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	14G237	A. BUILDING _____ B. WING _____	11/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNT TERRACE	1180 SOUTH FOURTH STREET KANKAKEE, IL 60901

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W 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY INSPECTION OF CARE SURVEY	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the governing body failed to develop and implement a system which resulted in the facility being clean and well maintained as evidenced by the significant amounts of built in subsurface dirt present in areas used for bathing and throughout the floors in the kitchen area. This affected all 13 individuals living in the facility (R1 through R13). Findings include: Observations were made on 11/9/15 from 11:30am to 6:00pm and again on 11/10/15 from 11:30am to 3:00pm of built in dirt throughout the dining room floor. The dining room is an area where individuals R1 through R13 were observed to convene for active treatment, leisure time, snacks, and meals. Observations were made on 11/10/15 at 2:00pm of 1(bathroom A) of 2 bathrooms on the women side. The bathtub which also is used as a shower for R2, R3, R4, R6, R7, R11, R12, and R13 had an area that had dried plaster 8 inches by 10 inches covering the inner side of the bathtub. The bathtub also had dirt that appeared to be housed	W 104		

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

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W 104	Continued From page 1 beneath the surface. The plastered area was had an uneven elevated surface. Observation was made at the same time of the bathtub in bathroom 1(bathroom A) of 2 had dirt that appeared to be housed beneath the surface all around the tub. An interview with E4, Direct Support staff at the time of the observations confirmed the findings and when asked why was the plaster on the tub in the women's side, she stated it was covering a crack and asked how long has it been like that, E4 answered "for months." The above findings were also shared with the Acting Administrator, E1 at 2:30pm on 11/1/15	W 104		
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 conduct a thorough investigation of an individual (R1) who experienced 7 inpatient psychiatric hospitalizations after acts of physical aggression against staff and other individuals who live in the home. This failure potentially affected all individuals served (R2 through R13.) Findings include: Facility policy titled Physical Injury and Illness/Individual Medical Emergencies, policy number 5.57 H. states, "The Quality/Administrator shall conduct any necessary	W 154		

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W 154	Continued From page 2	W 154		

interviews or inquiries to establish the probable cause of the injury and documents the finding on the progress note (form #GP-15). and J. states "The Quality Intellectual Disability Professional will transfer any pertinent information from the progress note (form #GP-15) about the incident onto the Quality Assurance Meeting."

Facility policy titled Investigation Committee number 5.24 states, "The Investigation committee shall be responsible for the following; C. "To protect individuals from harm." and A. "Any home employee or agent who witnesses or suspects a violation of individuals rights, peer to peer " " shall immediately" "use the following protocol" E. "The committee members shall meet to review allegations, conduct interviews and examine the information available that is pertinent to the incident."

Facility Incident reports were reviewed on 11/9/15 and 11/10/15. The incidents were as follows:

1/9/15, R1 started throwing items in the home then scratched and pushed a Direct Support Person, 911 was called and R1 was admitted to the hospital.

1/19/15, review of a progress note/GP-15 states R1 walked in telling staff to give him his medicine. staff asked him to wait for his medication. R1 finished then threw items and attacked staff. The incident failed to show evidence that the facility conducted an investigation.

2/2/15, A letter to Illinois Department of Public Health states R1 threatened to harm himself, other residents and staff, 911 was called and R1 was admitted to hospital. The incident failed to

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W 154	Continued From page 3 have evidence that an incident report was written or that the facility investigated. 2/18/15, a note without title but a bottom of note states "sent from my iphone" states, "update on R1, he is being admitted and he did break a table lamp at the facility trying to throe it at staff/residents, when he grabbed the lamp he hit himself in the face and broke his glasses. His newest behavior is getting in the face of other residents and yelling at them that they stole his what ever." A document titled "safety committee" dated 2/18/15 failed to include staff interviews, whether or not R1 or other clients in the home sustained injuries as a result of the incident. The resolution on the same document states, "Remind R1 to identify indicators of aggressive tendencies or triggers to negative behaviors patterns and to address staff when these triggers are present so that he can utilize healthy and effective coping strategies to safely handle negative emotions." 5/10/15, Progress note/GP-15 states R1 hit, spit, cursed, pulled staff hair, threw printer, lamp on floor threatened to hit everyone in the house, 911 was called and R1 was hospitalized. The incident lacked evidence that an investigation was conducted 6/2/15, R1 displayed physical aggression to staff, 911 was called and R1 was hospitalized. The facility failed to show evidence that an investigation was conducted. 8/2/15, R1 was admitted to in patient psychiatric unit after throwing objects, hit a female staff in the head, spit in the face of the police officer, and pulled the fire alarm.	W 154		

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W 154	Continued From page 4 8/26/15, peer to peer incident, R4 was aggressive to R3. 8/31/15, peer to peer incident, R3 was aggressive to R4. A survey entrance interview was conducted with E2, QIDP and E3, Regional Trainer on 11/9/15 at 11:35am, E2 was asked to submit allegations of abuse neglect, incidents that are reportable to Illinois Department of Public Health. The surveyor received only partial information of incidents that occurred to individuals that lived in the home, example of the 7 hospitalizations involving R1, only 2 incident reports were given. On day two of the survey (11/10/15) the staff E2 and now E1, Acting Administrator were not able to present evidence of investigation of 9 of 9 incidents reviewed. Interview on 11/10/15 at 2:30pm with E1, Acting Administrator confirmed the above incomplete investigations of the above 9 incidents.	W 154		
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility did not assure program plans were monitored by a Qualified Intellectual Disability Professional who made plan revisions based on behavior data collected from all staff who serve the individual. The facility did not assure plans were amended and revised as individuals served experienced significant events such as in-patient psychiatric	W 159		

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W 159	Continued From page 5 hospitalizations. This affected 2 of 2(R1 and R4) individual in the sample. Findings include: Facility policy titled Physical Injury and Illness/Individual Medical Emergencies, policy number 5.57 H. states, "The Quality/Administrator shall conduct any necessary interviews or inquiries to establish the probable cause of the injury and documents the finding on the progress note (form #GP-15). and J. states "The Quality Intellectual Disability Professional (QIDP) will transfer any pertinent information from the progress note (form #GP-15) about the incident onto the Quality Assurance Meeting." K. "Any follow-up action or medication prescribed by the physician shall be summarized in the monthly QIDP summary (form #GP-99) and in the nursing notes (form #GP-35). Record review for R1 states a 31 year old male with several diagnosis including Psychotic Disorder, Post Traumatic Stress Syndrome, Oppositional Defiance Disorder, Depressive Disorder, and Schizophrenic Disorder. He has a Broad Independence age of 10 years and 8 months and a Moderate intellectual level of functioning. R1 have a behavior program that requires tracking for physical and verbal aggression. The following incident reports were reviewed on 11/9/15 and 11/10/15 1/9/15, R1 started throwing items in the home	W 159		

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W 159	Continued From page 6	W 159		

then scratched and pushed a Direct Support Person, 911 was called and R1 was admitted to the hospital.

1/19/15, review of a progress note/GP-15 states R1 walked in telling staff to give him his medicine. staff asked him to wait for his medication. R1 finished then threw items and attacked staff. The incident failed to show evidence that the facility conducted an investigation.

2/2/15, A letter to Illinois Department of Public Health states R1 threatened to harm himself, other residents and staff, 911 was called and R1 was admitted to hospital. The incident failed to have evidence that an incident report was written or that the facility investigated.

2/18/15, a note without title but a bottom of note states "sent from my iphone" states, "update on R1, he is being admitted and he did break a table lamp at the facility trying to throe it at staff/residents, when he grabbed the lamp he hit himself in the face and broke his glasses. His newest behavior is getting in the face of other residents and yelling at them that they stole his what ever."
A document titled "safety committee" dated 2/18/15 failed to include staff interviews, whether or not R1 or other clients in the home sustained injuries as a result of the incident. The resolution on the same document states, "Remind R1 to identify indicators of aggressive tendencies or triggers to negative behaviors patterns and to address staff when these triggers are present so that he can utilize healthy and effective coping strategies to safely handle negative emotions."

5/10/15, Progress note/GP-15 states R1 hit, spit,

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W 159	Continued From page 7 cursed, pulled staff hair, threw printer, lamp on floor threatened to hit everyone in the house, 911 was called and R1 was hospitalized. The incident lacked evidence that an investigation was conducted 6/2/15, R1 displayed physical aggression to staff, 911 was called and R1 was hospitalized. The facility failed to show evidence that an investigation was conducted. 8/2/15, R1 was admitted to in patient psychiatric unit after throwing objects, hit a female staff in the head, spit in the face of the police officer, and pulled the fire alarm. 8/26/15, peer to peer incident, R4 was aggressive to R3. 8/31/15, peer to peer incident, R3 was aggressive to R4. Review of daytraining behavior tracking show R1 for August 2015 had 8 episodes of verbal aggression, September 2015 had 2 episodes of verbal aggression, and October 2015 had 2 episodes of verbal aggression and 1 act of physical aggression. Review of the monthly QIDP summary did not include this data from daytraining site. Review of the monthly QIDP summary for the month of July, August, and September do not mention any of the above significant occurrences for R1, R3, or R4. Review of R4's Individual Service Plan at the	W 159		

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W 159	Continued From page 8 daytraining site was dated 12/12/13. The current ISP at the facility is dated 12/19/14. An interview was conducted E2, Qualified Intellectual Disability Professional, QIDP on 11/10/15 at 12:00pm, E2 confirmed that R1's 7 inpatient psychiatric hospitalizations should have been part of the QIDP's monthly note as well as part of the Individual Service Plan. E2 also confirmed that behavior data from R1's daytraining site was not incorporated into R1's monthly behavior reports and therefore incorrect data was shared with R1's psychiatrist on his 9/1/15 or 10/13/15 visit. E2 states that the home " have a difficult time corresponding with them. They are suppose to send the data by the 5th of each month." E2 also confirmed that the daytraining site should have had R4's most current ISP.	W 159		
W 341	483.460(c)(5)(ii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to promote infection control techniques for clients sharing nail emory boards, nail polish, and nail clippers. This was observed for 1 of 1 (R11) out of the sample but have the potential to impacted all of the individuals living in the home	W 341		

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W 341	Continued From page 9 R1 through R10 and R12 and R13. Findings include: Observations were made on 11/9/15 at 3:50pm of R11 sitting at the dining room table preparing to polish her fingernails. She had a small green basket in front of her with 15 bottles of various colored fingernail polish . In the bottom of the basket were 3 used emery boards and a nail clipper. R11 selected the color nail polish she wanted from the basket and started to take the top off. An interview was conducted with E2, Qualified Intellectual disability Professional at the time of the finding. E2 confirmed the nail polish basket was a community basket and was shared by all the individuals. E2 also removed the used emory boards from the container. E2 states the nail polish basket is kept in the activity room.	W 341		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that evacuation drills were conducted at least quarterly. Findings include: Evacuation / Fire drills were reviewed for the past 12 months. Quarterly drills were missing for; First shift = second and third quarter in 2015.	W 440		

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W 440	Continued From page 10 This was confirmed by E3 (Facility Trainer) on 11/9/15 at 1pm.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to have two varied disaster drills per shift. Findings include: The drills were reviewed for the past 12 months. Only one varied disaster drill was run on the first shift. This was confirmed by E3 (Facility Trainer) on 11/10/15 at 1pm.	W 441		
W 487	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client receives enough food. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure individuals can access second helpings at meals. this was observed a for 1 of 1 (R5) individual outside of the sample who was not offered second helpings and the potential to affect all individuals served (R1 -R4 and R6 - R13). Findings include:	W 487		

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W 487	Continued From page 11 Observations were made of the dinner meal on 11/9/15 from 5pm to 6pm. The clients were served family style the following food items from the menu: Pot roast, gravy, roasted potatoes with onions and carrots, Harvard beets, bread, margarine, skim milk, and water. The diets listed for each individual were all regular diets except for R11 needed gluten free food. E5, cook placed a serving platter of the pot roast in 8 slices on table A and 8 slices to table B. E5 then placed a serving bowl of the potatoes table A which had 7 individuals (R3, R4, R5, R6, R10, R11, and R13) but the bowl of potatoes placed on table B was only one quarter filled. The surveyor asked E5 why did table B receive less than half the helpings of potatoes than table A and E5 states she had more potatoes that she would bring out. Table B had 6 (R1, R2, R7, R8, R9, and R12) individuals eating there. All 13 individuals served themselves independently. R2 scooped one serving spoon of potatoes and inserted spoon for a second serving when E6, Direct Support Person states, "That's enough R2" All clients ate their pot roast. At 5:25pm, the pot roast serving tray was empty on both tables. E5 was asked if there was more pot roast and she stated "yes, we have more." The pot roast was sitting on the kitchen counter on the side of the oven covered with foil paper and was not visible to the individuals. R5, is deaf per his Individual Service Plan dated 2015 and cannot communicate verbally was	W 487		

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W 487	Continued From page 12 observed to eat his food rapidly and carry his empty plate into the kitchen, when R5 turned to exit the kitchen, the surveyor asked the cook how would he know that there are seconds available if the clients cannot see the covered pot roast and is not offered to them. Surveyor communicated with R5 through sign language and asked if he wanted seconds as he left the dining area. R5 signed back yes and E5 then uncovered the roast and gave him more. Dinner completed at 5:45pm and none of the clients R1 - R13 were offered seconds. An interview was conducted with E5 at 5:40pm, E5 states the pot roast is discarded after the meal and that her training is that the clients at given a certain portion and unless they ask seconds are not offered. An interview with E2, Qualified Intellectual Disability Professional was conducted the same day at 5:50pm. E2 was not able to validate that second helpings were offered and states that if the individuals are on a special diet they cannot have seconds. E2 was reminded that none of the individuals R1 through R13 were on a special diet that would prevent them from offered seconds.	W 487		