

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

PRINTED: 10/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARBROOK CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3201 WEST CAMPBELL STREET</b> <b>ROLLING MEADOWS, IL 60008</b>		
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W 000	INITIAL COMMENTS	W 000			
W 122	<p>INCIDENT INVESTIGATION</p> <p>Incident of 9/5/16 / IL# 88566</p> <p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to ensure clients were free from abuse and neglect for 1 of 1 client in the sample(R1), who was allegedly slapped on the face by a Direct Care Staff member. The facility failed to ensure:</p> <ul style="list-style-type: none"> <li>* Clients were free from abuse and neglect; R1 was witnessed being slapped on the right cheek by a Direct Care Staff on 9/5/16:</li> <li>* The allegation of abuse was reported immediately to the Administrator;</li> <li>* The allegation of abuse was thoroughly investigated;</li> <li>* The potential for further abuse was not prevented when the accused abuser remained in contact with R1 for 5-10 minutes after the witnessed abuse;</li> <li>* Staff who were trained annually, were re-trained on their Abuse and Neglect Policy, ensuring staff are aware abuse will not be tolerated; any witnessed or suspected abuse needs to be reported to the Administrator</li> </ul>	W 122			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1 immediately, further potential abuse needs to be prevented while the investigation is in progress, and appropriate corrective action must be taken.  Findings include:  Refer to deficiencies cited under:  W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  W153 - The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the Administrator and to other officials in accordance with State law through established procedures.  W154 - The facility must have evidence that all alleged violations are thoroughly investigated.  W155 - The facility must prevent further potential abuse while the investigation is in progress.  W157 - If the alleged violation is verified, appropriate corrective action must be taken.	W 122			
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to follow its policy and procedure to prevent abuse for 1 of 1 allegation	W 149			

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W 149	<p>Continued From page 2</p> <p>of abuse reviewed, affecting R1. R1 was witnessed by a staff Registered Nurse, being slapped on his right cheek by a Direct Care Staff on 9/5/16.</p> <p>Findings include:</p> <p>The facility policy entitled, "Abuse and Neglect Policy," with a revision date of 9/15 was reviewed. It reads, but is not limited to, "Under no circumstances shall any abuse or neglect of a client be tolerated...."</p> <p>Any person witnessing, hearing about or observing evidence of abuse or neglect of a client must report it immediately to the Administrator or the Administrator's designee. Failure to report immediately may result in disciplinary action up to and including possible termination of employment. Any finding of abuse or neglect of a client is grounds for immediate dismissal.....</p> <p>Any report of abuse, neglect or exploitation of a client shall be communicated to the Administrator or the Administrator's designee for immediate and thorough investigation and proper action....</p> <p>Abuse is defined as: Any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility..."</p> <p>R1 was observed on 9/14/16 at 2:00pm in the multi purpose room. R1 was observed to be up ambulating. When asked a question, R1 did not respond, but when requested by staff to follow direction, R1 was able to do so. R1's Individual Service Plan dated 8/9/16 was reviewed. R1 has the documented diagnoses of Autistic Disorder, Cyclothymic Disorder and Severe Mental</p>	W 149			

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W 149	<p>Continued From page 3</p> <p>Retardation. This document states that R1 is able to communicate his wants and needs through gestures with staff and peers. R1's Behavior Program dated 9/1/15 was reviewed. R1 has the targeted behaviors of aggression, agitation, stealing, wandering, and inappropriate food behavior, which is described as attempting to place a non-edible into his mouth, such as cleaning liquid, cologne, perfume or lotions.</p> <p>The Injury Report for R1, dated and timed 9/5/16 at 9:30am was reviewed. It states that the author of the report(E4, Registered Nurse) walked into the Red Hall TV room, and upon entering the room witnessed a staff member, E6(Direct Care Staff) reach out and slap R1 on his left side of his face/upper body. R1 was assessed, and has no bruising, discoloration or signs of injury. Facial expressions and movement are at baseline. Staff(E6) was placed on Administrative leave.</p> <p>The Summary of the Incident Report for R1, authored by E3(Quality Assurance Facilitator), was reviewed. This report is dated 9/9/16. The summary reads, but is not limited to, "On September 5th, 2016 a nurse at this facility(E4) alleged that E6, Direct Care Professional slapped R1 on the left side of his face/upper body...</p> <p>E4(Registered Nurse), made the allegation against E6 and provided the following statement on 9/5/16.</p> <p>* At approximately 9:30am this morning, I walked into the Red Hall's TV room and saw a staff member reach out and slap the right side of R1's face/upper body. It happened quickly, and I was unable to say for certain at the time if contact was made with the face or body. I immediately said, "Don't do that", and the staff(E6) responded with,</p>	W 149			

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W 149	<p>Continued From page 4</p> <p>"I'm sorry, I'm sorry."</p> <p>* I spoke with the Q(Qualified Intellectual Disability Professional), E5, and the Administrator(E1) was notified. The staff wrote a statement and signed the Administrative Leave form and was placed on Administrative Leave effective immediately. While E5 and I(E4) explained the procedure to the staff member, he confirmed that it was the right side of the client's face where the contact was made.</p> <p>E5, QIDP, the following was included in her statement provided on 9/6/16:</p> <p>* On Monday, September 5, 2016, I arrived at work at approximately 9:05am. E4, a nurse at the facility saw me, and asked if I could come into the nursing office as she needed to speak with me. E7(Shift Supervisor) went into the office as well. E4 proceeded to tell us that upon entering R1's room a few minutes prior to my arrival, she witnessed E6 slap R1 on the cheek. I asked her if she had contacted E1 or E8(Assistant Administrator) and she stated that she had not done so yet. I told her that we needed to get in contact with E1 right away. When E4 got off the phone, she stated that E1 wanted E6 placed on Administrative Leave effective immediately.</p> <p>* Once the three of us were seated(E4,E5,E6), I informed E6 that I was placing him on Administrative Leave due to an allegation of abuse to a client, R1, that was reported to me by E4. I explained that it was told to me that E4 witnessed E6 slap R1 on the cheek. I attempted to speak about what it meant to be on Administrative Leave when E6 interrupted and said the following, "No, no, please do not do this. I am so sorry, I can't lose my job, I just got it back three weeks ago. I promise I did not hit hard, it was a gentle slap, more like a tap, please."....I</p>	W 149			

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W 149	<p>Continued From page 5</p> <p>explained that this is a formal procedure and that an investigation would be taking place....I asked him if he understood everything I had said. He stated that he did and said, "I know what I did was wrong, and I am so sorry, I just gave him a tap on the cheek." I asked E6 at that time if he would place his statement in writing.</p> <p>E6 provided the following written statement to QIDP, E5 and nurse, E4 on 9/5/16: * At about 9:25am, a client R1, drank from a bottle by a staff. I gave him a gentle tap on his cheek to admonish him. The nurse on duty(E4) said I should not have done that. I was sorry about that.</p> <p>E3, Quality Assurance Facilitator interviewed E6 on 9/7/16. The reason for the interview was explained. E6 confirmed that he, R1 and E4 were the only witnesses of this incident that occurred in the Red TV room. E6 provided the following written statement: * At about 9:25am on the 5th day of September 2016, I was working in the Red Hall of the facility. After breakfast, I went into the TV room where clients relaxed. I saw R1 drinking from a bottle with a blue content. I was alarmed as blue is an uncommon color for juices. I took the bottle from him. I sat down to read the content of the bottle and found that it was a good drink, and not something that could harm him. Then I touched his cheek to get his attention to listen to me. Then I pointed to the bottle and made a side by swipe to signify, "no" to R1. * It was at this point that I touched his cheek that the nurse on duty came in and said that I should not have done that. I said I was sorry if it was inappropriate. But I'm stating in no uncertain terms that I meant no harm or abuse to R1. I</p>	W 149			

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W 149	<p>Continued From page 6</p> <p>could not have tried to save him from drinking what I thought was unsafe, and turned around to abuse him.</p> <p>Due to this incident occurring in the Red Hall Living (TV) Room, video surveillance is not available.</p> <p>Conclusion/Summary: Based on information gathered, the allegation of abuse made against E6 is unsubstantiated...The nurse stated in written form that it happened so quickly and that she was unable to say for certain if contact was made to the face or body. The nurse that made the allegation of physical abuse assessed R1, and no injuries were found.</p> <p>This investigation is concluding that E6's intervention strategy was not an approved method, but was not abusive. E6 will be retrained on proper redirection and intervention strategies."</p> <p>E4 was interviewed on 9/14/16 at 2:30pm. E4 confirmed that she was the staff nurse who witnessed R6 slap R1 on 9/5/16. E4 was informed that the facility investigative report indicates that originally she reported the slap to have occurred to the left side of R1's face, but later changed to the right side of R1's face. E4 stated that when she filled out the incident report, she wrote left side, but afterwards, when she gave her statement, and really focused on what she witnessed, she realized it was the right side of R1's face. E4 was also made aware that the time she indicated the abuse to have been witnessed in her statement, differed from the time E5 gave in her statement. E4 stated that she never really looked at her watch when the abuse was witnessed. E4 stated that it really was an</p>	W 149			

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W 149	Continued From page 7 estimate, and maybe E5's time was most accurate. E4 asked if she could summarize what she witnessed that morning on 9/5/16. E4 stated she walked into the Red Hall TV room just as she witnessed E6 slap R1 on his right cheek with his left hand. E4 stated it was a hard hit, and she told E6 not to hit R1. E4 stated she then left the TV room, and told the other nurse working with her that day what she had just witnessed. E4 explained that she really did not know exactly what to do, and was asking her co-worker for guidance. E4 stated that her co-worker really did not know what to do either, so she then went toward the entrance wing of the facility, and saw the shift supervisor. E4 stated that E7(Shift supervisor) really was not exactly sure what paperwork needed to be obtained, so it was at this time that E5 entered the building and she told E5 what she had witnessed. E5 guided her through the process, and asked her if she had called E1 yet. E4 stated that she had not, so they proceeded to look for the proper paper work and called E1. E4 explained that E1 instructed her to place E6 on Administrative Leave, and make sure he leaves the building. E4 stated that it was probably 5-10 minutes from the time she witnessed the abuse, until the time they told E6 that he was being placed on administrative leave. E4 confirmed that she left E6 alone in the TV room, with R1 during that 5-10 minute time frame, and realizes now that she should have removed R1 from the situation, and made sure E6 was away from any clients after she witnessed that abuse. E4 stated that she felt uncomfortable telling E6 that he needed to leave, even though she knew that was what she was required to do. E4 stated that when E5 and her went into the TV room to tell E6 he was being placed on Administrative Leave, E6 was in the room	W 149			



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W 149	<p>Continued From page 8</p> <p>sleeping. E4 stated that E5 had to call his name two times before he opened his eyes. E4 was asked why she did not report that in her statement, or while she was being interviewed, during the investigative process. E4 stated that she was never interviewed by anyone regarding this witnessed abuse. E4 stated she was never asked to give a statement either, but just wrote one because she thought she should. E4 stated that she did not tell anyone about the sleeping because when she has reported staff sleeping in the past, nothing ever gets done about it anyway. E4 stated that E5 could verify that E6 was sleeping. E4 stated that they(Administration) let E6 come back to work the following weekend, and she is shocked that they would let someone work here after he had abused a client. E4 stated that she realizes that she reported the abuse late, and didn't remove E6 immediately from R1 and the other residents in the facility, and is very sorry about that. E4 stated that E6 has been working again, and she doesn't think that the facility has even re-trained him on the Abuse and Neglect policy.</p> <p>During an interview with E6 on 9/14/16 at 2:45pm, E6 was asked if he could provide a detailed summary about what occurred on the morning of 9/5/16, when he was placed on Administrative Leave. E6 stated that he was not officially assigned to care for R1 that morning, but when he came into the Red Hall TV room, he saw R1 drinking from a bottle that had blue liquid in it. E6 explained that R1 has a behavior of drinking any drink he can find, whether it is his drink or someone else's. E6 stated that he thought it was a chemical, and when he saw that he had already started drinking it, he immediately grabbed the bottle from his hand, and reviewed what it was</p>	W 149			

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W 149	<p>Continued From page 9</p> <p>that he was actually drinking. E6 stated that when he realized it was an energy drink, and not a chemical of some kind, he went over to R1. At that time R1 was looking away from him, and wanted to make sure he(R1) understood he should not drink liquids that did not belong to him. E6 stated that he touched him with his finger on his right cheek. E6 stated that he wanted him to look at him. E6 was informed that the nurse who witnessed that slap to R1's face also reported that he was sleeping when she and E5 came back to tell him that he was being placed on Administrative Leave. E6 stated that he did have his eyes closed, but was processing what occurred. E6 stated that he was just thinking about what happened. E6 was asked if anyone trained him, after the investigation was completed, and he was allowed to return to work. E6 stated that no one retrained him. E6 stated that he came back to work the Saturday after the incident occurred,(9/10/16) and has been working every day up until today, and after this interview, will also work the evening shift.</p> <p>During an interview with E1 on 9/14/16 at 3:00pm, E1 was informed that E4 told this writer that on the morning of 9/5/16, when both E4 and E5 went to tell E6 that he was being placed on Administrative Leave for allegedly slapping R1 on the right cheek, E6 had his eyes closed, and appeared to be sleeping. E1 was made aware that E4 did not write this in her statement, but that E5 could verify that E6 was in fact sleeping. E1 stated that she was not aware about this allegation, and that she was going to immediately place E6 back on Administrative Leave. E1 was also made aware that E4 did not tell E1 or anyone in management about E6 sleeping, because in the past, when she has saw someone sleeping</p>	W 149			

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W 149	<p>Continued From page 10</p> <p>on the job, and she reported it, nothing happened as a consequence, so she just stopped reporting this going forward. E4 did not provide any specifics as to who or when this occurred. E1 denied E4's statement, but said that if someone would report that staff was sleeping on the job, she would investigate that allegation, and it would be addressed.</p> <p>During an interview with E5(Qualified Intellectual Disability Professional) on 9/15/16 at 10:55am, E5 stated that when she arrived at work that day, E4 approached her as she was walking in the door, and told her that she needed to discuss something with her. E5 stated that E4 told her she saw E6 slap R1 on the right cheek. E5 asked her if this was reported to E1 yet. E4 replied she had not called her, so E5 told E4 that she needed to report this immediately. E5 stated that she thought this occurred at around 9:05 or 9:10, but she really can't be sure, because she does not remember looking at the clock when E4 reported this to her. E5 stated that E1 told E4 that they needed to place E6 on Administrative Leave immediately, so E5 asked E4 where E6 currently was in the building. E5 stated that E4 told her that she witnessed the abuse in R1's bedroom,(but E4 and E6 all verified that the alleged abuse occurred in the TV room of the Red Hall). E5 stated that E4 told her he was still in the TV room with R1. E5 stated that she could not believe that E4 would leave E6 in the facility where he was with R1 and other clients, as he could potentially abuse someone else. E5 knew she needed to remove E6 immediately from the facility, and away from the clients, so she, along with E4 asked him to come with her to the conference room(which is locked, and away from other clients). E5 was asked if E6 was sleeping</p>	W 149			

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W 149	Continued From page 11 when she entered the TV room with E4. E5 stated that she cannot be sure, but his eyes were closed, and she called his name a couple of times before he opened them(his eyes). E5 was asked if R1 was still in the room that E6 was sitting in with his eyes closed. E5 stated that she could not be sure if R1 was still in that room, but that many other clients were in that room with E6. E5 was asked why she did not include that she witnessed E6 with his eyes closed in her personal statement. E5 stated that she did mention that. This writer showed her the report E3 authored, which had her personal statement included. E5 confirmed that was part of her statement, but that the statement she authored was much longer and more detailed. E5 went to retrieve her statement, and it did in fact include that she witnessed E6 with his eyes closed. It also included information of E6 being persistent in obtaining his charger for his phone before he left, even though it had just been explained to him that he needed to leave the building, and have no further contact with any other clients or staff in the building. E5 explained that E6 would not listen, and proceeded to retrieve his own charger. E5 stated she followed him, and stood between him and any other clients who came into close contact with E6. E5 stated at one point he started to talk with another staff member, and attempted to explain to that person that he was being accused of hitting R1, and E5 had to again be very firm with E6, and escorted him out of the building, explaining yet again that he is not allowed to discuss this situation with any staff members who work at this facility. E5 was asked why she did not report this information when she was interviewed during this investigative process. E5 stated that no one asked to interview her. E5 stated that she was just asked to give a statement.	W 149			

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W 149	Continued From page 12  During an interview with E3 on 9/15/16 at 2:00pm, E3 was asked if he was the staff member who authored and investigated the allegation of physical abuse towards R1 on 9/5/16. E3 confirmed that he was. E3 was informed that E5 presented to this writer a much longer version of her statement than what was included in his investigation, and was asked why he omitted the allegation that E6 was found sleeping in the TV room. E3 stated that he did not think that information was relevant to what he was investigating. E3 stated that he asked E6 about it when he interview him, and he said he was just shocked about what was happening, and denied he was sleeping. So for that reason, he did not include this in his report. E3 was asked if he realized that the incident report indicates R1 was slapped on his left cheek, yet all of the statements report the right cheek. E3 stated that he did not determine that fact. E3 was asked if he realized that the times reported by E4 and E5 do not match, and that E6 was left alone for a period of 5-10 minutes with R1 and other clients from the time he was witnessed slapping R1, until he was escorted out of the building, after being placed on Administrative Leave. E3 stated that he did not realize that fact either. E3 was asked if he determined that E5 thought the alleged abuse occurred in R1's room, while E4 reported that the abuse occurred in the Red Hall TV room. E3 stated that he must have missed that fact as well. E3 was asked if he interviewed anyone either than E6. E3 stated that in the past, while he was investigating allegations of abuse and neglect, if he determined an allegation to be substantiated, he would be asked by the reviewing committee for statements. E3 stated that going forward, he now asks for statements only, and rarely	W 149			

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W 149	Continued From page 13 interviews, unless he feels he needs an additional explanation. E3 was asked if E6 was retrained prior to returning to work on Saturday, 9/10/16. E3 explained that when he completed his investigation, and E1 signed off on it, E1 informed him that they wanted to get E6 back on the schedule by the end of the week. E3 explained that they are short staffed, especially on the weekends, so they needed to get E6 back out onto the floor to work. E3 stated that he asked E1 if some training should be done before he returns to work, and E1 stated yes. E3 stated that normally it is not his job to retrain, so he was trying to put some information together for his retraining, but confirmed that to date, E6 has not been retrained on abuse and neglect. E3 was asked if nursing had been retrained, as E4 was late reporting the alleged abuse immediately to the Administrator, as well as did not remove E6 from R1 and other clients, to protect other clients from potential abuse. E3 stated that the nursing staff has not been retrained. E3 was asked why he did not include in his investigation, that E6 did not immediately leave the building, and insisted that he go back by the clients, to obtain his charger, when E5 instructed him to leave the building. E3 stated he does not know why he did not add that to his investigation. E3 stated that this is just so hard, when its one staff alleging abuse against another staff, and there are no witnesses. E3 stated that E6 denied he hit R1 hard, but rather tapped him, so that is why he did not substantiate it as abuse.	W 149			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported	W 153			

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W 153	<p>Continued From page 14</p> <p>immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, staff failed to report 1 of 1 allegation of abuse reviewed, immediately to the Administrator, involving R1.</p> <p>Findings include:</p> <p>The Injury Report for R1, dated and timed 9/5/16 at 9:30am was reviewed. It states that the author of the report(E4, Registered Nurse) walked into the Red hall TV room, and upon entering the room witnessed a staff member, E6(Direct Care Staff) reach out and slap R1 on his left side of his face/upper body. R1 was assessed, and has no bruising, discoloration or signs of injury. Facial expressions and movement are at baseline. Staff(E6) was placed on Administrative leave.</p> <p>The Summary of the Incident Report for R1, authored by E3(Quality Assurance Facilitator), was reviewed. This report is dated 9/9/16. The summary reads, but is not limited to, "On September 5th, 2016 a nurse at this facility(E4) alleged that E6, Direct Care Professional slapped R1 on the left side of his face/upper body...</p> <p>E4(Registered Nurse), made the allegation against E6 and provided the following statement on 9/5/16.</p> <p>* At approximately 9:30am this morning, I walked into the Red Hall's TV room and saw a staff member reach out and slap the right side of R1's face/upper body. It happened quickly, and I was unable to say for certain at the time if contact was</p>	W 153			

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W 153	<p>Continued From page 15</p> <p>made with the face or body. I immediately said, "Don't do that", and the staff(E6) responded with, "I'm sorry, I'm sorry."</p> <p>* I spoke with the Q(Qualified Intellectual Disability Professional), E5, and the Administrator(E1) was notified. The staff wrote a statement and signed the Administrative leave form and was placed on administrative leave effective immediately. While E5 and I(E4) explained the procedure to the staff member, he confirmed that it was the right side of the client's face where the contact was made.</p> <p>E5, QIDP, the following was included in her statement provided on 9/6/16:</p> <p>* On Monday, September 5, 2016, I arrived at work at approximately 9:05am. E4, a nurse at the facility saw me and asked if I could come into the nursing office as she needed to speak with me. E7(Shift Supervisor) went into the office as well. E4 proceeded to tell us that upon entering R1's room a few minutes prior to my arrival, she witnessed E6 slap R1 on the cheek. I asked her if she had contacted E1 or E8(Assistant Administrator) and she stated that she had not done so yet. I told her that we needed to get in contact with E1 right away. When E4 got off the phone, she stated that E1 wanted E6 placed on Administrative Leave effective immediately....</p> <p>E6 provided the following written statement to QIDP, E5 and nurse, E4 on 9/5/16:</p> <p>* At about 9:25am, a client R1, drank from a bottle by a staff. I gave him a gentle tap on his cheek to admonish him. The nurse on duty(E4) said I should not have done that. I was sorry about that.</p> <p>Conclusion/Summary:</p>	W 153			



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W 153	<p>Continued From page 16</p> <p>Based on information gathered, the allegation of abuse made against E6 is unsubstantiated...The nurse stated in written form that it happened so quickly and that she was unable to say for certain if contact was made to the face or body. The nurse that made the allegation of physical abuse assessed R1 and no injuries were found.</p> <p>This investigation is concluding that E6's intervention strategy was not an approved method, but was not abusive. E6 will be retrained on proper redirection and intervention strategies."</p> <p>E4 was interviewed on 9/14/16 at 2:30pm. E4 confirmed that she was the staff nurse who witnessed R6 slap R1 on 9/5/16. E4 asked if she could summarize what she witnessed that morning on 9/5/16. E4 stated she walked into the Red hall TV room just as she witnessed E6 slap R1 on his right cheek with his left hand. E4 stated it was a hard hit, and she told E6 not to hit R1. E4 stated she then left the TV room, and told the other nurse working with her that day what she had just witnessed. E4 explained that she really did not know exactly what to do, and was asking her co-worker for guidance. E4 stated that her co-worker really did not know what to do either, so she then went toward the entrance wing of the facility, and saw the shift supervisor. E4 stated that E7(Shift supervisor) really was not exactly sure what paperwork needed to be obtained, so it was at this time that E5 entered the building and she told E5 what she had witnessed. E5 guided her through the process, and asked her if she had called E1 yet. E4 stated that she had not, so they proceeded to look for the proper paper work and called E1. E4 explained that E1 instructed her to place E6 on Administrative Leave, and make sure he leaves</p>	W 153			

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W 153	<p>Continued From page 17</p> <p>the building. E4 stated that it was probably 5-10 minutes from the time she witnessed the abuse, until the time they told E6 that he was being placed on administrative leave. E4 stated that she realizes that she reported the abuse late, and is very sorry about that.</p> <p>During an interview with E5(Qualified Intellectual Disability Professional) on 9/15/16 at 10:55am, E5 stated that when she arrived at work that day, E4 approached her as she was walking in the door, and told her that she needed to discuss something with her. E5 stated that E4 told her she saw E6 slap R1 on the right cheek. E5 asked her if this was reported to E1 yet. E4 replied she had not called her, so E5 told E4 that she needed to report this immediately. E5 stated that E1 told E4 that they needed to place E6 on Administrative Leave immediately, so E5 asked E4 where E6 currently was in the building. E6 stated that E4 told her he was still in the TV room with R1. E5 stated that she could not believe that E4 would leave E6 in the facility where he was with R1 and other clients, as he could potentially abuse someone else. E5 knew she needed to remove E6 immediately from the facility, and away from the clients, so she, along with E4 asked him to come with him to the conference room(which is locked, and away from other clients).</p> <p>During an interview with E3 on 9/15/16 at 2:00pm,E3 was asked if he was the staff member who authored and investigated the allegation of physical abuse towards R1 on 9/5/16. E3 confirmed that he was. E3 was asked if nursing had been retrained, as E4 was late reporting the alleged abuse immediately to the Administrator, as well as did not remove E6 from R1 and other clients, to protect other clients from potential</p>	W 153			

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W 153	Continued From page 18 abuse. E3 stated that the nursing staff has not been retrained.  During an interview with E1(Administrator) on 9/14/16 at 1:35pm, E1 was asked if E4 and the nursing staff had been re-trained on the requirement of reporting all allegations of potential abuse and neglect immediately to the Administrator. E1 stated that she did not want to discipline E4 because she was so upset about what she witnessed, and E4 realizes now that she should have called me right away.	W 153			
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 allegation of abuse reviewed, was thoroughly investigated, involving R1.  Findings include:  The facility policy entitled, "Abuse and Neglect Policy," with a revision date of 9/15 was reviewed. It reads, but is not limited to, "Under no circumstances shall any abuse or neglect of a client be tolerated....  Any person witnessing, hearing about or observing evidence of abuse or neglect of a client must report it immediately to the Administrator or the Administrator's designee. Failure to report immediately may result in disciplinary action up to and including possible termination of	W 154			

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W 154	<p>Continued From page 19</p> <p>employment. Any finding of abuse or neglect of a client is grounds for immediate dismissal.....</p> <p>Any report of abuse, neglect or exploitation of a client shall be communicated to the Administrator of the Administrator's designee for immediate and thorough investigation and proper action....</p> <p>Abuse is defined as: Any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility..."</p> <p>The Injury Report for R1, dated and timed 9/5/16 at 9:30am was reviewed. It states that the author of the report(E4, Registered Nurse) walked into the Red hall TV room, and upon entering the room witnessed a staff member, E6(Direct Care Staff) reach out and slap R1 on his left side of his face/upper body. R1 was assessed, and has no bruising, discoloration or signs of injury. Facial expressions and movement are at baseline. Staff(E6) was placed on Administrative leave.</p> <p>The Summary of the Incident Report for R1, authored by E3(Quality Assurance Facilitator), was reviewed. This report is dated 9/9/16. The summary reads, but is not limited to, "On September 5th, 2016 a nurse at this facility(E4) alleged that E6, Direct Care Professional slapped R1 on the left side of his face/upper body...</p> <p>E4(Registered Nurse), made the allegation against E6 and provided the following statement on 9/5/16.</p> <p>* At approximately 9:30am this morning, I walked into the Red Hall's TV room and saw a staff member reach out and slap the right side of R1's face/upper body. It happened quickly, and I was unable to say for certain at the time if contact was</p>	W 154			

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W 154	<p>Continued From page 20</p> <p>made with the face or body. I immediately said, "Don't do that", and the staff(E6) responded with, "I'm sorry, I'm sorry."</p> <p>* I spoke with the Q(Qualified Intellectual Disability Professional), E5, and the Administrator(E1) was notified. The staff wrote a statement and signed the Administrative leave form and was placed on administrative leave effective immediately. While E5 and I(E4) explained the procedure to the staff member, he confirmed that it was the right side of the client's face where the contact was made.</p> <p>E5, QIDP, the following was included in her statement provided on 9/6/16:</p> <p>* On Monday, September 5, 2016, I arrived at work at approximately 9:05am. E4, a nurse at the facility saw me and asked if I could come into the nursing office as she needed to speak with me. E7(Shift Supervisor) went into the office as well. E4 proceeded to tell us that upon entering R1's room a few minutes prior to my arrival, she witnessed E6 slap R1 on the cheek. I asked her if she had contacted E1 or E8(Assistant Administrator) and she stated that she had not done so yet. I told her that we needed to get in contact with E1 right away. When E4 got off the phone, she stated that E1 wanted E6 placed on Administrative Leave effective immediately.</p> <p>* Once the three of us were seated(E4,E5,E6), I informed E6 that I was placing him on Administrative Leave due to an allegation of abuse to a client, R1, that was reported to me by E4. I explained that it was told to me that E4 witnessed E6 slap R1 on the cheek. I attempted to speak about what it meant to be on Administrative Leave when E6 interrupted and said the following, "No, no, please do not do this. I am so sorry, I can't lose my job, I just got it back</p>	W 154			

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W 154	<p>Continued From page 21</p> <p>three weeks ago. I promise I did not hit hard, it was a gentle slap, more like a tap, please."....I explained that this is a formal procedure and that an investigation would be taking place....I asked him if he understood everything I had said. He stated that he did and said, "I know what I did was wrong, and I am so sorry, I just gave him a tap on the cheek." I asked E6 at that time if he would place his statement in writing.</p> <p>E6 provided the following written statement to QIDP, E5 and nurse, E4 on 9/5/16:</p> <p>* At about 9:25am, a client R1, drank from a bottle by a staff. I gave him a gentle tap on his cheek to admonish him. The nurse on duty(E4) said I should not have done that. I was sorry about that.</p> <p>E3, Quality Assurance Facilitator interviewed E6 on 9/7/16. The reason for the interview was explained. E6 confirmed that he, R1 and E4 were the only witnesses of this incident that occurred in the Red TV room. E6 provided the following written statement:</p> <p>* At about 9:25am on the 5th day of September 2016, I was working in the red hall of the facility. After breakfast, I went into the TV room where clients relaxed. I saw R1 drinking from a bottle with a blue content. I was alarmed as blue is an uncommon color for juices. I took the bottle from him. I sat down to read the content of the bottle and found that it was a good drink, and not something that could harm him. Then I touched his cheek to get his attention to listen to me. Then I pointed to the bottle and made a side by swipe to signify, "no" to R1.</p> <p>* It was at this point that I touched his cheek that the nurse on duty came in and said that I should not have done that. I said I was sorry if it was</p>	W 154			

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W 154	<p>Continued From page 22</p> <p>inappropriate. But I'm stating in no uncertain terms that I meant no harm or abuse to R1. I could not have tried to save him from drinking what I thought was unsafe, and turned around to abuse him.</p> <p>Due to this incident occurring in the Red Hall Living (TV) Room, video surveillance is not available.</p> <p>Conclusion/Summary: Based on information gathered, the allegation of abuse made against E6 is unsubstantiated...The nurse stated in written form that it happened so quickly and that she was unable to say for certain if contact was made to the face or body. The nurse that made the allegation of physical abuse assessed R1 and no injuries were found.</p> <p>This investigation is concluding that E6's intervention strategy was not an approved method, but was not abusive. E6 will be retrained on proper redirection and intervention strategies."</p> <p>E4 was interviewed on 9/14/16 at 2:30pm. E4 confirmed that she was the staff nurse who witnessed R6 slap R1 on 9/5/16. E4 was informed that the facility investigative report indicates that originally she reported the slap to have occurred to the left side of R1's face, but later changed to the right side of R1's face. E4 stated that when she filled out the incident report, she wrote left side, but afterwards, when she gave her statement, and really focused on what she witnessed, she realized it was the right side of R1's face. E4 was also made aware that the time she indicated the abuse to have been witnessed in her statement, differed from the time E5 gave in her statement. E4 stated that she</p>	W 154			

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W 154	Continued From page 23 never really looked at her watch when the abuse was witnessed. E4 stated that it really was an estimate, and maybe E5's time was most accurate. E4 asked if she could summarize what she witnessed that morning on 9/5/16. E4 stated she walked into the Red hall TV room just as she witnessed E6 slap R1 on his right cheek with his left hand. E4 stated it was a hard hit, and she told E6 not to hit R1. E4 stated she then left the TV room, and told the other nurse working with her that day what she had just witnessed. E4 explained that she really did not know exactly what to do, and was asking her co-worker for guidance. E4 stated that her co-worker really did not know what to do either, so she then went toward the entrance wing of the facility, and saw the shift supervisor. E4 stated that E7(Shift supervisor) really was not exactly sure what paperwork needed to be obtained, so it was at this time that E5 entered the building and she told E5 what she had witnessed. E5 guided her through the process, and asked her if she had called E1 yet. E4 stated that she had not, so they proceeded to look for the proper paper work and called E1. E4 explained that E1 instructed her to place E6 on Administrative Leave, and make sure he leaves the building. E4 stated that it was probably 5-10 minutes from the time she witnessed the abuse, until the time they told E6 that he was being placed on administrative leave. E4 confirmed that she left E6 alone in the TV room, with R1 during that 5-10 minutes time frame, and realizes now that she should have removed R1 from the situation, and made sure E6 was away from any clients after she witnessed that abuse. E4 stated that she felt uncomfortable telling E6 that he needed to leave, even though she knew that was what she was required to do. E4 stated that when E5 and her went into the TV	W 154			



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W 154	<p>Continued From page 24</p> <p>room to tell E6 he was being placed on Administrative leave, E6 was in the room sleeping. E4 stated that E5 had to call his name two times before he opened his eyes. E4 was asked why she did not report that in her statement, or while she was being interviewed, during the investigative process. E4 stated that she was never interviewed by anyone regarding this witnessed abuse. E4 stated she was never asked to give a statement either, but just wrote one because she thought she should. E4 stated that she did not tell anyone about the sleeping because when she has reported staff sleeping in the past, nothing ever gets done about it anyway. E4 stated that E5 could verify that E6 was sleeping. E4 stated that they(Administration) let E6 come back to work the following weekend, and she is shocked that they would let someone work here after he had abused a client. E4 stated that she realizes that she reported the abuse late, and didn't remove E6 immediately from R1 and the other residents in the facility, and is very sorry about that. E4 stated that E6 has been working again, and she doesn't think that the facility has even re-trained him on the Abuse and Neglect policy.</p> <p>During an interview with E6 on 9/14/16 at 2:45pm, E6 was asked if he could provide a detailed summary about what occurred on the morning of 9/5/16, when he was placed on Administrative Leave. E6 stated that he was not officially assigned to care for R1 that morning, but when he came into the Red Hall TV room, he saw R1 drinking from a bottle that had blue liquid in it. E6 explained that R1 has a behavior of drinking any drink he can find, whether it is his drink or someone else's. E6 stated that he thought it was a chemical, and when he saw that he had already</p>	W 154			

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W 154	<p>Continued From page 25</p> <p>started drinking it, he immediately grabbed the bottle from his hand, and reviewed what it was that he was actually drinking. E6 stated that when he realized it was an energy drink, and not a chemical of some kind, he went over to R1. At that time R1 was looking away from him, and wanted to make sure he(R1) understood he should not drink liquids that did not belong to him. E6 stated that he touched him with his finger on his right cheek. E6 was asked if R1 was deaf, or blind. E6 stated that he is neither, but just wanted to make sure he had his attention. E6 stated that he wanted him to look at him. E6 was informed that the nurse who witnessed that slap to R1's face also reported that he was sleeping when she and E5 came back to tell him that he was being placed on Administrative Leave. E6 stated that he did have his eyes closed, but was processing what occurred. E6 stated that he was just thinking about what happened.</p> <p>During an interview with E1 on 9/14/16 at 3:00pm, E1 was informed that E4 told this writer that on the morning of 9/5/16, when both E4 and E5 went to tell E6 that he was being placed on Administrative Leave for allegedly slapping R1 on the right cheek, E6 had his eyes closed and appeared to be sleeping. E1 was made aware that E4 did not write this in her statement, but that E5 could verify that E6 was in fact sleeping. E1 stated that she was not aware about this allegation, and that she was going to immediately place E6 back on Administrative Leave. E1 was also made aware that E4 did not tell E1 or anyone in management about E6 sleeping, because in the past, when she has saw someone sleeping on the job, and she reported it, nothing happened as a consequence, so she just stopped reporting this going forward. E4 did not provide any</p>	W 154			

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W 154	<p>Continued From page 26</p> <p>specifics as to who or when this occurred. E1 was made aware of this allegation as well. E1 denied E4's statement, and said that if someone would report that staff was sleeping on the job, she would investigate that allegation, and it would be addressed.</p> <p>During an interview with E5(Qualified Intellectual Disability Professional) on 9/15/16 at 10:55am, E5 stated that when she arrived at work that day, E4 approached her as she was walking in the door, and told her that she needed to discuss something with her. E5 stated that E4 told her she saw E6 slap R1 on the right cheek. E5 asked her if this was reported to E1 yet. E4 replied she had not called her, so E5 told E4 that she needed to report this immediately. E5 stated that she thought this occurred at around 9:05 or 9:10, but she really can't be sure, because she does not remember looking at the clock when E4 reported this to her. E5 stated that E1 told E4 that they needed to place E6 on Administrative Leave immediately, so E5 asked E4 where E6 currently was in the building. E5 stated that E4 told her that she witnessed the abuse in R1's bedroom,(but E4 and E6 all verified that the alleged abuse occurred in the TV room of the Red Hall). E5 stated that E4 told her he was still in the TV room with R1. E5 stated that she could not believe that E4 would leave E6 in the facility where he was with R1 and other clients, as he could potentially abuse someone else. E5 knew she needed to remove E6 immediately from the facility, and away from the clients, so she, along with E4 asked him to come with him to the conference room(which is locked, and away from other clients). E5 was asked if E6 was sleeping when she entered the TV room with E4. E5 stated that she cannot be sure, but his eyes were</p>	W 154			

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W 154	Continued From page 27 closed, and she called his name a couple of times before he opened them(his eyes). E5 was asked if R1 was still in the room that E6 was sitting in with his eyes closed. E5 stated that she could not be sure if R1 was still in that room, but that many other clients were in that room with E6. E5 was asked why she did not include that she witnessed E6 with his eyes closed in her personal statement. E5 stated that she did mention that. This writer showed her the report, which had her personal statement included in that specific report. E5 confirmed that was part of her statement, but that the statement she authored was much longer and more detailed. E5 went to retrieve her statement, and it did in fact include that she witnessed E6 with his eyes closed. It also included information of E6 being persistent in obtaining his charger for his phone before he left, even though it had just been explained to him that he needed to leave the building, and have no further contact with any other clients or staff in the building. E5 explained that E6 would not listen, and proceeded to retrieve his own charger. E5 stated she followed him, and stood between him and any other clients who came into close contact with E6. E5 stated at one point he started to talk with another staff member, and attempted to explain to that person that he was being accused of hitting R1, and E5 had to again be very firm with E6, and escorted him out of the building, explaining yet again that he is not allowed to discuss this situation with any staff members who work at this facility. E5 was asked why she did not report this information when she was interviewed during this investigative process. E5 stated that no one asked to interview her. E5 stated that she was just asked to give a statement.	W 154			

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W 154	Continued From page 28 During an interview with E3 on 9/15/16 at 2:00pm, E3 was asked if he was the staff member who authored and investigated the allegation of physical abuse towards R1 on 9/5/16. E3 confirmed that he was. E3 was informed that E5 presented to this writer a much longer version of her statement than what was included in his investigation, and was asked why he omitted the allegation that E6 was found sleeping in the TV room. E3 stated that he did not think that information was relevant to what he was investigating. E3 stated that he asked E6 about it when he interview him, and he said he was just shocked about what was happening, and denied he was sleeping. So for that reason, he did not include this in his report. E3 was asked if he realized that the incident report indicates R1 was slapped on his left cheek, yet all of the statements report the right cheek. E3 stated that he did not determine that fact. E3 was asked if he realized that the times reported by E4 and E5 do not match, and that E6 was left alone for a period of 5-10 minutes with R1 and other clients from the time he was witnessed slapping R1, until he was escorted out of the building, after being placed on Administrative Leave. E3 stated that he did not realize that fact either. E3 was asked if he determined that E5 thought the alleged abuse occurred in R1's room, while E4 reported that the abuse occurred in the Red Hall TV room. E3 stated that he must have missed that fact as well. E3 was asked if he interviewed anyone either than E6. E3 stated that in the past, while he was investigating allegations of abuse and neglect, if he determined an allegation to be substantiated, he would be asked by the reviewing committee for statements. E3 stated that going forward, he now asks for statements only, and rarely interviews, unless he feels he needs an additional	W 154			

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W 154	Continued From page 29 explanation. E3 was asked why he did not include in his investigation, that E6 did not immediately leave the building, and insisted that he go back by the clients, to obtain his charger, when E5 instructed him to leave the building. E3 stated he does not know why he did not add that to his investigation. E3 stated that this is just so hard, when its one staff alleging abuse against another staff, and there are no witnesses. E3 stated that E6 denied he hit R1 hard, but rather tapped him, so that is why he did not substantiate it as abuse.	W 154			
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must prevent further potential abuse while the investigation is in progress.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure prevention of further potential abuse was implemented after 1 of 1 allegation of abuse was witnessed, involving R1. Nursing staff allowed the alleged abuser to remain within contact of R1 and other potential clients for 5-10 minutes after the alleged abuse was witnessed.  Findings include:  The Injury Report for R1, dated and timed 9/5/16 at 9:30am was reviewed. It states that the author of the report(E4, Registered Nurse) walked into the Red hall TV room, and upon entering the room witnessed a staff member, E6(Direct Care Staff) reach out and slap R1 on his left side of his face/upper body. R1 was assessed, and has no bruising, discoloration or signs of injury. Facial expressions and movement are at baseline.	W 155			

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W 155	<p>Continued From page 30</p> <p>Staff(E6) was placed on Administrative leave.</p> <p>The Summary of the Incident Report for R1, authored by E3(Quality Assurance Facilitator), was reviewed. This report is dated 9/9/16. The summary reads, but is not limited to, "On September 5th, 2016 a nurse at this facility(E4) alleged that E6, Direct Care Professional slapped R1 on the left side of his face/upper body...</p> <p>E4(Registered Nurse), made the allegation against E6 and provided the following statement on 9/5/16.</p> <p>* At approximately 9:30am this morning, I walked into the Red Hall's TV room and saw a staff member reach out and slap the right side of R1's face/upper body. It happened quickly, and I was unable to say for certain at the time if contact was made with the face or body. I immediately said, "Don't do that", and the staff(E6) responded with, "I'm sorry, I'm sorry."</p> <p>* I spoke with the Q(Qualified Intellectual Disability Professional), E5, and the Administrator(E1) was notified. The staff wrote a statement and signed the Administrative leave form and was placed on administrative leave effective immediately. While E5 and I(E4) explained the procedure to the staff member, he confirmed that it was the right side of the client's face where the contact was made.</p> <p>E5, QIDP, the following was included in her statement provided on 9/6/16:</p> <p>* On Monday, September 5, 2016, I arrived at work at approximately 9:05am. E4, a nurse at the facility saw me and asked if I could come into the nursing office as she needed to speak with me. E7(Shift Supervisor) went into the office as well. E4 proceeded to tell us that upon entering R1's</p>	W 155			

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W 155	<p>Continued From page 31</p> <p>room a few minutes prior to my arrival, she witnessed E6 slap R1 on the cheek. I asked her if she had contacted E1 or E8(Assistant Administrator) and she stated that she had not done so yet. I told her that we needed to get in contact with E1 right away. When E4 got off the phone, she stated that E1 wanted E6 placed on Administrative Leave effective immediately.</p> <p>* Once the three of us were seated(E4,E5,E6), I informed E6 that I was placing him on Administrative Leave due to an allegation of abuse to a client, R1, that was reported to me by E4. I explained that it was told to me that E4 witnessed E6 slap R1 on the cheek. I attempted to speak about what it meant to be on Administrative Leave when E6 interrupted and said the following, "No, no, please do not do this. I am so sorry, I can't lose my job, I just got it back three weeks ago. I promise I did not hit hard, it was a gentle slap, more like a tap, please."....I explained that this is a formal procedure and that an investigation would be taking place....I asked him if he understood everything I had said. He stated that he did and said, "I know what I did was wrong, and I am so sorry, I just gave him a tap on the cheek." I asked E6 at that time if he would place his statement in writing.</p> <p>E6 provided the following written statement to QIDP, E5 and nurse, E4 on 9/5/16:</p> <p>* At about 9:25am, a client R1, drank from a bottle by a staff. I gave him a gentle tap on his cheek to admonish him. The nurse on duty(E4) said I should not have done that. I was sorry about that.</p> <p>E3, Quality Assurance Facilitator interviewed E6 on 9/7/16. The reason for the interview was explained. E6 confirmed that he, R1 and E4 were</p>	W 155			



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W 155	<p>Continued From page 32</p> <p>the only witnesses of this incident that occurred in the Red TV room. E6 provided the following written statement:</p> <p>* At about 9:25am on the 5th day of September 2016, I was working in the red hall of the facility. After breakfast, I went into the TV room where clients relaxed. I saw R1 drinking from a bottle with a blue content. I was alarmed as blue is an uncommon color for juices. I took the bottle from him. I sat down to read the content of the bottle and found that it was a good drink, and not something that could harm him. Then I touched his cheek to get his attention to listen to me. Then I pointed to the bottle and made a side by swipe to signify, "no" to R1.</p> <p>* It was at this point that I touched his cheek that the nurse on duty came in and said that I should not have done that. I said I was sorry if it was inappropriate. But I'm stating in no uncertain terms that I meant no harm or abuse to R1. I could not have tried to save him from drinking what I thought was unsafe, and turned around to abuse him.</p> <p>Due to this incident occurring in the Red Hall Living (TV) Room, video surveillance is not available.</p> <p>Conclusion/Summary: Based on information gathered, the allegation of abuse made against E6 is unsubstantiated...The nurse stated in written form that it happened so quickly and that she was unable to say for certain if contact was made to the face or body. The nurse that made the allegation of physical abuse assessed R1 and no injuries were found.</p> <p>This investigation is concluding that E6's intervention strategy was not an approved</p>	W 155			

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W 155	<p>Continued From page 33</p> <p>method, but was not abusive. E6 will be retrained on proper redirection and intervention strategies."</p> <p>E4 was interviewed on 9/14/16 at 2:30pm. E4 confirmed that she was the staff nurse who witnessed R6 slap R1 on 9/5/16. E4 was asked if she could summarize what she witnessed that morning on 9/5/16. E4 stated she walked into the Red hall TV room just as she witnessed E6 slap R1 on his right cheek with his left hand. E4 stated it was a hard hit, and she told E6 not to hit R1. E4 stated she then left the TV room, and told the other nurse working with her that day what she had just witnessed. E4 explained that she really did not know exactly what to do, and was asking her co-worker for guidance. E4 stated that her co-worker really did not know what to do either, so she then went toward the entrance wing of the facility, and saw the shift supervisor. E4 stated that E7(Shift supervisor) really was not exactly sure what paperwork needed to be obtained, so it was at this time that E5 entered the building and she told E5 what she had witnessed. E5 guided her through the process, and asked her if she had called E1 yet. E4 stated that she had not, so they proceeded to look for the proper paper work and called E1. E4 explained that E1 instructed her to place E6 on Administrative Leave, and make sure he leaves the building. E4 stated that it was probably 5-10 minutes from the time she witnessed the abuse, until the time they told E6 that he was being placed on administrative leave. E4 confirmed that she left E6 alone in the TV room, with R1 during that 5-10 minutes time frame, and realizes now that she should have removed R1 from the situation, and made sure E6 was away from any clients after she witnessed that abuse. E4 stated that she felt uncomfortable telling E6 that he</p>	W 155			

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W 155	<p>Continued From page 34</p> <p>needed to leave, even though she knew that was what she was required to do.</p> <p>During an interview with E5(Qualified Intellectual Disability Professional) on 9/15/16 at 10:55am, E5 stated that when she arrived at work that day, E4 approached her as she was walking in the door, and told her that she needed to discuss something with her. E5 stated that E4 told her she saw E6 slap R1 on the right cheek. E5 asked her if this was reported to E1 yet. E4 replied she had not called her, so E5 told E4 that she needed to report this immediately. E5 stated that she thought this occurred at around 9:05 or 9:10, but she really can't be sure, because she does not remember looking at the clock when E4 reported this to her. E5 stated that E1 told E4 that they needed to place E6 on Administrative Leave immediately, so E5 asked E4 where E6 currently was in the building. E5 stated that E4 told her he was still in the TV room with R1. E5 stated that she could not believe that E4 would leave E6 in the facility where he was with R1 and other clients, as he could potentially abuse someone else. E5 knew she needed to remove E6 immediately from the facility, and away from the clients, so she, along with E4 asked him to come with him to the conference room(which is locked, and away from other clients).</p> <p>During an interview with E3 on 9/15/16 at 2:00pm,E3 was asked if he was the staff member who authored and investigated the allegation of physical abuse towards R1 on 9/5/16. E3 confirmed that he was. E3 was asked if nursing had been retrained, as E4 was late reporting the alleged abuse immediately to the Administrator, as well as did not remove E6 from R1 and other clients, to protect other clients from potential</p>	W 155			

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W 157	<p>abuse. E3 stated that the nursing staff has not been retrained.</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure appropriate corrective action was implemented, after 1 of 1 allegation of abuse was witnessed, involving R1.</p> <p>Findings include:</p> <p>The Injury Report for R1, dated and timed 9/5/16 at 9:30am was reviewed. It states that the author of the report(E4, Registered Nurse) walked into the Red hall TV room, and upon entering the room witnessed a staff member, E6(Direct Care Staff) reach out and slap R1 on his left side of his face/upper body. R1 was assessed, and has no bruising, discoloration or signs of injury. Facial expressions and movement are at baseline. Staff(E6) was placed on Administrative leave.</p> <p>The Summary of the Incident Report for R1, authored by E3(Quality Assurance Facilitator), was reviewed. This report is dated 9/9/16. The summary reads, but is not limited to, "On September 5th, 2016 a nurse at this facility(E4) alleged that E6, Direct Care Professional slapped R1 on the left side of his face/upper body...</p> <p>E4(Registered Nurse), made the allegation against E6 and provided the following statement on 9/5/16.</p>	W 157			

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W 157	<p>Continued From page 36</p> <p>* At approximately 9:30am this morning, I walked into the Red Hall's TV room and saw a staff member reach out and slap the right side of R1's face/upper body. It happened quickly, and I was unable to say for certain at the time if contact was made with the face or body. I immediately said, "Don't do that", and the staff(E6) responded with, "I'm sorry, I'm sorry."</p> <p>* I spoke with the Q(Qualified Intellectual Disability Professional), E5, and the Administrator(E1) was notified. The staff wrote a statement and signed the Administrative leave form and was placed on administrative leave effective immediately. While E5 and I(E4) explained the procedure to the staff member, he confirmed that it was the right side of the client's face where the contact was made.</p> <p>E5, QIDP, the following was included in her statement provided on 9/6/16:</p> <p>* On Monday, September 5, 2016, I arrived at work at approximately 9:05am. E4, a nurse at the facility saw me and asked if I could come into the nursing office as she needed to speak with me. E7(Shift Supervisor) went into the office as well. E4 proceeded to tell us that upon entering R1's room a few minutes prior to my arrival, she witnessed E6 slap R1 on the cheek. I asked her if she had contacted E1 or E8(Assistant Administrator) and she stated that she had not done so yet. I told her that we needed to get in contact with E1 right away. When E4 got off the phone, she stated that E1 wanted E6 placed on Administrative Leave effective immediately.</p> <p>* Once the three of us were seated(E4,E5,E6), I informed E6 that I was placing him on Administrative Leave due to an allegation of abuse to a client, R1, that was reported to me by E4. I explained that it was told to me that E4</p>	W 157			

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W 157	<p>Continued From page 37</p> <p>witnessed E6 slap R1 on the cheek. I attempted to speak about what it meant to be on Administrative Leave when E6 interrupted and said the following, "No, no, please do not do this. I am so sorry, I can't lose my job, I just got it back three weeks ago. I promise I did not hit hard, it was a gentle slap, more like a tap, please."....I explained that this is a formal procedure and that an investigation would be taking place....I asked him if he understood everything I had said. He stated that he did and said, "I know what I did was wrong, and I am so sorry, I just gave him a tap on the cheek." I asked E6 at that time if he would place his statement in writing.</p> <p>E6 provided the following written statement to QIDP, E5 and nurse, E4 on 9/5/16:</p> <p>* At about 9:25am, a client R1, drank from a bottle by a staff. I gave him a gentle tap on his cheek to admonish him. The nurse on duty(E4) said I should not have done that. I was sorry about that.</p> <p>E3, Quality Assurance Facilitator interviewed E6 on 9/7/16. The reason for the interview was explained. E6 confirmed that he, R1 and E4 were the only witnesses of this incident that occurred in the Red TV room. E6 provided the following written statement:</p> <p>* At about 9:25am on the 5th day of September 2016, I was working in the red hall of the facility. After breakfast, I went into the TV room where clients relaxed. I saw R1 drinking from a bottle with a blue content. I was alarmed as blue is an uncommon color for juices. I took the bottle from him. I sat down to read the content of the bottle and found that it was a good drink, and not something that could harm him. Then I touched his cheek to get his attention to listen to me.</p>	W 157			

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W 157	<p>Continued From page 38</p> <p>Then I pointed to the bottle and made a side by swipe to signify, "no" to R1.</p> <p>* It was at this point that I touched his cheek that the nurse on duty came in and said that I should not have done that. I said I was sorry if it was inappropriate. But I'm stating in no uncertain terms that I meant no harm or abuse to R1. I could not have tried to save him from drinking what I thought was unsafe, and turned around to abuse him.</p> <p>Due to this incident occurring in the Red Hall Living (TV) Room, video surveillance is not available.</p> <p>Conclusion/Summary: Based on information gathered, the allegation of abuse made against E6 is unsubstantiated...The nurse stated in written form that it happened so quickly and that she was unable to say for certain if contact was made to the face or body. The nurse that made the allegation of physical abuse assessed R1 and no injuries were found.</p> <p>This investigation is concluding that E6's intervention strategy was not an approved method, but was not abusive. E6 will be retrained on proper redirection and intervention strategies."</p> <p>E4 was interviewed on 9/14/16 at 2:30pm. E4 confirmed that she was the staff nurse who witnessed R6 slap R1 on 9/5/16. E4 asked if she could summarize what she witnessed that morning on 9/5/16. E4 stated she walked into the Red Hall TV room just as she witnessed E6 slap R1 on his right cheek with his left hand. E4 stated it was a hard hit, and she told E6 not to hit R1. E4 stated she then left the TV room, and told the other nurse working with her that day what</p>	W 157			

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W 157	Continued From page 39 she had just witnessed. E4 explained that she really did not know exactly what to do, and was asking her co-worker for guidance. E4 stated that her co-worker really did not know what to do either, so she then went toward the entrance wing of the facility, and saw the shift supervisor. E4 stated that E7(Shift supervisor) really was not exactly sure what paperwork needed to be obtained, so it was at this time that E5 entered the building and she told E5 what she had witnessed. E5 guided her through the process, and asked her if she had called E1 yet. E4 stated that she had not, so they proceeded to look for the proper paper work and called E1. E4 explained that E1 instructed her to place E6 on Administrative Leave, and make sure he leaves the building. E4 stated that it was probably 5-10 minutes from the time she witnessed the abuse, until the time they told E6 that he was being placed on administrative leave. E4 confirmed that she left E6 alone in the TV room, with R1 during that 5-10 minutes time frame, and realizes now that she should have removed R1 from the situation, and made sure E6 was away from any clients after she witnessed that abuse. E4 stated that she felt uncomfortable telling E6 that he needed to leave, even though she knew that was what she was required to do. E4 stated that they(Administration) let E6 come back to work the following weekend, and she is shocked that they would let someone work here after he had abused a client. E4 stated that she realizes that she reported the abuse late, and didn't remove E6 immediately from R1 and the other residents in the facility, and is very sorry about that. E4 stated that E6 has been working again, and she doesn't think that the facility has even re-trained him on the Abuse and Neglect policy.	W 157			



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W 157	<p>Continued From page 40</p> <p>During an interview with E6 on 9/14/16 at 2:45pm, E6 was asked if he could provide a detailed summary about what occurred on the morning of 9/5/16, when he was placed on Administrative Leave. E6 stated that he was not officially assigned to care for R1 that morning, but when he came into the Red Hall TV room, he saw R1 drinking from a bottle that had blue liquid in it. E6 explained that R1 has a behavior of drinking any drink he can find, whether it is his drink or someone else's. E6 stated that he thought it was a chemical, and when he saw that he had already started drinking it, he immediately grabbed the bottle from his hand, and reviewed what it was that he was actually drinking. E6 stated that when he realized it was an energy drink, and not a chemical of some kind, he went over to R1. At that time R1 was looking away from him, and wanted to make sure he(R1) understood he should not drink liquids that did not belong to him. E6 stated that he touched him with his finger on his right cheek. E6 was asked if R1 was deaf, or blind. E6 stated that he is neither, but just wanted to make sure he had his attention. E6 stated that he wanted him to look at him. E6 was asked if anyone trained him, after the investigation was completed, and he was allowed to return to work. E6 stated that no one retrained him. E6 stated that he came back to work the Saturday after the incident occurred,(9/10/16) and has been working every day up until today, and after this interview, will also work the evening shift.</p> <p>During an interview with E5(Qualified Intellectual Disability Professional) on 9/15/16 at 10:55am, E5 stated that when she arrived at work that day, E4 approached her as she was walking in the door, and told her that she needed to discuss something with her. E5 stated that E4 told her</p>	W 157			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARBROOK CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3201 WEST CAMPBELL STREET</b> <b>ROLLING MEADOWS, IL 60008</b>		
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W 157	<p>Continued From page 41</p> <p>she saw E6 slap R1 on the right cheek. E5 asked her if this was reported to E1 yet. E4 replied she had not called her, so E5 told E4 that she needed to report this immediately. E5 stated that she thought this occurred at around 9:05 or 9:10, but she really can't be sure, because she does not remember looking at the clock when E4 reported this to her. E5 stated that E1 told E4 that they needed to place E6 on Administrative Leave immediately, so E5 asked E4 where E6 currently was in the building. E5 stated that E4 told her he was still in the TV room with R1. E5 stated that she could not believe that E4 would leave E6 in the facility where he was with R1 and other clients, as he could potentially abuse someone else. E5 knew she needed to remove E6 immediately from the facility, and away from the clients, so she, along with E4 asked him to come with him to the conference room(which is locked, and away from other clients).</p> <p>During an interview with E3 on 9/15/16 at 2:00pm,E3 was asked if he was the staff member who authored and investigated the allegation of physical abuse towards R1 on 9/5/16. E3 confirmed that he was. E3 was asked if E6 was retrained prior to returning to work on Saturday, 9/10/16. E3 explained that when he completed his investigation, and E1 signed off on it, E1 informed him that they wanted to get E6 back on the schedule by the end of the week. E3 explained that they are short staffed, especially on the weekends, so they needed to get E6 back out onto the floor to work. E3 stated that he asked E1 if some training should be done before he returns to work, and E1 stated yes. E3 stated that normally it is not his job to retrain, so he was trying to put some information together for his retraining, but confirmed that to date, E6 has not</p>	W 157			

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W 157	Continued From page 42 been retrained on abuse and neglect. E3 was asked if nursing had been retrained, as E4 was late reporting the alleged abuse immediately to the Administrator, as well as did not remove E6 from R1 and other clients, to protect other clients from potential abuse. E3 stated that the nursing staff has not been retrained.	W 157			