| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14G140 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HIGHVIEW TERRACE | 409 NORTH HIGH STREET PARIS, IL 61944 |

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| W 000 | INITIAL COMMENTS<br><br>ANNUAL CERTIFICATION - FUNDAMENTAL<br><br>INSPECTION OF CARE | W 000 | | |
| W 104 | 483.410(a)(1) GOVERNING BODY<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure a system that provides for safe transport of individuals to and from the day training site, for 16 of 16 individuals of the facility (R's 1-16).<br><br>Findings include:<br><br>1. In review of an undated facility roster that validates level of functioning, There are 16 individuals who reside at this facility. R's 1 & 12 function in the mild range of mental retardation; R's 2, 3, 6, 8, 10, 11, 13, 14 & 16 function in the moderate range of mental retardation; R's 4, 5, 7, 9 and 15 function in the severe range of mental retardation.<br><br>Per observation, R5 requires a walker, gait belt and staff assist for all ambulation.<br><br>R14 (observations on 11/15/11, at 10:50 a.m., at the day training site), is ambulatory and wears a helmet.<br>Interview with E2 (Residential Services Director/Qualified Mental Retardation Professional - RSD/QMRP) on 11/15/11, at 1:30 | W 104 | | 12/16/11 |

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 104 | Continued From page 1<br>p.m., confirmed that R14's seizures are not totally controlled, and the helmet is for his safety during seizures.<br><br>R2 (per his 8/1/11 behavior management program), has a history of inappropriate sexual touch and has a formal staff monitoring system at the day training site and the facility. Per the program, R2 is not to sit next to female consumers in any day training setting. At the facility, R2 is not to sit on the sofas next to female individuals, and is to be monitored by staff when he goes to the women's end of the facility, where the laundry area is located.<br><br>In an interview with E2, on 11/17/11, at 10:10 a.m., E2 stated that the day training site has recently contracted with a local mass transit system, to provide transportation of residents to and from the day training site. E2 further stated that the only staff on the bus is the bus driver, that no staff from the day training site or facility accompany individuals on the transport. When asked, E2 stated that he was not aware of how the day training site was assuring the safety of individuals regarding seizures, behaviors and other possible transportation issues that might negatively impact individuals during transport.<br><br>E2 did call the day training site and obtained a copy of the day training's agreement with the mass transit system, on this same day. | W 104 | | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS<br><br>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 or to other | W 153 | | 11/23/11 |

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| W 153 | Continued From page 2<br>officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure a thorough investigation of R2's inappropriate touching behavior's, for 1 of 1 in the sample, who has a formal behavior management program for inappropriate sexual behavior (R2).<br><br>Findings include:<br><br>1. In review of R2's 7/18/11 Individual Service Plan (ISP), R2 functions in the moderate range of mental retardation. His 7/18/11 Scales of Independent Behavior-Revised (SIB-R), documents an overall functioning level of 8 years and 9 months.<br><br>During observations at the day training site on 11/15/11, at 10:45 a.m., R2 is independently ambulatory.<br><br>A "Mental Health Assessment Progress Note" dated 1/22/08 documents that R2 had anal intercourse with a female resident at another residential facility on 2007; and an incident of exposing his penis and inappropriate touch under clothing touch of another female consumer, at the day training site in 2008.<br><br>In review of 8/11 "QMRP Summary/Program Progress Notes", R2 had two occurrences of touching at the day training site.<br><br>In review of a "Maladaptive/Adaptive Behavior Recording Form" for 8/11, there is a checkmark | W 153 | | |

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| W 153 | Continued From page 3 | W 153 | | |

for "inappropriate touching" on 8/9/11 and 8/10/11. No further information is documented on these two forms.

In an interview with E2 (Residential Services Director/Qualified Mental Retardation Professional - RSD/QMRP), on 11/16/11, at 4:30 p.m., E2 stated that the above "inappropriate touching" occurred at the day training site, and these forms were documented by day training staff. When asked, E2 stated that no further information had been provided by the day training site, and he could not remember anything about either incidents. E2 further confirmed that he had not followed up or further investigated for either incident. E2 then stated he would call the day training site and obtain further information.

On 11/17/11, surveyor was presented with case notes from the day training site regarding the above incidents. (Per review of the day training case notes, the 8/9/11 incidents, R2 grabbed another males arm due to this individual touching his articles. Per the 8/10/11 case notes, R2 was holding hands with a female consumer in the lunch room. (Per R2's 8/1/11 behavior support program, R2 is not to sit directly next to any female consumer in any areas of the facility).

In a 11/17/11, 12:00 p.m. interview with E2, E2 confirmed that the following incidents at the day training site had not been further investigated by the facility:

- 5/27/11, 12:25 p.m. - R2 rubbing (consumer) down her right arm, was redirected and refused to move.
- 3/25/11, 2:40 p.m. - R2 was leaning over the seat in front of a female consumer, helping her

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| W 153 | Continued From page 4<br>with her seat belt. (In the same above interview, E2 stated he did not kino who the female was, but his "best guess" was that it was R7). | W 153 | | |
| W 240 | 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN<br><br>The individual program plan must describe relevant interventions to support the individual toward independence.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure monitoring during transportation, for 1 of 1 individual in the sample, who has a formal monitoring program at the facility and day training site, as related to his inappropriate sexual behavior (R2).<br><br>Findings include:<br><br>1. In review of R2's 7/18/11 Individual Service Plan (ISP), R2 functions in the moderate range of mental retardation. His 7/18/11 Scales of Independent Behavior-Revised (SIB-R), documents an overall functioning level of 8 years and 9 months.<br><br>During observations at the day training site on 11/15/11, at 10:45 a.m., R2 is independently ambulatory.<br><br>A "Mental Health Assessment Progress Note" dated 1/22/08 documents that R2 had anal intercourse with a female resident at another residential facility on 2007; and an incident of exposing his penis and inappropriate touch under clothing touch of another female consumer, at the day training site in 2008. | W 240 | | 12/16/11 |

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| W 240 | Continued From page 5<br><br>R2 has an 9/1/11 "Behavior Program Form" that identifies and addresses R2's inappropriate sexual expression. Per this program, while at the day training site, R2 is escorted from one area to another to ensure that inappropriate touch of other consumers does not occur. Additionally, R2 is not to sit directly next to any female consumers in the classrooms, production or lunch/break area, or other areas of the day training.<br><br>At the facility, staff are to monitor R2's access to written and video material which may lead him to sexual arousal and subsequent acting out. Staff are to be aware of R2's location in the facility at all times, and ensure that R2 is not in the laundry area, (which is located on the women's end of the building), without staff. Additionally, R2 is not to sit next to a female resident while on the sofa.<br><br>In review of this program, there is no evidence of a level of supervision for R2 during his transport to and from the day training site, or during transportation outings of any kind.<br><br>In an interview with E3 (Administrator), on 11/17/11, at 1:28 p.m., E3 confirmed that R2's 9/1/11 behavior support program does not address his level of supervision during transportation times. | W 240 | | |
| W 369 | 483.460(k)(2) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is not met as evidenced by: | W 369 | | 11/17/11 |

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| W 369 | Continued From page 6 | W 369 | | |

Based on observation, record review and interview, the facility failed to ensure that physician ordered medications are administered without error, for 1 of 13 individuals who received medications at the 11/15/11 p.m. medication administration (R5).

Findings include:

1. In review of R5's 9/11 physician's orders, R5 functions in the moderate range of mental retardation and receives Alphagan .1% Solution , one drop in both eyes two times daily for Glaucoma (7 a.m. & 5 p.m.).

On 11/15/11, at 3:00 p.m., 4:0 p.m. and 5:15 p.m., the medication administration was monitored by E1 (Direct Service Person - DSP).

R5 received physician ordered medications at 3:00 p.m., 4:00 p.m. and again at 5:15 p.m. R5 did not receive her physician ordered Alphagan during any of the above medication administration times.

At 5:24 p.m., after R6 received his physician ordered medications, E1 stated that the medication pass was completed.

At 5:30 p.m., supper was announced and individuals began their p.m. meal.

At 6:02 p.m., surveyor asked to speak with E2 (Residential Services Director/Qualified Mental Retardation Professional - RSD/QMRP), in the medication room. E2, at this time (6:02 p.m. on 11/15/11), confirmed that there was no documentation for having administered R5's Alphagan. E1 entered the medication room,

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| W 369 | Continued From page 7<br>stating she would give R5 her Alphagan. R5 was called to the medication room and received her Alphagan. | W 369 | | |