

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2014
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NAME OF PROVIDER OR SUPPLIER RAINTREE TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 501 EAST CHESTNUT CARBONDALE, IL 62901
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Z9999	<p>FINDINGS</p> <p>Statement of Licensure Violations:</p> <p>350.620a) 350.1060e) 350.1060f) 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>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>	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>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 350.1210 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. (Section 3-612 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>failed to ensure the rights of all individuals when they failed to ensure that 4 of 11 individuals of the facility (R2, R3, R4 and R5) are not subjected to peer to peer aggression/abuse from R1 as evidenced by the facility's failure to:</p> <ul style="list-style-type: none"> * Ensure that all staff of the facility are trained/certified in crisis intervention procedures whereby ensuring the safety of all individuals of the facility (R2 - R12) as well as staff of the facility; * Review and revise R1's behavior program as appropriate as based on his continued incidents of physically aggressive behavior; * Provide necessary supervision to R1 to prevent further peer to peer altercations; and * Ensure that all incidents of peer to peer aggression are documented, thoroughly investigated with corrective action taken to prevent future, potential occurrences. <p>Findings include:</p> <p>On 10/10/13, R1 became aggressive with R4 (his girlfriend). Prior to this incident, R1 had been evaluated by the psychiatrist on 09/11/13 (for incidents of increased aggression with one incident resulting in a black eye to R5) and again for a follow up psychiatric evaluation on 10/02/13. After this date, (10/02/13) R1 had six documented incidents of physical aggression towards peers of the facility when he hit R4 on 10/10/13, 10/26/13 and 11/26/13, hit R2 on 01/31/14, hit R3 on 02/20/14 and hit R2 again on</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>03/24/14. Review of R1's behavior program and as confirmed per interview with E2 (Qualified Intellectual Disabilities Professional/QIDP), no revisions and/or modifications have been made to R1's behavior program and/or level of supervision since the initiation of his program on 10/08/13. E2 (QIDP) also confirmed that the facility does not have reproducible evidence showing that all incidents of peer to peer aggression are thoroughly investigated with corrective action taken to prevent, future potential occurrences.</p> <p>Interviews with the facility staff identifies that R1, "...preys on residents that he thinks are weak and won't defend themselves" in addition to, "targeting female staff." Female staff of the facility states that it is difficult to handle R1 if he's having a behavior when there are no male staff around. E3 (DSP/Direct Support staff) states that she has been, "sent flying across the floor" when she has intervened for his behavior. E3 and E6 (DSP) both stated that R1 has targeted a new female staff (E8) and has caused her to run out of the facility to get away from him (R1). During these staff interviews and as confirmed per interview with E1 (Owner), staff of the facility are not trained/certified in crisis intervention techniques to address R1's aggressive behaviors and to ensure the safety of all individuals of the facility (R1- R12) as well as staff of the facility.</p> <p>The facility's policy and procedures regarding Abuse, Neglect, and/or Theft Policy states that the purpose of this policy is, "To ensure the safety and well-being of all residents," This policy goes on to state,</p> <p>"When an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that another resident of the facility is</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility."</p> <p>The Behavior Intervention Plan dated 10/08/13 identifies that R1 has diagnosis of Mild intellectual disability with additional diagnoses of Psychotic Disorder, Schizophrenia and Oppositional Defiant Disorder. It is identified that R1 has behaviors of physical aggression which is defined as when he becomes angry upon hearing something he feels is offensive and rushes at staff or peers and attempts to hit them. Antecedents conditions are identified and state that R1's physically aggressive behaviors occur all hours of the day and night, under all circumstances and in any environment when upset with staff.</p> <p>In review of the facility's investigations for peer on peer aggressive incidents, it is noted that R1 has had five documented incidents of peer to peer aggression in the past seven months (03/24/14, 02/20/14, 01/31/14, 10/10/13 and 09/07/13). However, R1's Behavior Data Sheets from September 2013 - present identifies that he has had a total of eight documented incidents (as compared to five) of peer to peer aggression occurring on:</p> <p>03/24/14 R1 was aggressive towards R2 in the dining room; 02/20/14 R1 was aggressive towards R3, E6 and E7 x 4 while in the med (medication) room in a behavior lasting 30 minutes; R1 was aggressive towards R3 in the shower room; 01/31/14 R1 aggressive towards R2 in the dining room;</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>11/26/13 R1 was aggressive towards R4 while in the med (medication) room; 10/26/13 R1 was aggressive towards R4 while in her bedroom; 10/10/13 R1 was aggressive towards R4 in the dining room; and 09/07/13 R1 was aggressive towards R4 in the hallway during med pass.</p> <p>In continued review of the facility's investigations and Behavior Data sheets from 09/13 to present, no documentation was located and/or provided to the surveyor during the survey dates to identify that an investigation was completed and appropriate action taken regarding R1's peer to peer aggression for:</p> <p>02/20/14 incident in the med room involving R3, 11/26/13 incident in the med room involving R4; and 10/26/13 incident in the bedroom involving R4.</p> <p>1) a) The facility's Investigation report dated 03/24/14 states, "R1 hit R2 on the right side of his neck with a flat hand. Staff (not identified) was not (in) position to intervene to prevent the hit. 24 Neuro-Check to insure that no further injury may have taken place."</p> <p>The corresponding Incident/Accident Report dated 03/24/14 identifies that R2 sustained a, "Red bruise on the back of head/neck."</p> <p>On 04/08/14, the facility presented a typed narrative stating, "When an incident occurred on 03/24/14, R1 was seen by his psychiatrist two days later on 03/26/14 for evaluation and treatment. At this visit, R1's medication Abilify was increased by 5 mg. (milligrams) daily and a</p>	Z9999		

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Z9999	<p>Continued From page 6</p> <p>follow up appointment was set for 04/23/14 or earlier if needed. This appointment was achieved within two days."</p> <p>There is no documentation contained within the facility's Investigation Report and/or the facility's narrative of 04/08/14 indicating that the facility took action to safeguard R2 and other individuals of the facility immediately after the incident. No documentation is contained in either of these reports to identify that safeguards were instituted and maintained while waiting the two days to get R1 in to see the psychiatrist.</p> <p>b) The facility's Investigation report dated 01/31/14 identifies that R1 hit R2 on this date. This report states, "At approximately 7:10 AM... R1 initiated a peer to peer event. He became upset after a misunderstanding with his peer R2. R1 hit R2 on the right, back side of his neck with a flat hand. Staff was not (in) position to intervene to prevent the hit..."</p> <p>There is no documentation contained within this report indicating that the facility took any further action to safeguard R2 and other individuals of the facility during this investigation.</p> <p>R2 was interviewed on 04/01/14 at 12:55 PM and stated, "R1 hit me. Hit me in my neck. Hit me in my head." When R2 was asked why R1 hits him, he stated, "Don't Know." R2 was asked if he hits R1 back after he (R1) hits him and he stated, "No." R2 stated that he had told E5 (Direct Support Person/DSP) and his mom (Z3) about R1 hitting him. R2 stated, "Don't like" when asked how it makes him feel when R1 hits him.</p> <p>E5 (DSP) was interviewed on 04/01/14 at 3:52</p>	Z9999		

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Z9999	<p>Continued From page 7</p> <p>PM and stated, "R1 has aggressive behaviors. You never know when he's going to do something. He's on a program to learn to manage his behavior and he knows the answer to every question. Does he follow his program when he gets upset? No. He (R1) has jumped E7 (DSP) 5-6x's. He generally goes after female staff. In the past few months he has hit R4, R8, R5 and R2." When E5 was asked if any of the individuals had expressed fear of R1, he stated, "I'm not sure that they are afraid of him. Basically they just stay away from him." When E5 was asked about the incident involving R1 and R2 on 03/24/14, he stated, "I was in the kitchen and R2 was cleaning off the tables or something. I heard the altercation. R1 said R2 was talking about him and that's why he hit him. R2 never bothers anyone and didn't say anything to R1." E5 stated, "I used to be a long time ago" when asked if he was CPI (Crisis Prevention Institute) trained and certified.</p> <p>Review of the facility's Incident and Accidents from 09/01/13 to present and in review of the facility's investigations for this same time frame, no documentation was located to identify that R1 was aggressive towards R8 as stated during interview with E5.</p> <p>R2's mother (Z3) was interviewed by telephone on 04/02/13 at 1:46 P.M. and confirmed that R2 had informed her that he had been hit by R1. Z3 stated, "I came to the facility Sunday to visit R2. We were talking in the front room and R1 came into the area. R2 got really close to me like he was scared of R1. When I asked him (R2) what was wrong, he said that he didn't like R1 'cause he (R1) had been hitting him. I asked the staff (unidentified) and they told me that R2 had been hit by R1 on two occasions that they knew of."</p>	Z9999		

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Z9999	<p>Continued From page 8</p> <p>During the interview with R7 on 04/01/14 at 1:10 P.M., he stated that he was not afraid of R1 but had seen R1 hit other individuals. R7 stated, "I saw R1 hit R2 before for no reason. R2 was in the dining room cleaning up (vacuuming, cleaning tables) when R1 just ran up and hit him real hard." R7 stated that he was unsure of when this incident occurred but thought it had occurred in the past few months. R7 stated, "R1 doesn't bother me. I stay away from him (R1) when he is upset and hitting people."</p> <p>E4 (DSP) was interviewed on 04/01/14 at 4:00 P.M. and stated that she had worked at the facility since 10/2013. E4 stated, "I have seen R1 hit R2 but I can't remember when this happened. I walked into the dining room and R2 was wiping off the table. R1 just jumped up and ran and hit and kicked R2. R2 didn't do anything to him (R1). R2 doesn't socialize or interact with any of the clients." When E4 asked if R1 lightly hits and/or kicks, she stated, "No, he (R1) fights hard like they fight on the street. He hits hard and he hit him (R2) hard." When asked if any of the individuals appear afraid of R1 she stated, "Sometimes they act like they are afraid of him. Like sometimes R3 will say, I'm not going in there and get hit (by R1). They know to keep away from him." E4 stated, "No" when asked if she was CPI trained and certified.</p> <p>E3 (DSP) was interviewed on 04/01/14 at 3:40 P.M. and stated that she had worked at the facility for three years. E3 stated, "R1 has gone after R2 a couple times recently for no reason. He has targeted E8 (DSP) who is a new staff and has worked here for six or seven months. She has had to run outside the building to get away from him. E6 (DSP) has had to intervene several</p>	Z9999		

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Z9999	<p>Continued From page 9</p> <p>times with R1 because he has a problem with women (in) authority. One time, R1 got me and sent me flying across the floor. I landed on all fours and hurt my knees. I had to go have them (my knees) checked out at the doctor because of this incident." E3 was then asked if the individuals at the facility appear afraid of R1 and she stated, "I think they are scared of him to a point, especially when he gets angry. I'm afraid he could hurt someone." E3 stated, "No" when asked if she was CPI trained and certified.</p> <p>On 04/08/14, the facility presented a typed narrative contending that action was taken by the facility after the 01/31/14 incident which states, "When R1 hit R2 incident 01/31/14, R2 and R1 were roommates and we moved R1 into another room with another resident that had no concerns or history of problems with R1. Six men (not identified) and their guardians were involved in this process. This move started on the 02/01/14 and was completed for all in 3 days."</p> <p>Review of the facility's Investigation Report for 01/31/14 and the facility's narrative of 04/08/14 does not indicate that the facility implemented additional safeguards outside of the bedroom area to address R1's aggressive behaviors.</p> <p>During the interview with E2 (QIDP) on 04/02/14 at 12:50 P.M., E2 confirmed that no changes were made to R1's behavior program (dated 10/08/13) and/or his level of supervision after these incidents. E2 stated, "No changes have been made to R1's behavior program (dated 10/08/13) because we felt that his behavior program remained appropriate."</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>2) The facility's Investigation report dated 02/20/14 states, "At approximately 7:00 AM... R1 initiated a peer to peer event. He became upset after being asked to get out of the shower when prompted by staff (unidentified). After R1 got dressed, he hit R3 on the left back side of his neck with a flat hand and pushed the staff member (unidentified) from behind. Staff was not (in) position to prevent the hit. No injuries requiring medical assistance were noted at the time of the incident.."</p> <p>The Behavior Data documentation for 02/20/14 identifies that at 6:30 A.M. R1 was aggressive towards R3, E6 and E7 four times while in the med (medication) room and that this behavior lasted thirty minutes. It is also noted that staff redirection was not successful</p> <p>E2 (QIDP) was interviewed on 04/02/14 at 12:50 P.M. regarding these two incidents which occurred on 02/20/14 and stated, "Those two incidents are the same incident." When E2 was asked why the locations and times of the incidents are different, she stated, "I'm not sure."</p> <p>Per review, there is no documentation contained in the Investigation report of 02/20/14 to support that the facility investigated the 6:30 A.M. incident. Neither the facility's Investigation report nor the behavior data documentation sheet for 02/20/14 indicates that the facility took action to safeguard R3 and other individuals of the facility after either of these incidents.</p> <p>R3 was interviewed on 04/01/14 at 11:35 A.M. and stated, "R1 hit me, yeah. Just stay away from him (R1)."</p>	Z9999		

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Z9999	<p>Continued From page 11</p> <p>E7 (DSP) was interviewed on 04/02/14 at 9:10 A.M. and stated, "I have worked at this facility since 2007. R1 and I just don't click. I generally try to stay away from him. He has hit me a bunch of times. We are supposed to do a hold/soft tissue hold for fifteen seconds but that doesn't do any good when he's running at you and hitting you... He hits hard and fights you like a man. E6 (DSP) has saved me several times or R1 would have got me." When E7 was asked if she thought the individuals are afraid of R1, she stated, "When he's acting up, yeah I think that they are scared of him. He gave R5 a black eye and caused bruising to her face. He's also given R4 a black eye before." When E7 was asked if she was afraid of R1 she stated, "I'm not scared of him, but I am scared for the clients." E7 stated, "No" when asked if she was CPI trained and certified.</p> <p>E6 (DSP) was interviewed on 04/01/14 at 9:50 AM and stated, "R1 doesn't like women. There have been many incidents where I have had to intervene due to his behaviors with female staff. It's difficult to handle him if he's having a behavior and there are no male staff around. R1 runs at staff when he goes after them. He has run E8 (DSP) out the door." When E6 was asked if R1 targets anyone, he stated, "He (R1) usually targets female staff and preys on residents that he thinks are weak and won't defend themselves." E6 stated, "I used to be certified but that was a long time ago" when asked if he was CPI trained and certified. When E6 was asked what type of staff interventions are used with R1 to intervene for his behaviors, he stated, "We try to redirect him and send him to his room. That's about all we can do and sometimes that doesn't work."</p>	Z9999		

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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) COMPLETE DATE
Z9999	<p>Continued From page 12</p> <p>In review of R1's behavior plan (dated 10/08/13), interventions with in this plan includes:</p> <p>"Staff will prompt R1 by redirecting in a calm fashion while informing him that the behavior he is displaying is inappropriate, perhaps they could accompany him to his room or a quiet place where he could calm down. In the event that staff has followed the above systematic interventions... and that these interventions have failed and R1 is engaged in a type of physical aggression behavior that personal injury is deemed imminent or an extreme event that has not been targeted occurs the following interventions will be employed. The facility staff will not use any restraining action unless all non-restraining interventions have failed and R1 is in danger of hurting himself or others...</p> <p>1) ...staff will clear the area... 2) Staff will redirect R1 to a quiet place... 4) Soft tissue holding of R1 will be implemented to assure the safety of R1 and others..."</p> <p>E2 (QIDP) was interviewed on 04/02/14 at 12:50 P.M. and confirmed that after the incidents of 02/20/14, no changes were made to R1's behavior program (dated 10/08/13) and/or his level of supervision.</p> <p>3) a) A Behavior Data sheet dated 11/26/13 at 4:38 P.M. identifies that R1 was physically aggressive towards R4 while in the med room. It is further documented that staff (E5/male DSP) redirected him successfully. There is no evidence that the facility investigated this incident and took action to protect R4 and others of the facility after this incident.</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2014
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Z9999	<p>Continued From page 13</p> <p>b) Another Behavior Data Sheet identifies that on 10/26/14 at 6:48 A.M. R1 was physically aggressive towards R4 while in her bedroom. Again, there is no evidence that the facility investigated this incident and took appropriate action to protect R4 and other individuals of the facility after this incident.</p> <p>c) Review of the facility's Investigation report dated 10/10/13 states, "R1 became upset pertaining to night time janitorial stress he was experiencing. R1 took his frustration out on a peer R4 when he got up out of his chair at breakfast, ran around the table and hit R4 on the top of the head. R4 sustained no injury as a result of the incident. Staff present at the time were unable to intervene. It happened quickly with no warning. R4 was given Tylenol and a 24 hour Neuro-Check was initiated..."</p> <p>There is no documentation showing that facility modified R1's behavior program and /or changed his level of supervision after his aggressive incidents (11/26, 10/26 or 10/10/13) towards R4.</p> <p>R4 was interviewed on 0/01/14 at 11:15 A.M. and stated, "R1 is my boyfriend. He's hit me, but that was a long time ago. One time I was eating and he just popped me right in the eye. I got a black eye, but that's been awhile ago. I think it was before Christmas. I'm not sure. He hits me sometimes but I've got ways of straightening him up. I just call him Porky and he quits."</p> <p>The facility's Investigation Report for 10/10/13 states that R1 was seen by Z2 (Psychiatrist) on 09/11/13 for evaluation and treatment. R1's Geodon was reinstated to 20 mg (milligrams) to assist with his aggressive behavior.</p>	Z9999		

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Z9999	<p>Continued From page 14</p> <p>In review of R1's Psychiatric Visit Note dated 09/11/13 this note states, "... He (R1) is not doing well. He has been on a very high dose of Geodon. We brought it down to the maximum dose of 160 mg. According to the staff, that has not worked well and he has been having a lot of problems. In fact he has been upsetting everyone and ended up with 1 or 2 black eyes..."</p> <p>Based on review of the facility's behavioral documentation and Investigation Reports, no documentation is noted that would identify that any staff and/or individual sustained a black eye as a result of R1's aggression.</p> <p>During the interview with E7 (DSP) on 04/02/14 at 9:10 AM and stated, "... He (R1) gave R5 a black eye and caused bruising to her face. He's also given R4 a black eye before."</p> <p>4) The facility's Investigation report dated 09/07/13 states, "At approximately 7:10 A.M. on 09/07/13 R1 initiated a peer to peer event. He became upset after a misunderstanding between his peer R5. R1 took offense to the comment that was made and struck R5 on her face resulting in no injury. Staff was not positioned to intervene to prevent the hit. R1 was redirected and calmed immediately and apologized to his peer..." This report goes on to say that R5 sustained no injuries as a result of this incident.</p> <p>Review of R5's Incident/Accident Report dated 09/07/13 (which was contained within her record) identifies that at 7:25 A.M., R5 sustained, "A scratch on her right side of neck and discoloration and redness around discoloration around left eye." Further follow-up documentation states that R5 has a dark, yellow line under her eye which</p>	Z9999		
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Z9999	<p>Continued From page 15</p> <p>was evident twelve days later on 09/19/13.</p> <p>E2 (Qualified Intellectual Disabilities Professional/QIDP) was interviewed on 04/02/14 and stated there was no documentation in the facility's investigation of 09/07/13 of anyone sustaining a black eye because, "R5's eye was not bruised at the time she was hit."</p> <p>5) On 04/08/14, the facility presented a typed narrative stating, "09/11 Psychiatric Report (encounter notes) identified 1-2 black eyes had occurred... R1 was seen as soon as an appt (appointment) could be made on 09/11/13 by Z2 (psychiatrist)... approximately 3-4 years prior R1 had caused a black eye by hitting a fellow resident (R4)... Recently on 09/07/13 this area was first reported as a thin red line below the left eye and a bruised on the cheek in close proximity to the left eye (characterized as a black eye). As a result of this visit... Z2 ordered reinstatement of 20 mg Geodon. This appointment was achieved within 6 days of the incident."</p> <p>During the interview with E2 (QIDP) on 04/02/14 at 12:50 P.M. she confirmed that with the exception of a medication change on 09/11/13, no other changes were made to R1's behavior program (dated 10/08/13) and/or his level of supervision after R5 sustained injury to her eye area on 09/07/13.</p> <p>In continued review of the typed narrative, the facility contends that actions were taken to address R1's physical aggression when the facility had him evaluated by the psychiatrist and/or the psychiatric nurse practitioner on 09/11/13, 10/02/13, 12/04/13 and 03/04/14.</p>	Z9999		

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Z9999	<p>Continued From page 16</p> <p>Review of the 10/02, 12/04 and 03/04/14 psychiatric visit reports identifies that these reports are routine follow up visits ordered by the psychiatrist and/or the nurse practitioner and do not appear to be precipitated by R1's aggressive behaviors. There is documentation in the 03/04/14 Psychiatric Visit Note which states, "E2 (QIDP/Qualified Intellectual Disabilities Professional) reports pt (patient/R1) did push a staff person down once last month when angry..." There is no documentation contained within any of these notes dated 12/04/13 or 03/14/14 which would identify that the facility informed the psychiatrist and/or the nurse practitioner of R1's peer to peer aggressive behaviors which occurred on 10/10/13, 10/26/13, 11/26/13, 01/31/14 or on 02/20/14.</p> <p>E1 (Owner) was interviewed on 04/02/14 at 4:00 P.M. and stated, "When a client is a perpetrator of abuse, we review his behavior program, make sure that we contact the psychiatrist, counsel the client, look across all environments, check his special considerations, such as losing an outing and we look at trends at patterns and antecedents." When asked if any changes had been made in R1's level of supervision as a result of his behaviors, E1 stated, "No, it's very difficult to provide close monitoring to R1 when his behaviors are occurring on roughly a month to month basis." E1 went on to say that if R1 becomes aggressive, staff are to redirect him and use the fifteen second soft tissue hold. E1 was then informed that during staff interviews, staff of the facility stated that the fifteen minute soft tissue hold was ineffective when dealing with R1, especially when "he's running at you to hit you." E1 was also informed that during staff interviews staff stated that they have not been provided with training and certification in crisis intervention</p>	Z9999		

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Z9999	<p>Continued From page 17</p> <p>techniques.</p> <p>E1 stated, "No" when asked if the facility's direct support staff have been trained/certified in crisis intervention techniques to manage R1's aggressive behaviors since staff state that present interventions are "ineffective" in addressing his behaviors.</p> <p>The Behavior Data sheets for R1 identifies that on 11/26/13 at 4:38 P.M. he became physically aggressive towards R4 while in the med room. It is further documented that staff (E5/male DSP) redirected him successfully. There is no evidence that the facility investigated this incident and took action to protect R4 and others of the facility after this incident.</p> <p>Another Behavior Data Sheet identifies that on 10/26/14 at 6:48 A.M. R1 was physically aggressive towards R4 while in her bedroom. Again, there is no evidence that the facility investigated this incident and took appropriate action to protect R4 and other individuals of the facility after this incident.</p> <p>There is no documentation showing that facility investigated these incidents or that R1's behavior program and /or his level of supervision was changed after his aggressive incidents on 11/26 or 10/26/13.</p> <p>E2 (QIDP) was interviewed on 04/02/14 at 12:50 P.M. and confirmed that the facility did not have reproducible evidence that these two incidents (11/26/13 and/or 10/26/13) were investigated by the facility.</p>	Z9999		

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Z9999	Continued From page 18 (A)	Z9999		