

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

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RAINTREE TERRACE

Facility Name

0042465

I.D. Number

501 EAST CHESTNUT, CARBONDALE, ILLINOIS 62901

Address

04/22/05

Date of Survey

COMPLAINT

Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE:

THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

“A” VIOLATION(S):

350.620a)
350.1230d)1)2)3)
350.3240a)b)c)d)e)

The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. (B)

Direct care personnel shall be trained in, but are not limited to, the following:

Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

Basic skills required to meet the health needs and problems of the residents.

First aid for accident or illness.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) (A,B)

A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A REISDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (Section 3-610 of the Act)

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A FACILITY ADMINISTRATOR WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER BY TELEPHONE AND IN WRITING TO THE RESIDENT'S REPRESENTATIVE. (Section 3-610) of the Act)

EMPLOYEE AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A REPORT OF SUSPECTED ABUSE OF A RESIDENT INDICATES, BASED UPON CREDIBLE EVIDENCE, THAT AN EMPLOYEE OF A LONG-TERM CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT EMPLOYEE SHALL IMMEDIATELY BE BARRED FROM ANY FURTHER CONTACT WITH RESIDENTS OF THE FACILITY, PENDING THE OUTCOME OF ANY FURTHER INVESTIGATION, PROSECUTION OR DISCIPLINARY ACTION AGAINST THE EMPLOYEE. (Section 3-611 of the Act)

These Regulations were not met, as evidenced by the following:

Based on observation, interview and file review, the facility has neglected to implement their policy and procedure for reporting and investigating allegations of abuse, mistreatment and or neglect by their failure to investigate an allegation of physical abuse of R1 by facility staff (E4), after becoming aware of the allegation on 04/11/05. After the facility became aware of the allegation of abuse, the facility allowed E4 to continue working at the facility which failed to safeguard and protect the individual (R1) and other individuals of the facility (R2 - R15).

1) Per review of the facility's policy regarding reporting and investigating allegations or mistreatment, identified:

"Suspected abuse, mistreatment or neglect of residents shall be reported immediately to the resident Services Director (RSD) and Administrator.

The Administration shall begin an investigation of the allegation. Personnel suspected of abuse mistreatment or neglect, shall be immediately suspended from active employment pending the outcome of the investigation.

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The investigation shall include interviews with all parties having knowledge of the allegation. All parties will be questioned individually and written reports assembled from each. Upon completion of interviews, the RSD, Administrator and Board of Directors shall determine if the allegation is founded. If founded, the staff member shall be terminated immediately.

Should the allegation involve another resident committing abuse or mistreatment, the Behavior Management and Human Rights Committee members shall be contacted to develop recommendations.

The Administration shall contact the Illinois Department of Public Health within 24 hours of receiving the allegation and follow with written report of the findings within 7 days."

During the Entrance Conference on 04/12/05 with E1 (Owner), E1 stated that the facility had had no allegations of abuse, neglect and or mistreatment recently, nor during the past two months.

Per interview with R1 on 04/12/05 at 10:00 A.M., R1 stated that an alleged abuse had occurred at, " 7:30 P.M. Sunday night." R1 stated, "E6 and E4 (Habilitation Staff) were the staff on duty. E6 called us in for meds. I told E6 that they needed to get R5 a helmet because she was banging her head. E6 told me to talk to E1. E4 told me to go to my room. I told him no. E4 grabbed my wheelchair and pushed me into the wall. I think it was a mistake. I fell out of the wheelchair. E4 pushed my wheelchair to my room, then pulled me by my right arm and drug me to my bedroom down the hall. I was laying on my back when he drug me down the hallway to my bedroom. R3, R7, R5 and R2 saw this, but E4 shut the door to the med room so they might not have seen anything. I've got rug burns on my back and bruises on my arm from E4 dragging me on the floor...". (Per interview with R2, R3, R5 and R7 on 04/12/05, all the individuals had knowledge of the incident, but did not witness R1 being dragged down the hall by E4.)

Observations of R1's back (with Z2 present) at 10:15 A.M., the surveyor noted reddened abrasions with bruising measuring approximately 3 inches by 3 inches on R1's upper left buttock and reddened abrasions with bruising measuring approximately 1 inch by 1 inch on R1's upper right buttock area. R1 was also observed to have small circular bruises in her inner right and left arm. During this observation, R1 confirmed that the facility staff had not checked her for injury until she showed E5 her injuries during the morning of 04/12/05.

R1 stated, "I think I got the bruises (under the arms) when E4 was trying to put me back in my wheelchair. E4 also pushed me in the back of my head to get me off of his foot... After all this happened, I went to talk with E4 who was in the dining room smoking. E4 blew smoke in my face and said that my mom doesn't like me and that my friends don't like me either. So, I slapped him in his face." During this interview, R1 confirmed that she did not throw herself out of her wheelchair during the incident and that she had told E5 (Habilitation Staff) yesterday morning (04/11/05). R1 also confirmed that E4 did not work on Monday following the incident, but had worked during the morning on 04/12/05.

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(Per interview with E5 (Habilitation Technician) on 04/12/05 at 2:15 P.M., E5 confirmed that R1 had showed her the marks on her back on 04/12/05. E5 stated, "R1 told me this morning at about 3:00 A.M. when she got up going to the bathroom. I saw the marks on her back. I didn't say anything to E3 because R1 had already told him. She told him yesterday about 7:30 A.M., when she (R1) was coming out of the med room and was in the hall. I heard her tell him (E3) about E4 dragging her...")

During the interview with R1 on 04/12/05, R1 informed the surveyor that Z1 had taken pictures of her bruising on 04/12/05 after she arrived to workshop.

Per interview with Z1 on 04/12/05 at 12:25 P.M., Z1 confirmed that R1 had informed her of the incident when she arrived to work on Monday (04/11/05). Z1 stated, "I interviewed R1 and examined her for injuries. I was not expecting to see rug burns, but R1 had abrasions on her upper buttocks that could have been rug burns. During this interview Z1 confirmed that an Incident Report had been completed and that the facility had been notified regarding R1's allegation against E4. Z1 stated, "I called E3 (RSD) about 2:00 P.M. yesterday and told him that R1 had alleged that E4 had drug her by her arm down the hall, blew smoke in her face and said inappropriate things to her. E3 told me that that was "absolutely absurd" and that R1 was upset because she and her mom had gotten into a fight."

Per interview with E4 (Habilitation Technician) on 04/12/05 at 2:37 P.M., E4 confirmed that an incident had occurred on 04/10/05 between himself and R1. E4 stated, "After R1 refused to leave the med room area, I physically assisted out of the area. R1 held on to the room divider and I was trying to pull back on her wheelchair and she came out of her wheelchair and went to her knees. I got behind her and attempted to pick her up twice. When I got her up, her hair got wrapped around my hand and the arm handle of the wheelchair... When I got her hair free, she sat up and started coming out of the wheelchair. I put my arm across her chest and took her to her room. She pushed the fire door so the door automatically shut. R6 was peeking around the corner when I took R1 to her room... Later R1 came out of her room and began yelling at me. I told her to go to her room... I didn't document anything until today." During this interview, E4 confirmed that he had shut the room divider when he left the med room and that the only other client present in the hall area was R6 who could not see what was happening because the fire door was closed. E4 denied dragging R1 down the hall, blowing smoke in her face and or saying anything negative to R1 during or after the alleged incident.

(Per interview with R6 on 04/19/05 at 4:50 P.M., R6 confirmed that she had been in the hall on 04/10/05 when E4 and R1 going down the hall, but confirmed that she could not see what was going on between E4 and R1.)

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Per interview with E3 (RSD) on 04/12/05 at 3:00 P.M., E3 confirmed that Z1 had notified him of R1's allegations on 04/11/05. E3 stated, " Z1 called me and told me that R1 had red eyes and that staff (E4) blew smoke in her face (R1's)." E3 also confirmed that Z1 had informed him that E4 had drug R1 down the hall. At 3:15 P.M., E3 stated, "I'm not sure that I recollect her (Z1) saying that R1 had alleged that E4 had drug her down the hall." When the surveyor asked E3 if he had checked R1 for bruising when she came home from workshop, E3 stated, "No, because I thought it related back to a behavioral event from Friday." E3 stated, "I checked her this morning and I noted a rash/slash bruising on her upper buttocks. The nurse is to see her tomorrow." During this interview E3 confirmed that Z1 had notified him of bruising to R1's upper buttock area. E3 also confirmed that he did not document that Z1 had called the facility on 04/11/05 and that no incident report had been completed by facility staff. When the surveyor asked E3 what he had done to address the allegations after workshop staff had notified him, E3 stated, "Nothing."

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