STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G295	A. BUILDING _____ B. WING _____	C 02/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADLOFF PLACE	50 ADLOFF LANE SPRINGFIELD, IL 62703

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W 153	Continued From page 16 had told E10 (nurse). E10 was interviewed on 2/1/06 at 12:25pm. E10 stated that a direct care staff member reported to her that E1 had hit R1. E10 stated that she informed the staff member that they had to turn it in, that they were a mandated reporter. E10 stated that she talked to an additional staff member who also gave the same information. E10 was asked if she was considered a supervisor. E10 stated yes. E10 stated that she was going to call the home office but did not have the number. No evidence was presented that the allegation of abuse was reported so that an investigation could be initiated. E1 continued to have opportunities for contact with residents in the facility from 1/13/06, the date of the alleged abuse, until 1/25/06 when E9 was notified by the surveyor of the allegation. Upon entering the facility on 1/25/06 at 9:45am, E1 was observed to be in the facility. On 1/25/06 at 2:45pm., a phone interview was conducted with E9 (Chief Operating Officer). E9 was notified at that time, by the surveyor, that the Department had received an allegation of abuse against the facility administrator. E9 indicated that the administrator would be put on administrative leave and that an investigation would be started.	W 153		
W9999	FINAL OBSERVATIONS Licensure Violations 350.620a) 350.1060h) 350.3240a)c)d)e)	W9999		

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W9999	Continued From page 17 Section 350.620 Resident Care Policies a) 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. Section 350.1060 Training and Habilitation Services . h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) c) 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) d) A facility administrator, employee, or agent	W9999		

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W9999	Continued From page 18 who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) 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 are not met as evidenced by the following: Based on interview and record review, regarding the allegation of abuse of R1 by staff on 1/13/06, the facility failed to develop and implement written policies and procedures that prohibit abuse in that; a) Facility staff failed to follow facility policy 300.04.2-1.C (Abuse and Neglect) regarding immediate notification of allegation of abuse, resulting in the staff person continuing to have opportunities for contact with residents in the facility from 1/13/06, the date of the alleged abuse, until 1/25/06. Facility Policy 300.04.2 does not contain a clear procedure on who to notify if the allegation of abuse is against the administrator, and staff did not demonstrate knowledge of who to notify in such cases. b) Facility failured to implement policy 300.04.5 (	W9999		

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W9999	Continued From page 19 Residence Communication Logs) by failing to maintain a Residence Communication Log for staff use. Findings Include: 1. R1, per current Individual Support Plan of 10/06/05, is a 34 year old female with diagnoses of Profound Mental Retardation and Autism. Written statement submitted, at the request of surveyor, by E4 (direct care) on 1/26/06, indicated that on 1/13/06, while sitting in the dining room assisting with breakfast, E4 heard what sounded like a clap and E1 (Administrator) made the statement, "Yes I hit her." The statement also alleges that E1 also said "If anyone (sic. would) like to call Public Health they can." E4 stated that when she turned around E1 was looking directly at her. E4 was interviewed on 1/26/06 at 9:47am. E4 stated that R1 was sitting at a table by the fire extinguisher which is on the outside wall. E4 stated that E1 was sitting at the table with R1. E 4 stated that she was sitting at the next table toward the hallway with her back to R1's table. A confidential interview was held with another facility staff on 1/26/06. This staff member was also assisting with breakfast that morning and stated that they heard a slap, heard E1's comment about Public Health, and reported that he was looking at E4. When asked where the various individuals were located, the staff member stated that R1 and E1 were at the table by the outside wall and that E4 was at the next	W9999		

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W9999	Continued From page 20 table over toward the hallway. E4 was interviewed on 1/25/06 at 10:05am. When asked who you would report abuse to if the alleged abuser was the administrator, E4 stated call 911. E5 (direct care) was interviewed on 1/ 25/06 at 10:10am. When asked who you would report abuse to if the alleged abuser was the administrator, E5 stated the 1 800 number (Illinois Department of Public Health Hotline). E6 (direct care staff) was interviewed on 1/25/06 at 12:50pm. When asked who you would report abuse to if the alleged abuser was a manager, E 6 stated, "I guess corporate." When asked if the number was available, E6 stated, "Not that I'm aware of , not hanging up." E2 (Qualified Mental Retardation Professional) was interviewed on 1/ 25/06 at 10:20am. When asked who to report alleged abuse to, E2 indicated to the administrator unless he was the one doing the abusing. When asked then who it would be reported to, E2 stated OIG (Office of Inspector General) and indicated that he was not familiar with how their policy is set up here. E2 was interviewed again on 1/26/06 at 2:35pm. When asked if the corporate number was posted or available to staff, E2 stated, "Not to my knowledge." Per confidential interview with direct care staff, they did not know if anyone had reported the allegation. The staff member indicated that they had told E10 (nurse). E10 was interviewed on 2/ 1/06 at 12:25pm. E10 stated that a direct care staff member reported to her that E1 had hit R1. E10 stated that she informed the staff member that they had to turn it in, that they were a mandated reporter. E10 indicated that she talked	W9999		

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W9999	Continued From page 21 to an additional staff member who also gave the same information. E10 was asked if she was considered a supervisor. E10 stated yes. E10 indicated that she was going to call the home office but did not have the number. On 1/25/06 at 2:45pm, a phone interview was conducted with E9 (Chief Operating Officer). E9 was notified at that time, by the surveyor, that the Department had received an allegation of abuse against the facility administrator. E9 indicated that the administrator would be put on administrative leave and that an investigation would be started. E1 continued to have opportunities for contact with residents in the facility from 1/13/06, the date of the alleged abuse, until 1/25/06 when E9 was notified by the surveyor of the allegation. Upon entering the facility on 1/25/06 at 9:45am, E1 was observed to be in the facility. Facility policy 300.04.2-1. C. states, "An employee suspecting or witnessing an incident, which may be defined as mistreatment, corporal punishment, threat, exploitation, neglect, abuse or as a serious injury, shall, according to state statues and facility policy: Report the incident to the supervisor, who shall immediately inform the Administrator or designee of the incident." The facility policy did not make clear who staff are to report allegations of abuse to when the allegation is against the facility administrator. The facility staff failed to immediately report an allegation of abuse so that an investigation could be initiated resulting in E1 continuing to have opportunities for contact with R1.	W9999		

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W9999	Continued From page 22 2. Facility policy 300.04.1 (Reporting Individual Unusual Incidents) section 4. states, "On each shift, staff discovering the evidence of an Individual Unusual Incident should consult the Resident Communication Log ... in order to determine whether a Form PS : 300.04.1-A, Individual Unusual Incident Report has previously been completed." Policy 300.04.5 (Residence Communication Logs) states, "facilities shall ensure that staff on all shifts use Form PS : 300.04.5-A, Residence Communication Log in an effort to enhance communications between all departments and staff. It is not a forum for complaints, but a vehicle to ensure good communication lines are kept open so that individual and department issues are addressed in a timely manner. Entries should include communications between shifts, documentation of Individual Unusual Incident Reports completed, documentation of any Behavioral Incident Reports completed, medical issues, maintenance and housekeeping issues, documentation of any visitors, LOA's, dietary issues, programming issues, individual needs, and any other information that needs to be shared between shifts and departments." On 1/26/06 at 1:50pm., E2 was asked for the Residence Communication Log. E2 stated, "I wonder where I might find that." E2 was asked if he was familiar with it, and he indicated that he wasn't. E2 confirmed that the facility does not have a communication log.	W9999		