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W9999	Continued From page 10 LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060b)2) 350.1060h) 350.3240a) 350.3240b) 350.3240e) 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 a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. b) Each resident shall have individual evaluations which shall: 2) Provide the basis for prescribing an appropriate program of training experiences for the resident. 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.	W9999		

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W9999	Continued From page 11 Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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. 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. These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to implement their policy to prevent abuse, neglect and mistreatment when they failed to: 1. Ensure that 1 of 1 incident of verbal abuse dated 3/18/07 was reported immediately to the Administrator. This incident involving R4 was reported to the Administrator on 3/20/07. Per the incident report, Z1 threatened to cut R4's fingers and nose off and took scissors out and mimicked performing the actual action; 2. Ensure that all 97 clients were provided with continuous nursing supervision on 3/18/07. Z1 left the facility for approximately 20 minutes; thereby leaving the facility with no nursing coverage; 3. Ensure that 1 of 1 incident of mistreatment dated 11/22/06 was reported immediately to the	W9999		

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Administrator. This incident of mistreatment involving R27 was reported to the Administrator on 12/5/06. Per the incident report, R27 had a note safety pinned to her pajamas that read, "Will Work for Pop;" and,
4. Ensure that staff involved in allegation of verbal abuse was immediately restricted from further contact with clients pending investigation. Per the incident report, R5, on 7/3/07, alleged that a staff told him he "stinks." R5 then put his hand through the window sustaining a laceration requiring 8 stitches and 6 staples.

These failures affect 2 of 2 incidents of abuse (R4 and R27) and 1 of 1 allegation of verbal abuse (R5) during the past year.

Findings include:

1) R4, per her face sheet, is a 27 year old female whose diagnoses includes Moderate Mental Retardation and Obsessive Compulsive Disorder. Per the Inspection of Care Information sheet, R4 has an adaptive behavior score of 4 years and 7 months.

The facility currently has 15 clients whose diagnosis include Mild Mental Retardation, 45 clients whose diagnosis includes Moderate Mental Retardation, 22 clients whose diagnosis include Severe Mental Retardation and 14 clients whose diagnosis includes Profound Mental Retardation.

The incident report dated 3/20/07 was reviewed. The incident report noted the following, "Staff reports Z1 threatened to cut fingers and nose off R4. Took scissors out and mimicked movement of performing act. Then left building unattended

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by nurse for 20 minutes (approximate)."

E6 (Program Assistant)'s statement was reviewed. E6 documented, " ....I heard the nurse tell R4 that she had a big knife which she would use to cut her fingers off with if she (R4) didn't stop reaching across the counter. Z1 went into the med (medication) room (and) came out with a pair of scissors (with blue handles). Z1 told R4 that 'see I have these, I will cut your fingers off, I will even cut your nose off and you'll look ugly with no nose.'.....After meds Z1 came came out of the office told me that she needed coffee. She had her jacket on, put the keys for the nursing department down in front of me said she would be right back. At first I thought she had to go to her car for her coffee but she said she would not be gone long. The nurse (was) took about 15 min (minutes) because apparently she went to the gas station."

Z1's statement was reviewed. Z1 documented, ".... I asked her (R4) if she wanted me to bite her fingers off because she was reaching across counter touching." Z1 added, "I just showed her the scissors for one minute then put away..." Z1 also verified that she left the facility to get coffee.

E1, Administrator/Executive Director was interviewed via phone on 7/17/07 at 9:50am. E1 verified that the facility has a policy that requires at least one nurse is in the building at all times.

E3, DON was interviewed on 7/17/07 at 9:45am and then at 10:08am. E3 stated, "We usually have a nurse for 8 hours and a treatment nurse for 6 hours during the 3-11pm shift." E3 then added that on 3/18/07, the treatment nurse first stated she was coming in late but did not come at

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all; thus leaving Z1 as the only nurse for the facility when she left the facility to get coffee from a nearby gas station.

E7, Director of Quality Assurance, was interviewed on 7/11/07 at 3:30pm. E7 stated that the incident was not reported until 3/20/07. E7 further added that the incident was reported by E6 who witnessed the incident on 3/18/07.

The facility's policy on abuse and neglect was reviewed. It includes as follows:
Verbal abuse is defined as "the use of verbal, written or gestured language that includes disparaging remarks or derogatory remarks to residents, regardless of the ability to comprehend. This includes humiliation, harassment, threats of punishment or sexual harassment."
Neglect is defined as "the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect also includes failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident physical or mental condition." Examples of neglect include "failure to provide adequate supervision."
Under reporting it noted, "Staff are expected to report abuse, neglect or mistreatment in a timely manner to those authorized as delineated in separate policy. Reporting is designed to identify areas of risk and thus enable early intervention. Reporting also ensures respectful treatment of residents and can help to identify risk factors that can removed from or eliminated from the environments."

E6 failed to implement the facility's abuse and neglect policy by neglecting to report the verbal

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abuse immediately. In addition, E6 failed to immediately notify the Administrator that the nurse left the facility.

2) R27, per her Inspection of Care Information (IOC), is a 45 year old female whose diagnosis includes Moderate Mental Retardation. R27, per her IOC information, has an adaptive score of 5 years and 6 months.

The incident report dated 12/6/06 was reviewed. A written note dated 12/5/06 by E8, Program Assistant, was reviewed. E8 wrote, "Date: Wed (Wednesday) (possibly) Mid-November. Staff was leading client (R27) thru hallway encouraging client to "ask him for money; ask her for money." R27 had safety pinned to her pajamas a handwritten sign (on note paper) that read: Will Work for Pop."

E8's statement dated 12/6/06 was reviewed. It noted, "I saw R27 and a staff (E9, Program Assistant) walking and R27 had a sign pinned to her saying, "I will work for pop." E8 added, "I confronted E9 by the main door area and told her, 'Don't have her ask for money.' After I said something, I didn't see her with the sign."

E9's statement dated 12/6/06 was reviewed. E9 wrote, "I E9 did not know that that was teasing the resident. We always interact with R27 like that...."

E10 (Supervisor)'s statement dated 12/6/06 was reviewed. E10 stated, "E8 came up to me at 11pm and appeared to be mad. E8 reported that a staff had a sign safety pinned 'will work for pop' on R27. E8 said the staff was taking R27 around begging for money."

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E7, Director of Quality Assurance was interviewed on 7/11/07 at 3:30pm. E7 stated, "Staff did not report it because they didn't think it was abuse." E7 was asked how the facility knew about the incident. E7 answered, "It was during the training for abuse and neglect."

The facility's policy on abuse and neglect was reviewed. It includes as follows:
Verbal abuse is defined as "the use of verbal, written or gestured language that includes disparaging remarks or derogatory remarks to residents, regardless of the ability to comprehend. This includes humiliation, harassment, threats of punishment or sexual harassment."

Under reporting it notes, "Staff are expected to report abuse, neglect or mistreatment in a timely manner to those authorized as delineated in separate policy. Reporting is designed to identify areas of risk and thus enable early intervention. Reporting also ensures respectful treatment of residents and can help to identify risk factors that can removed from or eliminated from the environments."

E10, supervisor, failed to implement the facility's policy on abuse and neglect when she failed to report and address the mistreatment of R27 that was reported to her by E8.

3) R5, per his face sheet, is a 47 year old male whose diagnoses includes Moderate Mental Retardation, Cerebral Palsy, Seizure Disorder and Intermittent Explosive Disorder. R5 has an adaptive score of 8 years and 6 months.

A note written by E11, nurse, dated 7/3/07 was reviewed. E11 wrote, "Client (R5) in Fireside

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W9999	Continued From page 17 Lounge when misunderstood staff (E12) saying he had a body odor and needed a shower, became agitated, hit picture wall by washroom, then pushed another client into wall and threw a book and then proceeded into bedroom and hit window with right arm causing severe laceration to arm and breaking the window...." E8, Program Assistant's statement dated 7/3/07 was reviewed. E8 wrote, "I was sitting in the fireside with my group when R5 came up to me with a complaint about staff. R5 claimed a staff person told him he 'stinks' and he asked if staff was allowed to say that. I told him I didn't smell anything, maybe he misunderstood." R5's statement dated 7/5/07 was reviewed. R5 stated, "I was in the big dining room for class and E12 stated, 'You stink.' I got really angry because she didn't even say she was sorry." E7, Director of Quality Assurance, was interviewed on 7/11/07 at 3:30pm. E7 was asked if E12 was separated from clients once R5 made the allegation, E7 answered, "No, she (E12) was not suspended. She was not on duty with him when he came back from the hospital." E7 then verified that E12 still had contact with other clients but not with R5. The facility's policy on abuse and neglect was reviewed. It includes as follows: Verbal abuse is defined as "the use of verbal, written or gestured language that includes disparaging remarks or derogatory remarks to residents, regardless of the ability to comprehend. This includes humiliation, harassment, threats of punishment or sexual harassment." Under Protection of Individuals it noted,	W9999		

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W9999	Continued From page 18 "Employees accused of abuse or neglect are immediately separated from residents by suspension or termination. Reinstatement will occur only after the completion of a thorough investigation conducted by a person qualified to do so. This investigation must clearly refute the allegation or fail to substantiate the allegation present." The facility failed to implement their policy on abuse and neglect when they failed to ensure that E12 was immediately separated from the residents once the allegation of verbal abuse was reported. (A)	W9999		