision to prevent staff to peer abuse. -Develop and implement a system to ensure all allegations of abuse/neglect are reported and investigated. -To complete facility investigation on all allegations of abuse/neglect. -To develop a system which is known to staff and provide training regarding a chain of command to be followed when administrator fails to carry out duties. -Complete PICA sweeps for individuals exhibiting PICA behaviors. <p>Findings Include:</p> <p>The facility had been notified in the past of verbal abuse by E6. This failure affects all 15 individuals who reside in the facility and in contact with E6.</p> <p>Review of R5's ISP (Individual Service Plan) of 4/24/13, R5 is 27 year old verbal ambulatory female who functions in the Moderate Range of Intellectual Disabilities. Other Diagnosis include: Cerebral Palsy, Spinal Scoliosis and Depression.</p> <p>R5's Inventory for Client and Agency Planning dated 4/8/13 states R5 has an overall functioning level of 5 years and 9 months.</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>R5 is a very talkative with her peers and will interact with them. R5 is noted to be cooperative with staff and does follow through on directions. R5 is unable to access the community independently; however she is able to go outside alone and does not need to be monitored.</p> <p>R5 is able to identify her comb/brush and brushes her own hair. R5 likes her hair medium length and prefers to get her hair cut approximately every six to eight weeks. R5 does need assistance when styling her hair or putting make on.</p> <p>R5 can identify her grooming supplies and obtain the items before taking a shower. R5 does not use a blow dryer.</p> <p>R5 is currently taking Celexa 20mg daily for depression. R5 has a secondary diagnosis of Static Encephalopathy and Adjustment difficulties. R5 displays depression with disruptive behaviors in the form of crying without reason, making up stories (such as someone in her family has died or a peer followed her at workshop), repetitive questions and following others. R5 has a formal behavior program to reduce her disruptive behaviors.</p> <p>Interview with E2 (Direct Support Person) on 3/10/14 at 3:00pm, E2 stated that she worked the morning of 3/8/14. E2 stated around 9:00am she noticed that R5 was scratching that back of her head. E2 noticed that there was an area of hair missing (unknown amount) from R5's head. E2 asked R5 to come closer to her so she could examine R5's head. E2 indicated that it appeared that R5's hair had been singed. E2 called E4(Direct Support Person) into the room to also examine R5's hair. When E2 questioned R5 about her hair. R5 kept repeating</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>"I don't want to move, I like it here."</p> <p>Interview with E4 on 3/11/14 at 2:00pm, E4 stated on Saturday 3/8/14, she worked the morning shift with E2. E2 asked E4 to look at the back of R5's head. E4 stated that there was a big piece of R5's hair missing and the hair appeared to had been singed. E4 asked R5 if she had burnt her hair with a blow dryer or a curling iron. R5 was crying and stating "I don't want to move, I like it here."</p> <p>E4 stated that during the week she is scheduled from 7:00am-10:00am to assist with the morning bath schedule and grooming. E4 continued to state that R5 will request me to fix her hair before workshop. E4 fixed R5's hair on 3/5/14 and did not have any concerns with R5. E4 was scheduled off on 3/6/14. R5 refused to have her hair fixed on 3/7/14 by E4.</p> <p>E2 and E4 stated that R5 was unable to tell them what happen to her and E2 called E1 (Residential Service Director) about the issue. There is no evidence that E1 came to the facility to check on R5 on 3/8/14.</p> <p>There is no documented evidence that either E2 or E4 contacted E1 on the morning of 3/8/14.</p> <p>Interview with E5 (Direct Support Person) on 3/12/14 at 9:30am, E5 stated she was scheduled to work on 3/8/14 at 3:00pm. E4 stated to her that something happened to R5's hair but refused to tell the staff. E5 escorted R5 down to her bedroom and examine her hair. E5 stated that a large piece (undetermined size) of R5's hair was missing and it appeared to have been singed. E5 questioned R5 about her hair and at first R5 refused to respond. E5 reassured R5 that she had done nothing wrong but wanted to make sure that no one was hurting her. E5 stated that R5</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>told her that E6 (Direct Support Person) caught her hair on fire. E5 asked her to repeat what she said. R5 stated that E6 used her cigarette lighter and burnt her hair. R5 told E5 that E6 was mad at her for being outside and took her lighter and burnt her hair. R5 stated that this happened Wednesday night(3/5/14) after supper. (The staff schedule did list E6 scheduled on the afternoon shift on 3/5/14). E5 stated that R5 does have a history of making up stories, but usually when R5 is lying she mixes the story up. R5 repeated the facts over and over again.</p> <p>E5 called E1 (approximately 4:00pm) on 3/8/14 to report the allegation against E6. E1 response to E5 was " E6 wouldn't do something like that and is probably lying." Again there is no documented evidence that E1 was notified.</p> <p>IDPH (Illinois Department of Public Health) surveyors became aware of the allegation on 3/10/14 at 10:30am. E1 informed the surveyors that an investigation was being conducted and E6 had been removed from duty as of 3/8/14.</p> <p>Interview with R5 on 3/11/14 at 3:00pm, " R5 stated that on 3/5/14, R5 followed E6 outside when she was taking a smoke break. E6 was mad at me for going outside with her. E6 burnt my hair with her lighter." Surveyor asked R5 to demonstrate what happen. (Using a tube of lip balm as a lighter) Surveyor was standing with her back to R5. R5 held surveyor's shoulder and placed the tube to surveyor's head and proceed to make a circular motion. (R5 was extremely upset during demonstration).</p>	Z9999		

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Z9999	<p>Continued From page 6</p> <p>Continued interview with E2 on 3/10/14 at 3:00pm, E2 stated that the evening staff hold the Resident Council meeting once a month. At that time residents discuss the upcoming outings for the next months..E2 stated during a meeting last fall (Oct/Nov of 2013), E2 and E4 told the residents if they have any concerns with staff this is the time to voice the concerns. E2 stated several residents including R6 indicated that E6 can be loud at times and sometime mean to us. E2 wrote this down on the minutes and turned it into E1.</p> <p>E2 stated that E1 informed her she could not write this down on the Resident Council Minutes and had to re-write the form from Oct/Nov 2013 notes.</p> <p>Interview with E4 on 3/11/14 at 2:00pm, E4 stated that she was involved with that Resident Council Meeting last fall that was conducted by E2 and remember that E1 return the Resident Council Meeting Minutes to E2 and informed her to re-write the form.</p> <p>E4 stated that residents always ask which staff are working the following day. The residents get upset when they are informed that E6 is scheduled. E4 indicated that clients behaviors increase when E6 is working.</p> <p>When asked if E1 was aware of this, E4 stated " how could you not notice."</p> <p>Interview with E1(Resident Service Director) on 3/11/14 at 10:30am, E1 stated that at Resident Council Meeting, residents talk about upcoming outings and any concerns they have with staff or another residents. E1 stated if the clients have concerns, staff will write them down on the minutes and give them to E1.</p> <p>E1 confirmed that the facility has not investigated any allegations with staff regarding concerns that</p>	Z9999		

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Z9999	<p>Continued From page 7</p> <p>where expressed at the Resident Council Meetings.</p> <p>Review of the Resident Council Minutes for the last year, there was no documented evidence of concerns voiced by the residents.</p> <p>R6 is a verbal ambulatory male who functions in the Mild Range of Intellectual Disabilities. Interview with R6 on 3/10/14 at 3:20pm, R6 stated that he does attend Resident Council Meeting. At one meeting we told E2 and E4 that E6 is mean to us. R6 stated that I am scared of her and she doesn't need to be working around people like us . She treats R8 (nonverbal male functioning in the profound range) really bad. R6 stated we told them but no one ever did anything about it.</p> <p>The facility policy (2/14), Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being.</p> <p>2) Review of the facility resident roster undated documents R3 is a 67 year old male who functions at a Severe level of Intellectual Disability.</p> <p>Review of R3's Individual Service Plan (ISP) dated 4/24/13 documents under "What have I accomplished this year... Long Term Goal #1: R3 will reduce his Aggression behavior to 1 incident per month for 3 consecutive months. Summary Section: R3's incidents of PICA (ingestion of non-food items) are usually his picking up</p>	Z9999		

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Z9999	<p>Continued From page 8</p> <p>cigarette butts. His (R3) aggression is typically towards himself he will hit the walls with his fist or will scratch himself when he is upset." The ISP continues to document a total of 26 incidents of PICA behavior from April 2012 to April 2013. The ISP does not document a goal specific to PICA behaviors.</p> <p>The Individual Service Plan continues to state under "Programs that R3 will be working on this year... 1. LTG (long term goal) Behavior Improvement Plan- addresses his PICA/explosive behavior.</p> <p>Review of R3's Behavior Management Program (BMP) dated 11/13 documents, "R3 displays PICA behavior in the form of picking up cigarette butts and eating them. Under "Operational Definition" it states "PICA behavior is defined as picking up cigarette butts and eating them." Under "Documentation" it states, "Staff will record all incidents of PICA on a interval data section (computer charting program)..."</p> <p>The BMP continues to document under "Environmental Indicators of Behaviors: R3 will pick up cigarette butts any time he sees the opportunity. Staff is to keep their cigarettes locked up at the facility (either in their cars or in a locked room at the facility.) This will help decrease the temptation of wanting to take cigarettes from others when he doesn't have any. When anyone smokes outside, they are to dispose of their butts in the enclosed containers provided for them. Cigarette butts are not to be thrown in the yard, as this is a temptation for R3. R3 will look for cigarette butts whenever he is outside or on an outing. R3 may become upset anytime he is re-directed from this activity, which can lead to his aggression behaviors."</p>	Z9999		

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Z9999	<p>Continued From page 9</p> <p>R3's Behavior Plan continues to document under "Method: PICA Behavior,</p> <ol style="list-style-type: none"> 1. At any time R3 attempts to look for cigarette butts, staff is to redirect R3 by asking him to help them with an activity or with a domestic duty that he enjoys. If redirection is successful staff should give R3 verbal praise. 2. If R3 does not want to follow a directive from staff, staff will ask R3 what he is looking for. If it is cigarettes, staff is to remind R3 that it is un-healthy for him to eat cigarette butts etc...(i.e. they are dirty, have others germs on them, can cause him to become sick, etc...). 3. If he continues to engage in looking for cigarette butts staff are to try and guide R3 away from the area (in ten second intervals). While at the same time giving positive verbal reinforcement to go participate in an activity that he enjoys. 4. If R3 puts cigarette butts in his mouth then staff is to ask R3 to spit it out and go rinse his mouth out with water-while explaining that those objects are not edible and if he would like a snack (sugar free candy, gum, etc.) he needs to remove the object. 5. If R3 ingested the object staff will document the PICA behavior on the interval data section (computer charting program). Should R3 eat an object that is poisonous; staff is to notify the RSD (Resident Services Director) and/or Nursing." R3's behavior plan does identify to contact poison control after ingesting a poisonous object. <p>Review of the Behaviors Log for R3 dates 03/13 through 03/14 documents 16 incidents of PICA behaviors. This log documents the number of incidents that occur monthly.</p> <p>During interview on 03/11/14 at 11:15 AM E1</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>(Administrator) stated they did not have documentation showing where the PICA incidents occurred or details of the incidents. When asked for their PICA policy E1 referred the surveyor to the Abuse/Neglect policy. E1 stated they do weekly PICA sweeps of the outside areas.</p> <p>Review of the facility "Check list for facility outside clean up" shows on 1/2/14, 1/23/14, and 2/6/14 "some cigs on parking lot." On 1/9/14 states "some cigs on front." On 1/16/14 the log states, "clean." On 1/30/14 the log states, "some cigs on patio." There is no documentation after 2/6/14.</p> <p>There is no documentation showing the facility addressed where the cigarette butts were coming from and/or how to reduce or eliminate them from being on the facility property. There is no documentation of an update to R3's ISP.</p> <p>Observation on 3/10/14-3/11/14 between 9:00am -6:00pm, cigarette butts were observed all over the yard and driveway where R5 or any resident visiting the facility who has a diagnosis of PICA has access to ingesting the butts.</p> <p>Review of the facility abuse/neglect policy did not document policy related to PICA behaviors.</p> <p>During interview on 3/11/14 at 11:52 AM E1 stated the BMP addresses PICA behaviors. We in-service staff on the abuse/neglect policy. PICA is not included in that policy (Abuse/Neglect).</p> <p>During interview with E1 on 3/11/14 at 2:00 PM when asked for copies of the facility investigations related to R3's incidence of PICA. E1 stated we do not investigate incidents of PICA.</p>	Z9999		

