STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G351	A. BUILDING ______ B. WING ______	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACHTREE ESTATES	1370 STATE ROUTE 127 SOUTH JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 11 LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.1060h) 350.3240a) 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 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, 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	W9999		

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Continued From page 12

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on observation, interview and record review, client to client abuse has occurred and the facility has failed to take action to protect the individuals and prevent reoccurrence for 6 of 15 individuals at the facility (R4, R5. R6, R7, R8 and R9) who have been subjected to physical abuse from R1 and R2. The facility failed to:

- Provide necessary staff supervision to R1 and R2 to prevent client to client abuse;

- Review and revise R1's and R2's behavior intervention plans as appropriate to reduce the incidents of client to client abuse; and

- Implement a system which ensures that sufficient safeguards are in place and implemented to prevent further occurrences of client to client abuse.

Findings include:

The facility's Unusual Incident Report/Abuse Neglect and or Theft Incident Report dated 04/14/09 states, "... R2 was going outside for his cigarette when he pushed R1 who was holding the door open for R8. R1 turned around to get away from R2 when R2 hit him on the back R1 then tried to shove R2 and they both went to the ground. During the scuffle, R8 was knocked down to the ground...." The facility's Incident Report dated 04/14/09 also states that R8

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W9999	Continued From page 13 received three abrasions to her left knee and one abrasion to her left index finger and one abrasion to her left wrist. R8's walker was also broken during the altercation between R2 and R1. After this incident, R2 was placed on one-on-one supervision and the facility concluded that R2 pushed and hit R1, R1 shoved R2, and that R8 was knocked down during the incident. No further recommendations and or actions were contained in this report. 1) On 05/13/09, R2 was observed at the facility arriving home from work at 3:15 P.M. R2 spoke with the surveyor and then ambulated independently into the facility's dining room. R2 was observed from 3:15 P.M. to 3:45 P.M. and was not observed to be closely supervised by staff. R2 went outside and to various areas of the facility independently without staff supervision. E1 (Administrator) was interviewed on 05/15/09 at 3:15 P.M. and confirmed that R2 was presently on general supervision. E1 stated, "R2 is on general supervision. R2 was placed on one on one staff supervision for a twenty four hour period after the 04/14/09 incident. R2 did not have any more incidents of physical aggression within a twenty four hour period, so he then was removed from one on one supervision and placed back on general supervision." The facility's Policy and Procedure for Resident Supervision and Special Observation dated 07/03/03 defines general supervision as supervision, "At designated times 1) breakfast 2) departure for work or 9:00 on weekends, holidays, inclement weather days or other days of special circumstances in which the residents are	W9999		

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not attending the workshop...3) lunch 4) arrival home from work or 3:00 P.M. for non work days... 5) supper 6) 8:00 P.M. This level applies to each individual resident throughout waking hours, unless it is deemed necessary that a more intensive level of Supervision is necessary..."

Further review of this policy also states that the individuals of the facility will be adequately supervised and provided, "the frequency and intensity of supervision necessary for each individual to ensure his or her safety and security."

In reviewing the facility's incident reports it was noted that the facility failed to provide necessary supervision to prevent R2 from physically aggressing against R1, R5, R8 and R9. R2 has had seven documented incidents of physical aggression towards other individuals of the facility from February 2009 to present. R2 also has had one documented incident of physical aggression at the facility's off site day training program. These reports identified:

02/22/09 - R2 became upset and "poked her (R8) in the right lower left eye lid with a fork," after R8 tried to tell him what to do. R8 was examined by the nurse and found to have, "...small red dot to right eye lid and her right eye. Right eye was sl. (slightly) swollen. No bleeding noted. Ice pack was given to res. (resident) to hold on right eye."

03/07/09 - R2 was yelling with R1 and hit R1 in the back with his fist;

04/05/09 - R2 hit R5 on the left side of his head with a closed fist. The facility's Unusual Incident Report/Abuse Neglect and or Theft Incident

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Report dated 04/26/09 states, "On 04/05/09 at 8:15 P.M., R5 and R2 were entering the dining room... when staff asked them to step out until the floor dries. R2 did not want to comply and R5 began arguing with R2 about leaving the dining room. R5 and R2 left the dining room and then staff heard them arguing. Staff went into the activity room and saw R2 strike R5 on the back of the head with an open hand while R5 was yelling at R2."

04/16/09 - R2 hit a peer on the lft side of his face with a closed fist at the facility's offsite day training program;

04/26/09 - R2 hit R9. The facility's Unusual Incident Report/Abuse Neglect and or Theft Incident Report dated 04/26/09 states, "R2 did slap R9 and R9 did push R2. R2 was aggravated at another resident over her saying R2 owed her a cigarette. Staff went to intervene with R2 and the female peer when R9 walked by and R2 slapped him."

05/01/09 - R2 was bumped by R5 and became agitated, hitting R5 with a closed fist to the right side of his face. R5 sustained a reddened area the size of a half dollar to his right cheek;

05/04/09 - R2 threw a plastic trash can at R1 after arguing with R1.

R2's Behavior Treatment Plan (with a revised date of 10/29/08) identifies that he is a 50 year old male who functions at a moderate level of mental retardation and has diagnosis of Schizophrenia, Paranoid Type. This plan also states that R2 has a Short Term Goal to reduce incidents of physical aggression to 0 per month

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W9999	Continued From page 16 for 6 consecutive months. Interventions within this plan include: - "Follow recommendations in the proactive section of the behavior plan; - Be observant and intervene quickly if R2 is exhibiting behavioral antecedents to becoming agitated (clench fist/pacing/facial features/patting peer on the head); - If R2 is in the act of being physically aggressive, give him a firm verbal prompts to "stop"; - Attempt to redirect him to an alternate task or activity;. - If the above interventions are unsuccessful, use the least restrictive CPI (Crisis Prevention Institute) techniques to protect the client and peers from harm to self or others; and - Once the behavior has stopped, attempt to resolve what was upsetting R2..." Further review of this behavior plan does not identify specific methods and/or levels of supervision needed to prevent R2 from aggressing against others. Additionally, no documentation was contained within this plan identifying that R2's behavior plan has been revised since 10/29/08 due to his continued aggression towards others. During the interview with E2 (Assistant Administrator) on 05/13/09 at 4:40 P.M., E2 stated "No" when asked by the surveyor if R2's behavior plan had been revised since 10/29/08. 2) R1's Behavior Treatment Plan dated (revised) 10/29/08 identifies that R1 is a 32 year old male who functions at a mild level of mental retardation and has diagnoses of Schizophrenia. This plan further identifies that R1 has physical aggressive	W9999		

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W9999	Continued From page 17 behaviors including, poking, closed fist hits, open hand slaps, scratching, pushing, kicking and biting. This plan also states that R1 is to be under "Continuous Supervision." The facility's Policy and Procedure for Resident Supervision and Special Observation dated 07/03/03 defines Continuous Supervision as, "Visual observation is maintained or whereabouts are known and visual contact is maintained with nearest exit door to the individual being monitored...." On 05/13/09, R1 was observed at the facility arriving home from work at 3:15 P.M. R1 entered the QMRP's office and greeted the surveyor. R1 then reached for the surveyor's picture identification badge that was located around the surveyor's neck. Staff were present in the doorway of the office, but were not close enough to prevent physical contact if R1 became aggressive. R1 was redirected from the office and ambulated independently into the dining room area of the facility. Staff were not observed to maintain a close distance to R1 when in the dining room. From 3:15 P.M. to 3:45 P.M., R1 went outside and to various areas of the facility independently, without staff supervision. In reviewing the facility's incident reports it was also noted that the facility failed to provide necessary supervision to prevent R1 from physically aggressing against R2, R4, R5, R6, R7 and R8. While he was on continuous supervision, R1 has had twelve documented incidents of physical aggression towards other individuals of the facility from February 2009 to	W9999		

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W9999	Continued From page 18 present. R1 also has had two documented incidents of physical aggression at the facility's off site day training program. The incident reports for R1 identified: 02/04/09 - R1 hit R2 on the arm with a belt (5:00 P.M.) and then came out of his room and went after R2 again hitting E2 (Assistant Administrator) with the belt; 02/11/09 - R1 hit E2, E3 (QMRP/Qualified Mental Retardation Professional) and hit R4 on the left jaw and slapped R5 on the left side of his face. R4 and R5 both had redness to the left side of their jaws after being hit by R1; 02/24/09 - R1 hit his roommate (R6) on the left side of his face with an open hand after being escorted to his bedroom; 02/25/09 R1 was upset over a stolen wall outlet and attempted to kick an unknown peer, twice; 03/03/09 - R1 pushed R2 for no apparent reason; 03/04/09 - R1 hit R2 in the head at the facility's offsite day training program; 03/07/09 R1 and R2 were yelling at each other and R1 hit R2 in the back of his head with his fist; 03/11/09 - R1 slapped a female peer on the right side of her face at the facility's offsite day training program; 04/25/09 - R1 hit R6 in the head with a necklace that he was wearing around his neck. R6 sustained a reddened area just above his right ear;	W9999		

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W9999	Continued From page 19 04/29/09 - R1 kicked a male peer in the back while at the facility's offsite day training program; 05/02/09 - R1 hit R7 in the back (8:59 A.M.) and then in the head (2:27 P.M.); 05/05/09 - R1 hit R6. The facility's Unusual Incident Report/Abuse Neglect and or Theft Incident Report dated 05/05/09 states, "R1 and R6 are roommates... R1 did slap R6..."; 05/12/09 - R1 hit R5 in the stomach with closed fist after a confrontation with R2. Further review of R1's behavior plan does not identify that R1's behavior plan has been revised since 10/29/08 due to his continued aggression towards others. During the interview with E2 (Assistant Administrator) on 05/13/09 at 4:40 P.M., E2 stated "No" when asked by the surveyor if R1's behavior plan had been revised since 10/29/08. On 05/15/09 at 3:00 P.M., E1 (Administrator) provided the surveyor with Special Program Reviews dated for 04/26, 05/03 and for 05/06. These reviews identify that R1 was placed on one on one supervision after his incidents of aggression (04/25, 05/02 and 05/05). These reviews also stated that R1 was taken off the one on one supervision within 24 hours of the behavioral incident and returned to continuous supervision. No documentation is contained within these reviews that would indicate that the special program reviewers recommended and or implemented additional supervision to prevent R1 from aggressing against his peers.	W9999		

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W9999	Continued From page 20 E1 was interviewed on 05/15/09 at 3:15 P.M. and stated, "We began investigating incidents of resident to resident aggression after receiving a memo from the Department (Illinois Department of Public Health) in February of 2009. At the facility, many of the individuals function at a mild level of mental retardation (R1, R3, R4, R5, R6, R8, R9, R10 and R11) and are constantly arguing amongst themselves. R1 and R2 are constantly arguing with each other and have had multiple incidents of aggressing against each other. When we investigate, R1 and R2 generally state that the other person had hit them first. We have just started our new system as of 05/15/09 which will promptly notify administration of any incidents of resident to resident aggression. We have not had time to implement this system for monitoring trends and patterns of resident to resident abuse." (A)	W9999		