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	14G229	A. BUILDING _____ B. WING _____	03/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE INN-COBDEN	114 ASH STREET COBDEN, IL 62920

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W 264	Continued From page 14 was sustained. E1 (Administrator) was interviewed on 03/08/07 at 3:00 P.M.. During this interview, E1 reviewed the facility's incident and accident tracking log. At this time, E1 confirmed that that the facility's current tracking mechanism does not identify the person that was targeted which would assist in determining if a trend or a pattern is occurring. When E1 was asked how this information is presented to the facility's specially constituted committee? E1 stated, "I usually only include the number of behavioral incidents that the individual has had for that particular month. I don't identify any specifics regarding the behavior incidents." The facility's specially constituted committee meeting reports from 03/08/07 - 02/07/08 were reviewed. Documentation within these minutes identified that the number of behavioral incidents for each individual is included in the report. These minutes did not identify that specific information had been requested by the committee regarding the other individual(s) involved in the behavioral incidents or the severity of the behaviors. Further documentation did not identify that the specially constituted committee has made suggestions to the facility regarding the facility's practice of reviewing and monitoring behavioral incidents for trends and patterns, especially client to client behaviors.	W 264		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060b)1) 350.1060c)1)2)	W9999		

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W9999	Continued From page 15 350.1060d)e)h) 350.3240a) 350.3240f) 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: 1) Be based upon the use of empirically reliable and valid instruments whenever such tools are available. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate,	W9999		

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W9999	Continued From page 16 properly trained and supervised staff shall be available to administer these programs. 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 f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. These Requirements were not met as evidenced by: Based on observations, interviews and record review the facility has failed to fully develop their policy prohibiting abuse and neglect when they failed to fully describe wheat constitutes abuse and neglect. In addition, the facility failed to put preventative measures in place to prevent the reccurrence of harm to others, when 1 of 1 resident (R6) in the facility began displaying increased incidents of physical and verbal aggression toward other residents living in the facility.	W9999		

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W9999	Continued From page 17 Findings include: Upon review of R6's Medication Administration Record dated 02-2008, R6 is a 40 year old female who functions at a Severe level of mental retardation. Other diagnosis include: Impulse Control Disorder. During review of R6's ICAP (Inventory for Client and Agency Planning) dated 06-07-07, R6 functions at an overall age equivalency of 4 years and 8 months. Per review of R6's Individual Program Plan dated 06-07-07, documentation states that R6 has an I.Q. of 28. Documentation also states that R6 has a diagnosis of Obsessive Compulsive Disorder and Common Variable Immunodeficiency Syndrome. Per review of the facility's incident and accident reports for the month of 02-2008, surveyor noted 18 documented incidents of R6's displaying physical aggression towards others. These incidents include: 1. 02-06-08 - Kicked R7 (a 49 year old male who functions at a moderate level of mental retardation) on the right knee causing redness. 2. 02-06-08 - Hit R1 (a 37 year old male who functions at a mild level of mental retardation) above the left eye causing bruising. 3. 02-06-08 - Spit on R13 (a 52 year old female who functions at a moderate level of mental retardation and requires the assistance of a walker/cane for ambulation).	W9999		

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W9999	Continued From page 18 4. 02-06-08 - Kicked R14 (a 65 year old male who functions at a moderate level of mental retardation) on the right shin. 5. 02-07-08 - Picked up a chair and hit R2 (an 82 year old female who functions at a moderate level of mental retardation and requires the assistance of a walker for ambulation) in the back of the legs with it. 6. 02-09-08 - Slapped R2 on the face causing redness. 7. 02-14-08 - Hit R9 (a 45 year old male who functions at a moderate level of mental retardation) 4 times on the upper back. 8. 02-14-08 - Hit R14 a several times on the upper back and the back of his head. 9. 02-14-08 - Hit R11 (a 53 year old male who functions at a moderate level of mental retardation) 5 times on the upper back. 10. 02-10-08 - Slapped R2 in the face 11. 02-06-08 - Hit R4 (a 69 year old female who functions at a profound level of mental retardation) on the right shoulder. Per review of R6's incidents regarding Impulse Control, surveyor noted that from 02-01-08 until 02-27-08 R6 has had 22 documented episodes of bossing, spitting, threatening, cursing at and attempting to hit peers. During review of the facility's incident reports, surveyor also noted that during a behavior on	W9999		

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W9999	Continued From page 19 02-03-08, R6 hit a staff person and broke her scapula. Other physical aggressive episodes were documented for the month of 02-2008 in regards to R6 kicking, slapping and punching staff causing bruising and redness. Per interview with E2 (Residential Service Director) on 02-29-08 at 10:35 a.m., E2 said that on 02-03-08, R6 was having a, "regular behavior type situation" when R10 (a 48 year old male who functions at a moderate level of mental retardation) became upset and tried to get hold of R6. E2 continued to say that when staff stepped between R6 and R10, R6 hit the staff person and fractured her scapula. During continued review of R6's Individual Program Plan, documentation states that R6 is on behavior programs for: 1. Physical Aggression (defined as hitting, slapping, pinching, kicking, spitting on others, also includes attempts to engage in this behavior). 2. Impulse Control (defined as verbally abusing others, e.g. yelling or screaming, name calling and talking rudely to others). R6 is also on behavior programs for property destruction and self injurious behavior. Per interview with E2 (Residential Service Director) on 02-29-08 at 8:45 a.m., E2 stated that R6 was diagnosed with Immunodeficiency Syndrome approximately 2 years ago and began getting Immunoglobulin infusions monthly. E2 stated that she has noticed an increase in R6's behaviors since beginning the infusions. E2 continued to say that R6's behaviors increased in 2006 to the point where she required admission to a state operated facility until her medication regime to control the behaviors could be adjusted. E2 said that R6 was admitted to the	W9999		

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W9999	Continued From page 20 state operated facility on 05-02-06 and was discharged back to this facility on 06-21-06. E2 said that R6's behaviors had diminished greatly, but have recently begun escalating again. When asked what actions the facility has taken to prevent R6 from abusing the other individuals who live in this facility, E2 said that, "we try to keep her away from the rest of the clients as much as we can. She stays in the kitchen with staff, folds clothes, wraps silverware, shreds papers." E2 continued to say, "she still bosses people, it's her impulse control disorder, she's got to be in control of everything around her and she gets agitated when she can't have this control." During interview with E1 (Administrator/Qualified Mental Retardation Professional) on 02-29-08 at 3:10 p.m., E1 said that the facility provides R6 with as much supervision as possible. E1 continued to say that R6 is seated in the kitchen for her meals. If she appears agitated, she has been taken to the psychiatrist repeatedly with an increase of Seroquel and Depakote. The facility transports R6 to day training and picks her up to prevent behaviors on the bus with other residents and that a token program has been implemented within her Behavior Program. E1 continued to say that after R6 broke a staff's scapula on 02-03-08, he contacted R6's mother/guardian regarding a 30 day discharge to another facility. E1 also said that nothing is official and that no paper work has been submitted regarding the discharge. During same interview, E1 confirmed that, other than the token system, R6's behavior program has not been revised since her Interdisciplinary Team meeting on 06-07-07, even though she	W9999		

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W9999	Continued From page 21	W9999		

continues to be aggressive towards her peers. E1 also stated that there has been no increased supervision for R6 since the 02-03-08 incident of R6 breaking a staff's scapula and the continued aggressive behaviors towards other residents.

Continuing the same interview on 02-29-08 at 3:10 p.m., E1 stated that R6 is abusive to the other residents who live in the facility and that she is a threat to them.

Documentation within R6's monthly QMRP notes show R6's behavioral episodes for physical aggression and Impulse Control for the months of:

12-2007 - 53 episodes

01-2008 - 38 episodes

02-2008 - 36 episodes

During review of the facility's Abuse and Neglect policy, surveyor noted that documentation states, "Policy: It is the policy of this facility to provide a safe environment for the individuals served that is free from abuse, neglect, and exploitation". Documentation continues to say, "Mistreatment of individuals will be defined as...." Surveyor found no actual definition of abuse or neglect within its policy.

On 02-28-08 at 2:15 p.m., when asked what the facility's definition of abuse or neglect was, E1 was unable to define either. When asked how the facility determined if abuse or neglect had occurred, E1 stated that there was no specific definition of abuse or neglect in their policy and that the policy was actually for staff to client