STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G310	A. BUILDING _____ B. WING _____	C 04/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYD AVENUE HOME	110 SOUTH BOYD AVENUE AMBOY, IL 61310

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W 000	INITIAL COMMENTS INCIDENT REPORT INVESTIGATION Incident: 3-22-14/IL69395	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 record review and interview the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse for 1 of 3 sample clients, R1 who was the recipient of R3's inappropriate behavior. Findings include: According to his 10-2-13 Person Centered Plan, (PCP), R1 is a 62 year old man who has a severe intellectual disability and whose diagnosis includes; visual and auditory hallucinations. R1 is also profoundly deaf. According to his 11-26-13 PCP, R2 is a 62 year old man who has a severe intellectual disability and whose diagnosis includes; intermittent explosive disorder. During a review of an Incident/Accident Report Form dated 3-22-14 that was written by DSP E6, it states that E6 was assisting a client in the bathroom and she heard a client in the living room saying "stop it" then the client came to the bathroom and said to her (R2's name). When E6 entered the living room she saw R1 and R2 sitting	W 149		

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

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W 149	Continued From page 1	W 149		

on the couch. R2 had R1's wrist and was holding R1's hand onto R2's penis. R2 had his pants undone. E6 then states that R1 "had a terrified look on his face" so she removed R1 from the situation and escorted him to the bathroom to wash his hands.

E6 goes on to describe R2's anger when asked to go to his bedroom and R2 was throwing things in his room. About 10 minutes later R2 came out of his room with his pants around his ankles and had his penis in his hand. R2 entered the living room and sat down; he refused to pull his pants up.

During a review of R2's Behavior Plan dated 1-15-14, it describes one of R2's target behaviors as Inappropriate Sexual Behavior, defined as; exposing or touching genital areas in a common area or in the community, attempting to or touching others inappropriately, making lewd/sexual comments, attempting to engage others in sexual activity (such as luring staff or peers into his bedroom for inappropriate reasons).

The plan lists many interventions. It includes the note that R2 should be redirected if he is sitting too close to a peer on the sofa. The plan also notes that R2 must be monitored closely...this plan was not implemented sufficiently to protect R1 from R2's behaviors.

On 4-21-14 at 4:15pm R3 began fussing as R2 was setting the table for supper. R2 reached out and hugged R3. DSP E5 said "no hugging (R2)". E5 repeated this three times and R2 paid her no attention at all and didn't let go of R3 until he was ready to return to setting the tables when he

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W 149	Continued From page 2 finally disengaged. During the evening meal on 4-21-14 DSP E5 sat next to R2 and monitored him closely. R2 went to his room after eating and when E5 returned to the dining room at 5:08pm she said that it was not unusual for him to get listless after eating and going to his room to lay down. E5 said then R2 tends to be down for the night.	W 149		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to provide sufficient direct care staff to manage and supervise 1 of 3 sample clients, R2 in accordance with his IPP when R2 displayed inappropriate behavior directed at R1. Findings include: According to his 10-2-13 Person Centered Plan, (PCP), R1 is a 62 year old man who has a severe intellectual disability and whose diagnosis includes; visual and auditory hallucinations. R1 is also profoundly deaf. According to his 11-26-13 PCP, R2 is a 62 year old man who has a severe intellectual disability	W 186		

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W 186	Continued From page 3	W 186		

and whose diagnosis includes; intermittent explosive disorder.

During a review of an Incident/Accident Report Form dated 3-22-14 that was written by DSP E6, it states that E6 was assisting a client in the bathroom and she heard a client in the living room saying "stop it" then the client came to the bathroom and said to her (R2's name). When E6 entered the living room she saw R1 and R2 sitting on the couch. R2 had R1's wrist and was holding R1's hand onto R2's penis. R2 had his pants undone. E6 then states that R1 "had a terrified look on his face" so she removed R1 from the situation and escorted him to the bathroom to wash his hands.

E6 goes on to describe R2's anger when asked to go to his bedroom and R2 was throwing things in his room. About 10 minutes later R2 came out of his room with his pants around his ankles and had his penis in his hand. R2 entered the living room and sat down; he refused to pull his pants up.

During observations on 4-21-14 two staff worked with 5 clients. At 4:30pm R2 was setting the table. E5 was working in the kitchen and E4 helped a client in the back of the house with his shower. R2 walked to the front of the house, without using his walker. As he returned to the dining room area R2 lost his footing and fell to the floor bruising his knee. Staff responded immediately and helped him. Then they reminded him to hold onto the table for support when he set the table. Staff was not aware that he had walked to the front of the house without his walker.

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W 186	Continued From page 4 At 4:35pm E4 went shopping with R4. At 5:08pm R2 said he didn't feel well so E5 escorted R2 to his room. As soon as they left the dining room R5 grabbed the scoop from a pan and served himself an extra scoop of meat beyond his diet. R1 then grabbed the scoop and served himself another scoop as well beyond his diet. E5 noted the difficulty when she was alone and then she took the pan of meat into the kitchen and locked the door before escorting R2 to his room. There was not sufficient staff available on this occasion either to manage and supervise them in accordance with their IPP.	W 186		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 3 sample clients, R2 receive sufficient interventions to achieve the objectives identified in his behavior plan. Findings include: According to his 11-26-13 PCP, R2 is a 62 year old man who has a severe intellectual disability and whose diagnosis includes; intermittent explosive disorder.	W 249		

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W 249	Continued From page 5 During a review of an Incident/Accident Report Form dated 3-22-14 that was written by DSP E6, it states that E6 was assisting a client in the bathroom and she heard a client in the living room saying "stop it" then the client came to the bathroom and said to her (R2's name). When E6 entered the living room she saw R1 and R2 sitting on the couch. R2 had R1's wrist and was holding R1's hand onto R2's penis. R2 had his pants undone. E6 then states that R1 "had a terrified look on his face" so she removed R1 from the situation and escorted him to the bathroom to wash his hands. E6 goes on to describe R2's anger when asked to go to his bedroom and R2 was throwing things in his room. About 10 minutes later R2 came out of his room with his pants around his ankles and had his penis in his hand. R2 entered the living room and sat down; he refused to pull his pants up. During a review of R2's Behavior Plan dated 1-15-14, it describes one of R2's target behaviors as Inappropriate Sexual Behavior, defined as; exposing or touching genital areas in a common area or in the community, attempting to or touching others inappropriately, making lewd/sexual comments, attempting to engage others in sexual activity (such as luring staff or peers into his bedroom for inappropriate reasons). The plan lists many interventions. It includes the note that R2 should be redirected if he is sitting too close to a peer on the sofa. The plan also notes that R2 must be monitored closely and must be within staff's line of sight at all times	W 249		

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W 249	Continued From page 6 when not in his home. During a review of R2's Monthly Behavior Summary for March 2014 there are numerous entries listing R2's behaviors, including; *3-1-R2 very bossy. He was masturbating on the van during an outing... *3-4-as staff approached his open bedroom door R2 was facing the door masturbating... *3-5-yelling & banging his walker... *3-11-yelling and screaming at a peer... *3-12-tried to hit peer twice... *3-12-masturbating with his door open... *3-14-bossing peers... *3-15-bossing peers & standing very close to everyone... *3-18-Bossing peers. Masturbating in room with door open... *3-21-shaking everyones hand... *3-22-masturbating in van during outing...broke his glasses... *3-24-poured coffee on floor...threw chair...yelled at & went after peer... *3-26-bossing peers. Masturbating with door open... *3-28-cussing & raising his fist... On 4-21-14 at 4:15pm R3 began fussing as R2 was setting the table for supper. R2 reached out and hugged R3. DSP E5 said "no hugging (R2)". E5 repeated this three times and R2 paid her no attention at all and didn't let go of R3 until he was ready to return to setting the tables when he finally disengaged. During the evening meal on 4-21-14 DSP E5 sat next to R2 and monitored him closely. R2 went to his room after eating and when E5 returned to the dining room at 5:08pm she said that it was not	W 249		

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W 249	Continued From page 7 unusual for him to get listless after eating and going to his room to lay down. E5 said then R2 tends to be down for the night.	W 249		