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

TAYLORVILLE TERRACE
Facility Name

0037234
I.D. Number

921 EAST MARKET STREET, TAYLORVILLE, ILLINOIS 62568
Address

Reviewed By

MAY 26, 2005
Date of Survey

COMPLAINT 0542038
Type of Survey

Surveyed By

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):

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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 weritten policies shall be followed in operation the facility and shall be reviewed at least annually.

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 RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (Section 3-160 of the Act)

A FACILITY ADMINISTRATOR, EMPLOYER, OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL ALSO REPORT THE MATTER TO THE DEPARTMENT. (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

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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.

The facility failed to do the following:

1) Failed to develop a plan and provide services to supervise and monitor R1 when she moved into her own apartment on 05/06/05 without means for self support and no plan was put into place for monitoring of safety, financial, health, and nutritional status until 05/12/05.

2) Failed to implement their own policy on reporting abuse, thereby potentially allowing abuse to continue (R1 through R12).

3) Failed to develop a discharge plan for R1.

1) Per review of Physician's Order Sheet, R1 is a 22-year-old female that functions at a mild level of mental retardation. Other diagnoses' include: Depression, Schizoaffective Disorder and Depressive Type Behaviors.

Per review of R1's Individual Program Plan dated 12-16-04, R1 has an Intelligence Quotient of 58.

Per review of Physician's Order Sheet, R1's medications include: Fluoxetine (Prozac) 30 milligrams daily for depression.

A) Per review of Physician's Order Sheet, R1 is a 22-year-old female that functions at a mild level of mental retardation. Other diagnoses' include: Depression, Schizoaffective Disorder and Depressive Type Behaviors.

Per review of R1's "Social Service Annual Update" dated 12-15-04, R1's current Broad Independence age is nine years and eight months. Last year R1's Broad Independence age was 11 years and seven months.

Per review of R1's Social Service Report dated 12-15-04, R1 was admitted to this facility on 11-14-02. Documentation states R1 has a history of elopement, hallucinations, suicidal behavior, agitation, depression, falsifying police reports and an arrest for disorderly conduct.

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Per review of R1's Behavioral Report dated December, 2004, documentation states Historical records reviewed indicate that R1's social judgment is poor. She is easily influenced by others".

Per review of R1's Behavior Management Program (no date documented), R1 is on a behavior program for crying, inappropriate verbalization, running away and non-compliant behavior.

Per review of R1's Social Service Annual Update dated 12-15-04, recommendations state "Review ability to maintain legal competency".

Per review of R1's Individual Program Plan dated 12-16-04, as documented under "Sexuality". Documentation states "R1 does have a history of being vulnerable".

Per review of R1's Individual Program Plan dated 12-16-04, "Team Recommendations and Concurrent Services" state "Provide assistance in the community" and "24-hour supervision".

Per interview with E1, Administrator, on 05-12-05, at 4:40 P.M., E1 stated that on 05-05-05, R1 had became angry, stating that she was her own person and that she was "Out of here". E1 said that R1 was taken to the local emergency room because she was so angry and upset. When R1 arrived at the local hospital, she was calm and was returned to the facility.

Per continuing interview with E1, on above date and time, E1 said that the next morning (05-06-05), R1 again began telling staff that she was leaving. R1 called E1 and said that she (E1) had tried to talk R1 out of leaving the facility.

E1 continued to say that E3, Licensed Practical Nurse, who was on duty at the time, called E1 to inform her that R1 had bagged up her personal possessions and said that she was leaving. E1 stated that she told E3 to write up the discharge papers and to get a check from R1 for the May, 2005 rent that she still owed to the facility.

E1 also stated that E3 wrote a check from R1's checking account to pay for the rent. R1 signed the check and then tore it up. E1 stated that R1 signed the discharge papers, and walked to an apartment complex.

Per observation, on 05-12-05 when surveyor checked her odometer, the odometer showed it was 2.2 miles from the facility to R1's rented apartment complex.

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Per continuing interview, with E1, when asked if staff assisted R1 with her move into her own apartment, E1 stated that she was not sure if they did or not but that they did not offer to drive her because they were trying to talk her out of leaving.

When asked how she moved her possessions into the new apartment, E1 stated that she was given her checkbook, medications, and her possessions and that she carried them with her when she left.

E1 continued to say that R1 was given the telephone numbers for her Doctor, Psychiatrist, Department of Human Services, Pre-Admission Screening Agent, Illinois Department of Public Health, Ombudsman, local mental health agency, Dentist, and Optometrist.

E1 continued to say that R1 called the facility on 05-06-05 and said that she was fine.

E1 stated that she received a telephone call on 05-07-05 from E4 (Former Residential Service Director) saying that R1 had called E4 and told her that she was hungry and lonely. E1 continued to say that she has told the staff at this facility that if R1 shows up and tries to cause trouble, to call the police.

Per review of facility's documentation, R1 discharged herself from the facility on 05-06-05.

Per interview with E1 on 05-12-05 at approximately 4:40 P.M., E1 stated that R1 moved out of the facility on 05-06-05 and that she contacted the local PAS (Pre-Admission Screening) agency on 05-09-05 and informed them that R1 had moved out into her own apartment.

Per interview with Z1 (PAS agent for Central Illinois Service Access / CISA) on 05-12-05 at 2:00 P.M., Z1 informed the surveyor that she had been notified Monday, 05-09-05, that R1 had been discharged from the facility. Z1 stated that she went to see R1 at her apartment and R1 had a mattress on the floor, a television set and a radio, also on the floor. Z1 continued to say that R1 had informed her that she had no money.

Per interview with E2, Resident Service Director, on 05-18-05, at approximately 10:15 A.M., E2 stated that she did not feel that R1 made a rational decision when she moved out of the facility on 05-06-05.

Per interview with R1 on 05-12-05 at approximately 5:50 P.M., when asked if anyone from the facility has checked on her since she moved out, R1 stated that E5 brought her the mattress on the floor and some personal stuff, and that E3 had taken her to the food pantry to get some food but that they were doing this, "Behind E1's back, because she told me I had to find my own way".

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Per interview with R1 on 05-12-05 at approximately 5:50 P.M., when asked if she was able to completely live on her own, R1 stated to surveyor that she needed help with balancing her checkbook and budgeting her money. When asked if she had any money, R1 stated that she had some dimes on the window ledge that was $1.00 and that she had two quarters and a penny in her purse but that she was going to get her (self) a "Pop" in a minute.

Per continuing interview with R1 on above date and time, when asked how she was going to live on her own with no money, no food, and no rent money for next month, R1 stated that she would probably get a check in June but that if she didn't, she did not know what she would do. R1 also stated that she owed the Social Security Office $1,900.00 (Per documents from the Social Security Office, R1 actually owes $19,000.00).

Per interview with E5 (Direct Support Person) on 05-12-05 at 5:00 P.M., E5 stated that on 05-06-05 when R1 decided that she was moving out, E5 helped R1 to move her possessions onto the front porch of the facility and then she (E5) left the facility because it was time for her to be off duty. E5 continued to say that she returned to the facility later that evening and helped her move her stuff (television, radio, and personal possessions) using E5's brothers' truck. E5 also stated that at that time, she took a mattress to the apartment for R1 to use. E5 continued to say that she did not feel that it was an appropriate decision for R1 to move out when she did.

Per interview with E3, Licensed Practical Nurse on 05-17-05 at 12:30 P.M., E3 stated that when R1 decided to move out of the facility and into an apartment, she (E3) called E1 and reported this to her. E3 stated that E1 told her that R1 was her own guardian and could make her own decisions and staff couldn't stop her if she wanted to leave because they would be restricting her rights. When asked if she felt that R1 was capable of making appropriate and informed decisions, E3 replied, "Not really".

Per review of R1's Individual Program Plan dated 12-16-04, Z3 (R1's brother) is documented as being R1's "Circles of Support".

Per interview with Z3 on 05-19-05 at 4:50 P.M., Z3 stated that the facility had contacted him a couple of years ago asking if he would be interested in being R1's guardian. Z3 said that the facility had told him that R1 was not capable of really taking care of herself, "Because of how her mind was". Z3 stated that he told the facility at that time that his only concern regarding guardianship would be that if R1 had to go to court he would not be able to take off work and go with her, and that he didn't know what responsibilities a guardian had. Z3 continued to say that he had talked to "The lady at (the facility)" about the state taking guardianship of R1, and the facility had informed him that there was nothing that they could do about state guardianship.

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Z3 stated that the facility has not gotten back to him about guardianship and what all goes with being someone's guardian since the original conversation so he thought that it had all been taken care of and that the state was R1's guardian.

Z3 also stated that he was not happy with the facility for discharging R1 and that he felt that the facility should have called him. He is her brother. Z3 stated that right now, all he knows is that she is in a neighboring town but he doesn't know where and that he doesn't have any way to call her or get in touch with her. Z3 continued to say that R1 does not know anyone in that town and he would like to see her closer to him.

When asked if he felt that R1 was capable of taking care of herself and making informed decisions, Z3 stated that R1 is not able to make her own decisions and that if a person tells her to do something, she will do it without question and is easily influenced. Z3 continued to say that if R1 were on her own without someone to help her and she was hungry, she would not be able to find food. Z3 also said that R1 cannot count money, that he and his wife have taken her to the store and when she buys something, she will lay all of her money on the counter and cashier picks out the amount needed. Z3 continued to say that R1 wrote him a check and that she wrote the check to "Brother" instead of his name. Z3 stated that R1 "could really be taken advantage of".

2) Per review of R4's Physician's Order Sheet, R4 is a 59-year-old male that functions at a Moderate level of mental retardation. R4's diagnoses' include: cataract in right eye and Muscular Dystrophy. R4 requires a wheelchair for mobility.

Per interview with E6 on 05-13-05, at 9:15 A.M., E6 informed surveyor that "back in the winter", she had walked into the facility and saw R4 lying on the floor and E7, (Direct Support Person, on midnight shift) was down on the floor beside him screaming for him to get up. E6 stated that E8 (Direct Support Person, on the midnight shift) was in the room also. E7 told R4 to get his, "lazy butt up". E6 said that at that time, she got a gait belt and assisted R4 to his wheelchair with the help of E7 and E8. E6 stated that she then told E7 to leave the room and she would take care of R4. E6 said that both E7 and E8 left the room.

Per same interview, E6 continued to say that she wrote the entire incident up and put it in E1's box in the office. E6 stated that there was a good chance that E1 had not gotten the report because when E7 and E8 were working, papers came up missing.

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Per review of facility's incident reports, surveyor noted several incidents regarding R4 falling on 12-02-04, when both E7 and E8 were working.
Findings are:

1:00 A.M., Living Room - Documentation states that on 12-02-04 at 1:00 A.M., R4 was being assisted to walk and fell to his knees in the living room. His knees were documented as being red and R4 did not complain of any pain.

5:30 A.M., Bathroom - Documentation states that on 12-02-04, at 5:30 A.M., R4 was being assisted to walk and he stopped walking and started sliding to the floor. Staff assisted him to the floor and he was placed on his "butt". Documentation continues to say that R4 had no complaints of pain.

6:00 A.M., Bedroom - Documentation states that on 12-02-04, at 6:00 A.M., R4, "Was walking & (and) gave up and slid to the floor. No injuries. He was in the doorway of his bedroom & (and) started to fall forwards and I held on to his underarms. (E8) held onto his pants & (and) lowered him on his butt. He started to lean to his left so I bent down & (and) sat by him holding him up. We brought a chair by him to help us move him. He wouldn't help us. Then another staff came got a gait belt, all three staff lifted him up into his wheelchair. He said his leg was sore when (E6) was moving it. He never complained after that".

Per review of facility's incident reports dated 12-02-04 at 5:00 P.M., Direct Care Staff documented that R4's "R big toe was swollen and bruised he stated that it hurt..."

Per continuing review of facility's incident reports, R4 was sent to the local emergency room by ambulance at 12:00 P.M.

Per review of R4's x ray report, dated 12-02-04, documentation states "There is an acute intraarticular fracture of the medial side of the base of the distal phalanx of the first toe..."

Per review of facility's investigation dated 12-05-04, documentation states "Investigation of the following:

Emergency Room Visit
Allegation of staff inappropriately treating a resident
Right's Restriction and violation of fire safety codes
Allegation of staff verbally abusing a resident".

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Per review of summary of the investigation, documentation states, "On 12/02/04, it was reported to RSD (Residential Service Director) by staff members, E6 (Kitchen Manager/Direct Care Person) and E3 (Licensed Practical Nurse) by phone at approximately 8:15 A.M. that the two MN (midnight) Shift staff, E8 and E7 inappropriately treated a resident R4, per E6 and that the residents were very upset with the two MN (midnight) Shift staff due to being unable to leave the living room area while waiting for the bus, per E3 and that residents were mistreated.

Per E3, (7am LPN) (Licensed Practical Nurse) E7 had yelled at R10 to "get your lazy ass up and don't act like a baby" while he was sitting on the floor. She also stated that several residents were very upset about staff not allowing them to wait for the workshop bus in their bedrooms. She also stated several residents were upset that the two staff had been yelling at the residents and from what she observed upon arrival to work (7am) that the residents were being mistreated and the two staff was making the residents very upset. She states E7 told resident R2 to shut up or she was not giving her a cigarette. She reports that E7 was in resident's (R3's) face yelling at her.

E6 (5 A.M., ADSP/Cook) states she witnesses E7 and E8 attempting to ambulate (R4), resident, without a gait belt (which is recommended for all transfers) and were treating this resident poorly because he was not "helping" with his transfer/ambulation. She states E7 told R4 that he was being lazy and that he needed to get up. E7 told R4 to "quit being so lazy, help yourself, quit making us lift you." After assisting the two staff with lifting him onto his wheelchair, she could tell R4 was uncomfortable..."

Per continuing documentation, it states, "...She (E6) also states that at around 7:30 A.M., she heard R13 yelling, R1 crying and being loud, R3 was upset and was running outside without a coat on".

Summary of Investigation, dated 12-05-04, states, "It is apparent that both E8 and E7 both responded to resident's behavior outbursts in a negative manner by raising their voices to them and also by shutting the exit doors to prevent anyone from leaving the area. They apparently had also created stress and upset the residents by closing door and requested that all remain in the living room."

Summary of Investigation continues to say, "Although they definitely violated policies, neither staff warrant termination of their employment."

Documentation of disciplinary action taken for E7 - "one-day suspension, written warning for the violation of resident's rights and safety codes by shutting the doors, and also a written warning for the mishandling of the residents behaviors by raising her voice to them.

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She also will receive a written warning for making the inappropriate statement of “don't be lazy towards R4.".

Documentation of disciplinary action taken for E8 - "one-day suspension, written warning for violating the resident's rights and safety codes by shutting the doors, and also a written warning for the mishandling of the residents behaviors by raising her voice to them.".

The facility was unable to provide any evidence that either staff were supervised or monitored upon their return to work, after their suspension.

Per review of the facilities, "Procedure - Protection/Response", documentation states:

1. All residents will be protected from harm during the investigation of possible abuse.

2. The person alleged to have abused a resident will be immediately suspended pending investigation. If the abuse was related to another resident, the alleged perpetrator will be separated from and not allowed unsupervised contact with the resident that was abused.

3. Following a through investigation, if the alleged abuse was not founded, the person will be reinstated with back pay. If the alleged abuse was founded, the person will be terminated...”

Per review of the facility's, "Procedure - Reporting", documentation states:

"1. If any incidents or possible incidents of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, misappropriation of property or neglect are observed or suspected, it is the responsibility of each partner, regardless of his responsibilities, or if on or off duty, to immediately report the incident to his immediate supervisor. The supervisor will then inform the Administrator or his designee as soon as an allegation is received...”

Per interview with E6 (Kitchen Manager/Direct Support Person) on 05-12-05 at 5:30 P.M., when asked if she had ever observed the clients being abused or neglected, E6 stated that she has seen E7 (Direct Support Person/Midnight Shift) and E8 (Direct Support Person/Midnight Shift), kicking the client's beds in the mornings and telling them to get up. E6 continued to say that if the clients do not get up immediately and take their medications that when they do get up and ask for the medication, they either get a dirty look or are told, "No they can't have them". E6 continued to say that the medications are circled as refused.

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Per same interview, E6 stated that both R3 and R6 have told her they are afraid of E8. E6 stated that they did and that she put her documentation and both clients documentation in a sealed envelope and put it in the office for E1.

Per interview with E5 (Direct Support Person) on 05-12-05 at 5:00 P.M., E5 stated that she had heard from a resident that E7 tells R10 to, "get his fat ass up...You're lazy". E5 said that she has not reported this because it was, "hearsay".

On 05-13-05 at approximately 10:30 A.M., surveyor informed E1 of allegations of verbal abuse against E7 and E8. E1 stated that both staff would be suspended until a complete investigation could be done.

On 05-17-05, E2 (Residential Service Director) informed surveyor that both E7 and E8 have been terminated from employment at this facility. E2 continued to say that both E7 and E8 had refused to leave the facility, and that the local law enforcement had been called and escorted both from the premises. E2 stated, "After seeing them act like that, they really shouldn't have been here".

(A)