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 11/05/2009

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

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W 331	Continued From page 26	W 331		

Per review of the 8/22/09 discharge instructions from the emergency room. The facility was to follow-up with R1's physician within 1-2 days and return if any signs/symptoms occurred.

Interview with E2(nurse) on 9/29/09 at 10:59am, R1 was taken to the emergency room on 8/22/09 for an evaluation. The ER report stated to follow-up with the facility's physician within 1-2 days. E2 stated that a follow-up was not completed per instructions.

W9999 FINAL OBSERVATIONS — W9999

LICENSURE VIOLATIONS

350.620a)
350.1060e)
350.1060h)
350.1060j)
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

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W9999	Continued From page 27 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. j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record. 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) These Regulations were not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement a policy to prevent abuse/neglect for 4 of 4 clients (R1,R2,R3,R4) in the sample and the potential to affect the other 12 individuals who reside in the facility (R5-R16), when they failed to: 1. Ensure the facility has policies and procedures for sexual activities and how to ensure sexual relationships are consenting without coercion.	W9999		

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W9999	Continued From page 28 2. Ensuring a system to assess human sexuality and ensure clients involved in sexual activities are capable of consent without coercion. 3. Thoroughly investigate allegations of sexual abuse for R2. 4. Adequately supervise 1 of 1 client who ingested paint, R1. 5. Ensure safeguards are in place to protect clients from physical abuse. Finding Include: 1) Per review of an 9/6/09 incident report, R2 and R3 were found in their bedroom in a "compromising sexual act." R2 and R3 were engaged in oral sex. R2's 9/8/09 ISP (Individual Support Plan) states R2 is a 25 year old ambulatory male who functions in the moderate range of mental retardation with Affective Disorder NOS, Intermittent Explosive Disorder NOS and mild Cerebral Palsy. R2's 9/1/09 ICAP (Inventory for Client and Agency Planning) over-all functioning level is 4 years and 3 months. Per review of R3's 5/29/09 ISP (Individual Support Plan), R3 is a 21 year old ambulatory male who functions with Borderline Intelligence and Bipolar Affective Disorder. R3's 1/6/09 ICAP (Inventory for Client and Agency Planning) over-all functioning level is 11 years and 5 months. Interview with E1(Administrator) on 9/29/09 at 11:00am, states the facility changed their roommate arrangement after talking to R2 and R3 about the situation. R3 told the facility that he had initiated the incident and it had happened	W9999		

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W9999	Continued From page 29 several times before. E1 stated neither individual is involved in a sex education/circles program and the facility has not implemented a sex education program for R2 and R3 since the incident. According to E1, the facility does not have a policy for sexual activities and how to ensure sexual relationships are consenting without coercion. R2's 9/8/09 ISP (Individual Support Plan) states that R2 does not recognize the difference between a friend and a stranger and occasionally needs to be prompted to maintain personal space with others as he will "hang" on staff. In an interview with Z1 (R2's guardian) on 9/29/09 at 2:00pm, she stated the facility (E4 Former Qualified Mental Retardation Professional) informed her that both residents were in agreement and the act was consensual. Z1 also stated that she talks to R2 on an on-going basis and is very involved in R2's life. Z1 stated that R2 called her on 9/6/09 and stated that he had a new roommate (R2 and R3 had been roommates since R3's admission in 5/09), but did not give a reason for this change. Z1 continued that E4 (Former Qualified Mental Retardation Professional) contacted her 2 days later on 9/8/09 and stated that R2 and R3 were discovered in a sexually compromising situation, and this incident was consensual since no physical force was reported. Z1 stated that R2 is easily persuaded by others and felt that R2 was unable to give consent for sexual activity. Review of R3's Behavioral Support Plan revised on 10/2/09, R3 has a targeted behavior of bullying which is defined as R3 has rubbed a dirty	W9999		

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W9999	Continued From page 30 mop in another resident face and called others names. R3's act of picking on someone he feels is less capable than him should be documented as bullying. R3's plan states that R3 should never be alone with another resident who is easily persuaded. R3 tends to bully others who are vulnerable. Per review of the facility abuse/neglect policy of 12/29/08: neglect is an intentional act or omission by an employee or person which denies the standard care and treatment due an individual as required by law, rules, regulations, policies, procedures, guidelines, or Individual Support Plan and the act results in any harm to the individual or where the act has the probable consequence of inflicting significant harm. On 9/29/09 at 10:30am, surveyor requested a copy of the facility investigation of the incident between R2 and R3 that occurred on 9/6/09. The facility investigation report only has documentation stating the date of the incident and what staff were on duty. The investigation does not include which individuals were involved in the sexual activity, the time of the incident, behaviors displayed by the individuals before or after the incident, statements from the individuals and what corrective actions were implemented by the facility. In an interview with E1 (administrator) on 9/29/09 at 11:10 am, surveyor questioned E1 about the incomplete investigation. E1 stated that the former QMRP (Qualified Mental Retardation Professional) who was in charge of the investigation is no longer employed by the facility and she was unaware that the investigation was not completed. E1 stated that the facility felt that	W9999		

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W9999	Continued From page 31 this was a consensual incident and was under the impression that the former QMRP (Qualified Mental Retardation Professional) had contacted the Department of Public Health. E1 acknowledged that the facility does not have a policy to determine whether the individuals are capable of consenting to a sexual relationship. On 10/28/09 at 8:12am, E1 was interviewed to confirm the facility does not have a policy to determine whether individuals are capable of consenting to a sexual relationship and ensuring safeguard are in place for clients who are vulnerable. 2) Per review of R3's 5/29/09 ISP (Individual Support Plan), R3 is a 21 year old verbal ambulatory male who functions with Borderline Intelligence and Bipolar Affective Disorder. R3's 1/6/09 ICAP (Inventory for Client and Agency Planning) over-all functioning level is 11 years and 5 months. R4's 3/10/09 ISP (Individual Support Plan) states, R4 is a verbal ambulatory male who functions in the moderate range of mental retardation with Downs Syndrome. R4's ISP states that he speaks to people he is comfortable with and is easily understood by others. Review of the facility's Individual Unusual Incident Report dated 10/10/09, written by E5 (DSP), states, "I was in the med room when R4's guardian came and said that she was tired of him putting his hands on her grandson." The incident report also states that the on-call person was notified immediately. Per interview with Z2 (guardian), on 10/21/09 at	W9999		

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W9999	Continued From page 32 9:30am, Z2 stated that she was on the telephone with her grandson (R4) on 10/10/09 around 4:00pm, when Z2 heard R3 say to R4, "Who are you talking to?" R4 replied "I am talking to my family." Z2 said she then heard R3 say, "Are you coming," and R4 replied, "In a minute." At that time I heard something that sounded like a slap and R4 yelled "Ouch" with a loud voice. Z2 asked R4 what had happened. At first he would not respond and then he said that R3 had hit him in the stomach. Z2 told R4 that she would be right over. Z2 stated that she expressed her anger to E5 (DSP) when she arrived at the facility and E5 was unaware of what had occurred. Z2 stated that E5 questioned R3 and learned that R3 had purposely hit R4 in the stomach. Z2 continued to say that she had heard that R4 had been hit by R3 before but had no proof, but this time she had heard it for herself. Z2 took R4 home that evening. Review of R3's Behavioral Support Plan on 10/2/09, R3's targeted behaviors are aggression which includes physical aggression toward the environment. The verbal aggression is characterized be threats of hitting and cursing. When upset R3 has hit and kicked the wall and has thrown over tables. Non Compliance of refusing to follow requests. Bullying which is defined as R3 has rubbed a dirty mop in another resident face and called others names. An act of picking on someone he feels is less capable than him should be documented at bullying. R3's plan states that R3 should never be alone with another resident who is easily persuaded. R3 also tends to bully others who are vulnerable. R3's behavior plan of 5/29/09 did not address R3's bullying others.	W9999		

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W9999	Continued From page 33 R3's behavior tracking sheet in October of bullying others was reviewed. R3 had 1 incident on the 5th, 5 incidents on the 7th, 2 on the 8th and 1 on the 10th of the month. The documentation does not reflect if R3 targeted one individual or several individuals in the facility. There is no evidence that trends and patterns were evaluated. During interview of 10/21/09 at 2:00pm with E1, the facility was unable to identify the victim(s) of R3's behaviors to determine how the facility planned to safeguard the individuals in the facility. 3) Per review of R1's ISP of 7/14/09 (Individual Support Plan), R1 is a 58 year old ambulatory female who functions in the profound range of mental retardation. In review of the facility's incident investigation on 8/22/09, R1 had gained access to the patio off the dining room unsupervised. E3 (direct support person) was doing laundry and getting other individuals up for the day and discovered R1 returning from the patio with paint on her face, neck and tongue. Document states R1 had possibly ingested the paint. Per interview with E3 on 10/5/09 at 10:00am, E3 had been on hallway getting clients up for breakfast and saw R1 earlier in the dining room. E3 stated he did not hear R1 leave the facility because the batteries for the patio door alarm were not working. E3 did not know how long the door alarm had not been working. E3 walked into the dining room and saw the paint on R1's face, neck and tongue. E3 stated that he had seen a	W9999		

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W9999	Continued From page 34 paint can in the facility dumpster the previous day. E3 looked at the label on the can and saw the poison control number and if the paint was ingested to drink water. E3 was able to contact E2 (nurse) who recommended R1 be taken to the emergency room. The 8/22/09 emergency services discharge instructions state R1 is to return for worsening signs or symptoms and to follow-up with the facility physician within 1-2 days. Per interview with E2 (facility nurse) on 9/29/09 at 11:00am, the facility did not make a follow up appointment with the facility physician. R1's ISP of 7/14/09 has a special precaution which states: "R1 will drink anything in a glass or cup, especially dark liquids, without regard to temperature or contents. R1 is to be in visual view unless in bed." R1's behavior plan of 7/10/09 has targeted behaviors of stealing drinks from others. Interview with E3 on 10/5/09 at 10:00am, E3 stated that staff are not assigned to a specific group of individuals to supervise throughout their shift and there is no evidence that R1 was in visual supervision during the morning of 8/22/09. (A)	W9999		