

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

PRINTED: 04/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/03/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>DEARBORN COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>520 SOUTH DEARBORN STREET KANKAKEE, IL 60901</b>		
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W 000	INITIAL COMMENTS	W 000			
W 120	<p>INCIDENT REPORT INVESTIGATION SURVEY INCIDENT OF 3/16/15 #76049</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure that the day training site thoroughly investigate allegations of abuse . This affected 1 of 1 (R1) clients in the sample and 3 of 3 (R2, R4, and R5) outside of the sample.</p> <p>Findings include:</p> <p>Record review includes an Individual Service Plan dated 1/6/15, R1 is a 43 year old female with multiple diagnoses including Cerebral Palsy, Bipolar Disorder, Depression, Anxiety Disorder with Obsessive Compulsive Disorder, History of Seizures, and right hand deformity. R1 has a moderate level of intelligence ambulates independently using a helmet and knee pads. Intelligent Quotient is 39 and ICAP (Inventory for Client and Agency Planning) age of 3 years and 1 month.</p> <p>A document titled, "Progress Note form GP-15", dated 3/16/15 at 9:30pm written by E1 states "R2 came and told staff E1 and E5 that R1 was pulling her hair out. E1 went to her room and noticed a patch of what seemed to be hair glued together. R1 told staff that Z2, DSP (Direct Support Person) (staff at daytraining) was putting</p>	W 120			

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 120	<p>Continued From page 1</p> <p>barrettes in her hair and taking pictures , and Z3 (DSP)(staff at day training was trying to get the glue out." "Golf ball size bald spot on the top of her head." The same note states E2 (Residential Service Director) was not notified at 9:30pm.</p> <p>A document written by Z1 (Daytraining Program Manager/QIDP/Office of Inspector General Liaison) dated 3/19/15 at 1:34pm titled "statement" includes, Z1's interview of R1 " staff put glue in my hair. It was staff from my house, when this interviewer asked her when this happened, first she said St. Patrick's day but then she said that it happened the week before."</p> <p>The daytraining site did not conduct an interview with R1 until 3 days after the allegation of abuse.</p> <p>Observations were made of R1 at the home on 4/1/15 from 1:30pm to 2:15pm. R1 was observed ambulating around the home independently. R1 removed her helmet very quickly using one hand to reveal her scalp on request from the surveyor, R1 have short brown hair and on top of R1's scalp contained an area of 4 centimeters by 2 centimeters of very short hair with new growth of hair over a spot where her scalp was partially exposed.</p> <p>Observations were made at the daytraining site of the classroom of R1 on 4/1/15 from 3:15pm to 3:45pm, R1 was picked up early by the home and was not in the classroom on this day. The classroom have 4 large lables that are placed together to form a backward L shape. There are several tables wnd activity cabinets with shelves. There were several paint cans on one of the tables and several areas of dried glue on 3 of the</p>	W 120			

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W 120	<p>Continued From page 2</p> <p>4 tables observed. There were two bottles of "industrial strength glue" there were sitting on the counter in the back of the classroom and several bottles of "school glue" and one glue stick that were stored in a drawer. The classroom instructor, Z2 (DSP) confirmed that the glue is used for both vocational work and for activities by the clients and staff</p> <p>An interview was conducted with R1 on 4/1/15 at 11:20am. R1 was asked if anyone including herself applied glue or any substance in her hair, R1 stated that E1 put glue in her hair then after a short period of time stated Z3 put glue in her hair then about 45 seconds later stated Z2 put glue in her hair. Surveyor asked R1 if she knew the reason why the individuals put glue in her hair and R1 stated E1 did not put the glue in her hair but helped to get it out. R1 walked away to the other side of the room and started singing a song that was on her radio. R1 was asked if she was afraid of any of the individuals she named and stated no. R1 denied anyone pulled her hair.</p> <p>An interview was conducted with Z1 on 4/1/15 at 12:50pm, Z1 was asked why R1 was interviewed 3 days later. Z1 stated that he was told that he was told by E2 that the allegation occurred on 3/17/15 instead of 3/16/15. Surveyor then showed Z1 that the incident report that he has is dated 3/16/15. Z1 states Z2 was removed from working with any individuals since the allegation of abuse. Z1 stated, "I should have interviewed her the same day, that was a mistake on my part."</p> <p>Z1 was asked in the same interview why was Z2 (DSP) who was named as 1 of the 2 alleged perpetrators in putting glue in R1's hair was not</p>	W 120			

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W 120	Continued From page 3 interviewed by the day training site. Z1 stated Z2 was not working that day, that she presented a doctor's note, and they have evidence of her timecard activity. Z1 was interviewed again later that same day at 3:45pm after surveyor discovered through record review that Z2 was working on 3/16/15, Z2 was off work on 3/17/15, and should have been interviewed. Z1 confirmed that the Z2 should have been interviewed. Z1 states that Z4 will be removed from working with individuals as of today until their investigation is completed.	W 120			
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, observations, and interview, the facility failed to implement policy related to allegations of abuse/neglect investigated by the facility. The facility also failed to safeguards individuals following allegations of neglect and abuse. These failures potentially affected 4 of 4 clients (R1, R2, R4, and R5) living at the facility.  Findings include:  Facility policy number 5.24 titled, Investigative Committee, states under A. "Any facility employee or agent who witnesses or a suspect a violation of resident rights, peer to peer incidents, reasonable suspicion of a crime, abuse, or neglect as well as injuries of unknown source shall immediately report the matter to facility management using the	W 149			

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W 149	<p>Continued From page 4</p> <p>following protocol:" "2. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: Administrator/Executive Director."</p> <p>"5. Staff statements will be documented on a progress note (form GP-15) by management and countersigned by the person being interviewed."</p> <p>"J. If the allegation is that another individual committed an act of abuse, appropriate action will be taken to safeguard the other individuals."</p> <p>Record review includes an Individual Service Plan dated 1/6/15, R1 is a 43 year old female with multiple diagnoses including Cerebral Palsy, Bipolar Disorder, Depression, Anxiety Disorder with Obsessive Compulsive Disorder, History of Seizures, and right hand deformity. R1 has a moderate level of intelligence ambulates independently using a helmet and knee pads. Intelligent Quotient is 39 and ICAP (Inventory for Client and Agency Planning) age of 3 years and 1 month.</p> <p>A document titled, "Progress Note form GP-15", dated 3/16/15 at 9:30pm written by E1 states"R2 came and told staff E1 and E5 that R1 was pulling her hair out. E1 went to her room and noticed a patch of what seemed to be hair glued together. R1 told staff that Z2, DSP (Direct Support Person) (staff at daytraining) was putting barrettes in her hair and taking pictures , and Z3 (DSP)(staff at day training was trying to get the glue out." "Golf ball size bald spot on the top of her head." The same note states E2 (Residential Service Director) was not notified at 9:30pm.</p> <p>Observations were made at the daytraining site of the classroom of R1 on 4/1/15 from 3:15pm to 3:45pm, R1 was picked up early by the home and</p>	W 149			

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W 149	<p>Continued From page 5</p> <p>was not in the classroom on this day. The classroom have 4 large tables that are placed together to form a backward L shape. There are several tables with activity cabinets with shelves. There were several paint cans on one of the tables and several areas of dried glue on 3 of the 4 tables observed. There were two bottles of "industrial strength glue" there were sitting on the counter in the back of the classroom and several bottles of "school glue" and one glue stick that were stored in a drawer. The classroom instructor, Z2 (DSP) confirmed that the glue is used for both vocational work and for activities by the clients and staff.</p> <p>An interview was conducted with E3 (Facility Representative) on 4/1/15 at 10:20am, E3 stated she was not notified of the allegation of abuse until 3/17/15 around 9:35pm (twenty four hours after the incident) when she received a call from E2 (RSD) that "his staff was told by R1 that staff at daytraining put glue in her hair and I told E2 to go to (name of day training site) and interview the staff and investigate the incident."</p> <p>Another interview was conducted with E3 the same day at 2:30pm, the surveyor pointed out that the according to the facility's incident report form GP-15, the allegation of abuse to R1 accorded on 3/16/15, the Administrator was not notified until 3/17/15, R1, R2, R4, and R5 were sent back to the daytraining site on 3/17/15 where the alleged perpetrators worked without an investigation initiated. E3 and E2 confirmed the above information.</p> <p>An interview was conducted with R1 on 4/1/15 at 11:20am. R1 was asked if anyone including herself applied glue or any substance in her hair, R1 stated that E1 put glue in her hair then after a</p>	W 149			

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W 149	<p>Continued From page 6</p> <p>short period of time stated Z3 put glue in her her hair then about 45 seconds later stated Z2 put glue in her hair. Surveyor asked R1 if she knew the reason why the individuals put glue in her hair and R1 stated E1 did not put the glue in her hair but helped to get it out. R1 walked away to the other side of the room and started singing a song that was on her radio. R1 was asked if she was afraid of any of the individuals she named and stated no. R1 denied anyone pulled her hair</p> <p>An interview was conducted with Z2 on 4/1/15 at 3:20pm. Z2 states, "We do work with glue in the classroom occasionally, but as you can see we keep it over here away from the clients and we work with them when we use it, the clients don't have access to it. I never put glue in R1's hair. I never took her helmet off. The only time I see her helmet off is when she may take it off to throw it sometimes if she has a behavior. I would never do anything like that. I never saw R3 put glue or anything in R1's hair. I'm not sure how she got glue in her hair because R1 doesn't even really like using glue because she will tell you, no, I will eat the glue so we watch all the clients when we work with glue. I never tried to get glue out of her hair because I have never seen glue in her hair."</p> <p>An interview was conducted with Z4 (DSP working at daytraining site) on 4/2/15 at 12:45pm. Z4 substitutes and provide lunch coverage in the classroom with R1. Z4 was asked if she had any knowledge about how R1 obtained the glue in her hair. Z4 states. " I wasn't even working in the classroom or anywhere around the classroom on 3/16/15. I don't have any knowledge of the incident, she never takes her helmet off."</p>	W 149			

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W 149	Continued From page 7  Several attempts were made to interview Z3 (DSP) by telephone on 4/1/15 at 1:30pm and 4:00PM, 4/2/15 at 12:45pm, and 4/3/15 at 11:25am. Messages were left each day.  According to the incident report/GP-15, the allegation of abuse were identified and reported by R1 on 3/16/15 at 9:00pm to E1, however; E1, DSP did not report the incident to Administrative staff until 3/17/15 at approximately 9:30 pm.  The late reporting resulting in R1, R2, R4, and R5 being sent to the same daytraining site the next morning without an investigation initiated against the alleged perpetrators, Z2 and Z3 (classroom instructors at the daytraining site.)  The facility did not implement policy to prohibit mistreatment when there are allegations of abuse.	W 149			
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 interview and record review, the facility failed to ensure that an allegation of abuse that was not identified by the facility was thoroughly investigated for one client in the sample (R1) and 3 of 3 clients outside the sample (R2, R3, and R4).  Findings include:	W 154			



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W 154	<p>Continued From page 8</p> <p>Facility policy number 5.24 titled, Investigative Committee, states under A. "Any facility employee or agent who witnesses or suspects a violation of resident rights, peer to peer incidents, reasonable suspicion of a crime, abuse, or neglect as well as injuries of unknown source shall immediately report the matter to facility management using the following protocol:" "2. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: Administrator/Executive Director."</p> <p>Facility policy number 5.57 titled, Physical Injury and Illness/Individual Medical Emergencies, H, "The QIDP/Administrator shall conduct any necessary interviews or injuries to establish the probable cause of the injury and document the finding on the Progress Note."</p> <p>Record review includes an Individual Service Plan dated 1/6/15, R1 is a 43 year old female with multiple diagnoses including Cerebral Palsy, Bipolar Disorder, Depression, Anxiety Disorder with Obsessive Compulsive Disorder, History of Seizures, and right hand deformity. R1 has a moderate level of intelligence ambulates independently using a helmet and knee pads. Intelligent Quotient is 39 and ICAP (Inventory for Client and Agency Planning) age of 3 years and 1 month.</p> <p>A document titled, "Progress Note form GP-15", dated 3/16/15 at 9:30pm written by E1 states "R2 came and told staff E1 and E5 that R1 was pulling her hair out. E1 went to her room and noticed a patch of what seemed to be hair glued together. R1 told staff that Z2, DSP (Direct Support Person) (staff at daytraining) was putting barrettes in her hair and taking pictures , and Z3</p>	W 154			

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W 154	<p>Continued From page 9</p> <p>(DSP)(staff at day training was trying to get the glue out." "Golf ball size bald spot on the top of her head." The same note states E2 (Residential Service Director) was not notified at 9:30pm.</p> <p>Observations were made at the daytraining site of the classroom of R1 on 4/1/15 from 3:15pm to 3:45pm, R1 was picked up early by the home and was not in the classroom on this day. The classroom have 4 large tables that are placed together to form a backward L shape. There are several tables with activity cabinets with shelves. There were several paint cans on one of the tables and several areas of dried glue on 3 of the 4 tables observed. There were two bottles of "industrial strength glue" there were sitting on the counter in the back of the classroom and several bottles of "school glue" and one glue stick that were stored in a drawer. The classroom instructor, Z2 (DSP) confirmed that the glue is used for both vocational work and for activities by the clients and staff.</p> <p>An interview was conducted with E3 (Facility Representative) on 4/1/15 at 10:20am, E3 stated she was not notified of the allegation of abuse until 3/17/15 around 9:35pm (twenty four hours after the incident) when she received a call from E2 (RSD) that "his staff was told by R1 that staff at daytraining put glue in her hair and I told E2 to go to (name of day training site) and interview the staff and investigate the incident." E3 confirmed that Z2 and Z3, staff at daytraining were not interviewed by the facility.</p> <p>An interview was conducted with E2 on 4/1/15 at 10:30am, according to E2, neither of the two staff members named by R1 in the allegation were not interviewed because one of them Z3 was</p>	W 154			

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NAME OF PROVIDER OR SUPPLIER  <b>DEARBORN COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>520 SOUTH DEARBORN STREET KANKAKEE, IL 60901</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 154	<p>Continued From page 10 removed from working with clients right away and the other staff member Z2 was off that day.</p> <p>An interview was conducted with R1 on 4/1/15 at 11:20am. R1 was asked if anyone including herself applied glue or any substance in her hair, R1 stated that E1 put glue in her hair then after a short period of time stated Z3 put glue in her hair then about 45 seconds later stated Z2 put glue in her hair. Surveyor asked R1 if she knew the reason why the individuals put glue in her hair and R1 stated E1 did not put the glue in her hair but helped to get it out. R1 walked away to the other side of the room and started singing a song that was on her radio. R1 was asked if she was afraid of any of the individuals she named and stated no. R1 denied anyone pulled her hair.</p> <p>According to the incident report/GP-15, the allegation of abuse was identified and reported by R1 on 3/16/15 at 9:00pm to E1, however; E1, DSP did not report the incident to Administrative staff until 3/17/15 at approximately 9:30 pm to E2 (RSD). The late reporting resulting in R1 being sent to daytraining the next morning without an investigation initiated against the alleged perpetrators, Z2 and Z3.</p> <p>The facility's investigation failed to include an interview with the 1 of the 2 alleged perpetrators, Z3 (R1's classroom instructor at daytraining)</p> <p>The facility failed to follow its policy for investigating allegations of abuse.</p>	W 154			