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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLINVILLE ESTATES	1221 SOUTH PLUM STREET CARLINVILLE, IL 62626

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W 000	INITIAL COMMENTS COMPLAINT INVESTIGATION Incident of 10/25/15 IL00081115 / 1545916 Incident of 11/10/15 IL00081454 / 1546216	W 000		
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 interview and record review, the facility failed to implement their system to prevent neglect/abuse for 2 of 3 individuals in the sample by: 1. The facility failed to ensure the safety for 1 of 1 individuals, inside the sample, who received burns to her body resulting in hospitalization and surgical procedure. 2. The facility failed to prevent individual abuse for 1 of 1 individual, inside the sample, who was given a nondrinkable liquid whom the individual drank. 3. Failing to stop abuse and follow the facility abuse policy of reporting abuse to management against residents. Findings Include: 1. The 'Annual Interdisciplinary Team Evaluation',	W 149		

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

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dated 10/31/14, identifies R1 as an individual who functions in the Profound level of Intellectual Disabilities. The 'Annual Interdisciplinary Team Evaluation' also include diagnosis of: Convulsive Epilepsy Generalized, Autism, Incontinence Urinary, ...and other nonspecific eruptions, and Anxiety. R1's 'Annual Interdisciplinary Team Evaluation' further documents under 'Self-Care, R1 does not shower independently and requires assistance to complete ... such as washing her body and washing her hair. R1 also requires the use of a shower chair.'

The facility 'Incident Report', dated 10/24/15 at 3:40 PM, documents E4, Direct Staff Person, DSP, 'When I arrived at work I was informed R1 didn't seem to be feeling well. I took her vitals (vital signs) and they were within normal limits. R1 got up to go to the restroom and I saw R1's bottom of her shirt and the top of her pants were damp, when R1 pulled her pants down to sit on the toilet I found blisters and skin peeling off her inner thighs down her inner leg to her calves. I helped R1 undress and into (a) gown and slippers and transported her to local hospital.'

On the 10/24/15 at 4:35 PM, the local hospital report documents:
'R1 who presents with chief complaint of burn... The time of occurrence was just prior to arrival. The burn was described as being red, painful, and blisters.
Skin: The location was the right vagina and vulva, hip, thigh, and knee... The estimated 2nd degree burn totaled 10%. The total present of body surface area burned was approximated to be less than 10%.'
Discharge Summary:
R1 presented to this hospital with a very large

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burn. From records, we really did not receive an exact story of how burn occurred... R1 burn was 2nd and 3rd degree, very large in the inner thighs and vaginal area. R1 was admitted here and given good wound care... Unfortunately, when I saw R1 the next day, R1 was developing fevers to 100.7 and R1's wcc (white blood count) increased to 13k (13,000). At that time I consulted another hospital who agreed to accept R1 to their burn center. R1 was transferred in good condition.'

The burn center at another local hospital R1 was transferred to on 10/25/15 at 12:09 PM documents:
'Skin: there are deeper burns present on the proximal thighs with a coagulation appearance, distal thighs and lower legs with blanching, erythematous superficial partial thickness burns. There is a clear line of demarcation on the bilateral anterior thighs. There are also erupted bulllea present on the labia with what appear to be partial thickness vs (verses) full burns.'

On 10/30/15 at 12:02 PM, R1 was observed sitting up in bed at burn center of hospital, one left wrist posey mitten on, an indwelling catheter, IV (intravenous) site on right hand, and semi alert.

On 10/29/15 at 2:50 PM, E2, Qualified Intellectual Disability Professional (QIDP), E2 stated she was not aware of how R1 received her burns, but state a hot water heater had recently been replaced and the tempering / mixing valve was not replaced at that time. E2 further stated at the time of the hot water heater being replaced, E2 was uniformed of the installation was being completed by a nonlicensed plumber.

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W 149	Continued From page 3 On 10/29/15 at 11:04 AM, during a telephone interview with Z1, R1's Medical Physician at the hospital burn unit, when Z1 was asked if R1 did have a burn, Z1 answered "Yes, due to the appearance and consistency, doesn't appear as a shower provided the burn, but hot liquid burned this affected area." When asked if any test was completed ruling out any bacteria-like burn, Z1 stated, "No, it (the testing) was not done, no reason or requirement to do so due to appearance of burn area." Z1 further stated R1 was in currently stable condition. On 10/30/15 at 11:54 AM, Z2, Registered Nurse at hospital burn unit, when interviewed, stated that a wound culture was completed on admission, as is common procedure, R1 has 3rd degree burns to labia and inner thighs bilaterally. Z2 further stated R1 had a surgical skin graft completed and unsure if more would be needed. The facility 'Policy on Abuse, Mistreatment, or Neglect of Residents', undated, documents: It is the policy of (facility name) that all residents are to live free of abuse, mistreatment, or neglect....All residents shall be protected from any abuse, mistreatment, or neglect. The resident's safety and welfare will be monitored at all times... 2. The facility 'Resident Roster', dated 2015, identifies R3 as an individual who functions in the Profound level of Intellectual Disabilities. The facility 'Resident Abuse Report Form', dated 11/12/15, documents 'E3, Direct Staff Person (DSP), put 5 oz (ounces) of vinegar in a cup and placed this on the dining room table. R3 picked	W 149		

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up cup to drink the liquid and while R3 was drinking the liquid E3 stopped him from drinking this completely. E3 admitted to E2, DSP, previously that he put vinegar into a cup for R3 to drink to stop him from drinking others drinks. E5, DSP, was interviewed ... knew this happened. E5 did not notify management. E5 admitted to knowing about this incident.'

On 11/12/15 at 1:41 PM, during an interview with E3, DSP, E3 confirmed that on the previous weekend E3 took a small glass, approximately 6 ounces, of vinegar and set it out so R3 would drink it, placing this on the dining room table, E3 said he had told E5, DSP, before E3 had done this. When asked if E5 had acknowledged he understood, E3 stated "Yes". E3 then waited and watched R3 pick up the glass of vinegar and drink about half before E3 then verbally stopped R3 from drinking the rest of the vinegar.

The facility 'Resident Roster', dated 2015, identifies R4 as an individual who functions in the Moderate level of Intellectual Disabilities.

On 11/13/15 at 11:33 AM, during an interview with R4, R4 stated he had seen E3, DSP, put the glass of vinegar on the table and watched R3 drink it.

On 11/13/15 at 11:23 AM, during an interview, E3 did admit when asked if he had drank a glass of something sitting on the table at home, E3 said "Yeah. " E3 then stated that R3 had stopped him before R3 was done drinking the whole glass. When asked E3 if vinegar was in the glass, E3 said " Yeah. "

The facility 'Resident Roster', dated 2015,

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identifies R5 as an individual who functions in the Mild level of Intellectual Disabilities.

On 11/13/15 at 11:41 AM, R5 was interviewed, R5 stated that he seen E3 put a glass of vinegar on the table, E3 stayed and left glass on table, R3 came in and drank it, E5, DSP asked R3 how the water tasted? E3 said " No. " R5 then stated that both E3 and E5 both laughed. E3 said he told a day training staff the next day.

On 11/13/15 at 10:52 AM, Z3, Day Training Direct Staff Person, was interviewed, Z3 stated that on 11/09/15 at 8:20 AM, R5 reported to Z3 that E3, DSP had set a cup of vinegar on the table for R3 to drink because E3 said that will teach E3 from taking other peoples drinks.

The facility 'Policy on Abuse, Mistreatment, or Neglect of Residents', undated, documents:
It is the policy of (facility name) that all residents are to live free of abuse, mistreatment, or neglect....All residents shall be protected from any abuse, mistreatment, or neglect. The resident's safety and welfare will be monitored at all times...

3. The facility 'Resident Roster', dated 2015, identifies R3 as an individual who functions in the Profound level of Intellectual Disabilities.

The facility 'Resident Abuse Report Form', dated 11/12/15, documents 'E3, Direct Staff Person (DSP), put 5 oz (ounces) of vinegar in a cup and placed on dining room table. R3 picked up cup to drink the liquid and as soon as R3 started drinking the drink E3 stopped him from drinking

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W 149	Continued From page 6 the rest. E3 admitted to E5 that he put vinegar into a cup for R3 to drink to stop him from drinking others drinks. E5, DSP, was interviewed ... knew this happened and did not stop this action. E5 did not notify management. E5 admitted to knowing about this incident.' On 11/13/15 at 11:41 AM, R5 was interviewed, R5 stated that he seen E3 put a glass of vinegar on the table, E3 stayed and left glass on table, R3 came in and drank it, E5, DSP asked R3 how the water tasted? E3 said " No. " R5 then stated that both E3 and E5 both laughed. E3 said he told a day training staff the next day. The facility 'Policy on Abuse, Mistreatment, or Neglect of Residents', undated, documents: It is the policy of (facility name) that all residents are to live free of abuse, mistreatment, or neglect....All residents shall be protected from any abuse, mistreatment, or neglect. The resident's safety and welfare will be monitored at all times... The facility ' Incident Report Policy and Procedures, undated, Purpose: To ensure prompt notification, proper response to, and reporting of ... abuse... Definition: 1. Observance of incident a. All facility staff have an obligation to report incidents when are observed. 3. Documentation a. An incident report shall be completed by the reporting staff member as soon as possible.	W 149		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported	W 156		

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W 156	Continued From page 7 to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to report to Illinois Department of Public Health (IDPH) the results of their investigations for 1 of 1 individuals, in the sample, (R2) who had received a fracture. Findings Include: The Physician's Order Sheet, (POS), dated 11/07/15, identifies R2 as an individual who functions in the Moderate level of Intellectual Disabilities. The POS for R2 also includes the diagnosis of Osteoporosis. On 09/12/15 R2 returned home form a home visit / family wedding. On 09/13/15, R2 told staff her ' boob ' hurt. Staff did a check of the breast area...and found nothing out of the ordinary. On 09/14/15 R2 went to day training and said her ' boob ' hurt... facility Registered Nurse was notified and x-ray (radiology test) completed.... indicating a healing fracture of the right 9th rib. On 10/28/15 at 11:08 AM, during an interview with E2, Qualified Intellectual Disability Professional, (QIDP), E2 confirmed she could not any find any evidence of this final investigation was reported to the Illinois Department of Public Health.	W 156		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the	W 189		

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employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to ensure that staff were trained to perform their duties efficiently & competently when staff failed to ensure 1 of 3 individuals, in the sample, (R2) was immediately reported to facility management of witnessed abuse.

Findings Include

The facility 'Resident Roster', dated 2015, identifies R3 as an individual who functions in the Profound level of Intellectual Disabilities.

The facility 'Resident Abuse Report Form', dated 11/12/15, documents 'E3, Direct Staff Person (DSP), put 5 oz (ounces) of vinegar in a cup and placed on dining room table. R3 picked up cup to drink the liquid and as soon as R3 started drinking the drink E3 verbally stopped R3 from drinking the rest. E3 admitted to E5, DSP, previously that he put vinegar into a cup for R3 to drink to stop him from drinking others drinks. E5, DSP, was interviewed ... knew this happened and did not stop this action. E5 did not notify management. E5 admitted to knowing about this incident.'

On 11/13/15 at 11:41 AM, R5 was interviewed, R5 stated that he seen E3 put a glass of vinegar on the table, E3 stayed and left glass on table, R3 came in and drank it, E5, DSP asked R3 how the water tasted? E3 said " No. " R5 then stated that both E3 and E5 both laughed. E3 said he told a day training staff the next day.

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W 189	Continued From page 9 The facility 'Policy on Abuse, Mistreatment, or Neglect of Residents', undated, documents: It is the policy of (facility name) that all residents are to live free of abuse, mistreatment, or neglect....All residents shall be protected from any abuse, mistreatment, or neglect. The resident's safety and welfare will be monitored at all times... The facility ' Incident Report Policy and Procedures, undated, Purpose: To ensure prompt notification, proper response to, and reporting of ... abuse... Definition: 1. Observance of incident a. All facility staff have an obligation to report incidents when are observed. 3. Documentation a. An incident report shall be completed by the reporting staff member as soon as possible.	W 189		