STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G360	A. BUILDING ______ B. WING ______	C 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLAND TERRACE	**15175 STATE STREET** **SOUTH HOLLAND, IL 60473**

(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 000	INITIAL COMMENTS INCIDENT REVIEW INVESTIGATION INCIDENT OF 01/06/16 / IL82762	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a consistent coordination of services between the facility and day training when: 1) R4 was removed from riding the day training van and kept home from day training for four working days while R1 and R3 continued to ride the van and attend day training after an allegation of abuse was alleged, 2) The day training provider did not communicate to the facility that Z1 works in the classroom as well as on the van, 3) The facility did not have knowledge of the actual working location of Z1 and 4) The facility did not verify and ensure that Z1 did not continue working directly with individuals across all settings. This affected three of three individuals (R1, R3 and R4) in the sample who ride the day training van and attend day training. Findings include: 1) Record review of the day training attendance sheet for R4 titled " Month: JANUARY 2016, NAME: (R4)" states that R4 was absent from day training on 01/07/16, 01/08/16, 01/11/16 and	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	Continued From page 1	W 120		

01/12/16.

During an interview held with E1(Administrator) on 01/19/16 at 12:00pm in the dining room, E1 confirmed that R4 was held back from riding the van and did not attend day training for four days while R1 and R3 continued to ride the van and attend day training after an allegation of abuse was alleged.

2) Record review of the day training document titled "Vehicle Route Assigned" without a date states: "Turtle Top- (Z5./Z1.(aide) (as of 1/7/16 no longer aide, as of 1/12/16 (Z8) will be the aide)". Document does not state that Z1 is also a direct support person in the classroom. Review of a facility email dated 01/07/16 at 8:48am from Z2; Day Training Director to Z9; Vice President/Supervisor states that the day training site was notified of an allegation of physical abuse made by R4 from E1 and informed that E1 would be conducting interviews. Further conversation through email dated 01/07/16 at 9:29am from Z2 to Z9 states " (Facility) resident did accuse a staff member at (Day training)." Documents described above did not state what the status of Z1 would be once the allegation of physical abuse was alleged and the facility did not inquire.

3) An interview was held on 01/19/16 at 12:00pm in the dining room area of the home with E1. E1 stated that she notified Z2 on 01/07/16 of the allegation of physical abuse alleged against Z1 but was not told the status of Z4 in relation to working, other than Z1 "no longer being an aide on the van, and I didn't know where she was

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W 120	Continued From page 2 working at that point." The facility did not have knowledge of the actual working location of Z1. 4) An interview was held with E1 on 01/19/16 at 12:00pm in the dining room area of the home. E1 stated "I did not think that I could suspend the program staff and we were just starting the investigation process, I did not know where Z1 was working." The facility failed to verify and ensure that Z1 did not continue working directly with individuals across all settings.	W 120		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to ensure client protections necessary to ensure individuals' safety from physical abuse and prevent reoccurrence for three of three individuals in the sample (R1, R3 and R4) who ride the day training van and attend day training when the facility failed to: 1) Ensure removal of an identified staff person; Z1 from direct contact with individuals once an allegation of abuse was identified to have occurred to R4 on 01/06/16. 2) Ensure behavioral incidents and injuries of unknown origin are reported and documented once they are discovered. 3) Ensure safeguards are in place to prevent	W 122		

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W 122	Continued From page 3 further abuse from occurring. Refer to deficiencies cited under: W120 - The facility must assure that outside services meet the needs of each client. W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	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 and interview, the facility failed to 1) Implement their policy of taking immediate corrective actions necessary to assure individuals' safety when they failed to remove a staff person from direct contact with individuals once an allegation of abuse was identified to have occurred to R4 and , 2) Prevent further abuse from occurring when they continued to send two individuals (R1 and R3) to the day training site where the accused was still working. This affected three of three individuals (R1, R3 and R4) in the sample who ride the day training van and attend day training. Findings include: Record review of the facility's policy 5.24 titled "Investigative Committee" dated 12/15 states: "The Investigative Committee shall be responsible for the following:	W 149		

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W 149	Continued From page 4 A. To identify, review and determine if alleged violations of any individuals rights, including abuse and neglect have occurred. B. To investigate allegations in a professional and impartial manner. C. To protect individuals from further harm." "Procedure" section states: "If the allegation is that an employee committed an act of abuse or neglect, the employee shall be suspended from duty until such time as the 1) Investigation is complete and, 2) The Administrator considers the report and takes administrative action." According to the "Final Investigation Summary" dated 01/13/16 for R4, R4 is an individual whose level of functioning is in the moderate range. R4 receives medication for anxiety and agitation, however she does not require medication for hallucinations and is considered "Good with names; remembering things. The maladaptive behaviors of concern are as follows: Yelling, stealing snacks, lying about stealing snacks, elopement and self abusive behavior (biting her arm, scratching arm, banging head, kicking and slapping her face and or loudly clapping her hands)." Review of facility's "Initial Investigation Report" dated 01/07/16 states that on 01/06/16, R4 returned home from day training and Direct Support Persons' (DSP)'s E4, E5 and E6 noticed "a bruise" underneath R4's left eye. R4 reported at that time that Z1 hit her in the eye. "In response to the allegation, immediate directive was given to keep R4 home from day training until the matter could be thoroughly investigated." However; through interview with E1 (Administrator) on 01/19/16 at 12:00pm in the dining room area of the facility, surveyor was	W 149		

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W 149	Continued From page 5	W 149		

informed that R1 and R3 continued to ride the van and attend day training but "should have been held back to safeguard them, but at the time, I was only thinking about R4's safety since she made the allegation."

Review of facility's "Final Investigation Summary" dated 01/13/16 states as follows:

On 01/06/16; R4 returned home from day training with "A bruise" observed under her left eye by home staff. Home Administrator, Guardian and Nurse were notified and the day training site was attempted to be notified but were closed for the day. R4 was taken to the Emergency room for treatment the same night of 01/06/16. E1 began conducting interviews with (DSP)'s E4, E5 and E6 who were present in the home upon R4's return.

On 01/07/16, E1 contacted Z2 (Day Training Director) via telephone and informed her that an allegation had been alleged by R4 against Z1 on 01/06/16. E1 conducted interviews with E3; Nurse, E4 (2nd interview), E5 (2nd interview), Z1 and DT DSPs (Z4, Z5, Z6, Z7).

On 01/08/16, E1 interviewed E7 and E8 (DSP)'s and R1, R3 and R4.

On 01/11/16, R1 and R4 were interviewed a second time and their story remained consistently the same while interviewed independently of each other that Z1 " punched R4 in the eye." R1 also alleged at this time that Z1 had " threatened him at the time of the incident on 01/06/16 that if he told anyone, he too, would get the same thing."

On 01/12/16, E1 notified Z2 of the new information obtained on 01/11/16 from R1 and

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W 149	Continued From page 6 discussed her findings from the above interviews. Conclusionary findings from the facility dated 01/12/16 are as follows: 1) Z1 will be suspended while the day training site conducts their own internal investigation as of 01/12/16. 2) Z2 stated that based on the findings from their investigation, a determination will be made regarding their next course of action. 3) R4 will return to day training upon suspension of Z1. Followup conclusionary report from the facility dated 01/13/16 "finds the matter of alleged physical abuse Substantiated." Facility failed to take immediate corrective action necessary to assure individuals' safety and to prevent further abuse from occurring when the incident occurred on 01/06/16. Z1 was not suspended until 01/12/16 and not terminated from all duties until 01/16/16. R1 and R3 continued to attend day training where Z1 was working in the classroom from 01/07/16 until 01/11/16, thus resulting in a 6 day delay in providing safety.	W 149		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that individual R4 received follow-up medical attention in a timely manner ; within twenty four to forty eight hours after	W 331		

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W 331	Continued From page 7	W 331		

discharge from the hospital, according to emergency room recommendations. This affected one (R4) of four individuals in the sample.

Findings include:

Review of facility's "Initial Investigation Report" dated 01/07/16 states that on 01/06/16, R4 returned home from day training and Direct Support Persons' (DSP)'s E4, E5 and E6 noticed "a bruise" underneath R4's left eye. R4 reported that Z1 hit her in the eye. R4 was transported to the emergency room on 01/06/16 at 6:04pm.

Review of emergency room discharge instructions/recommendations dated 01/06/16 for R4 states: "Follow up with your doctor or the referred doctor in the next 24 - 48 hours."

Review of facility's "Final Investigation Report" dated 01/13/16 states: "In-Service facility staff on following - up on all physician recommendations - (R4) did not see her physician within 24 - 48 hours after leaving the ER as recommended."

An interview was held with E1; Administrator in the dining room area of the home on 01/19/16 at 1:30pm. E1 stated that R4's appointment to see her primary care physician is not scheduled until 01/21/16. E1 confirmed that R4 did not follow up with her primary care physician within twenty four to forty eight hours after discharge from the hospital, according to emergency room recommendations.