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W 249	Continued From page 15 During telephone interview with E1, Administrator, on 3/11/10 at 1:34 P.M., E1 said staff are to follow R1's plan when R1 makes suicidal threats which includes removing anything from his room that he could use to harm himself.	W 249		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060e) 350.1210 350.3240a) 350.3240f) 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. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. 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) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence,	W9999		

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W9999	Continued From page 16 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. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to prevent neglect when they failed to provide a safe environment with adequate supervision for 1 of 1 sampled individual (R2) who sustained injuries after being assaulted by another peer (R3) and for 1 of 1 individual in the sample (R1) whose behavior plan was not implemented when he made suicidal threats. Findings include: 1) According to the facility's resident roster dated 3/4/10, R2 functions at the severe level of mental retardation. The Inventory for Client and Agency Planning (ICAP), dated 4/14/09, shows R2 has an overall age equivalent of 2 years, 11 months. 2) Per physician's orders dated 1/16/10 - 2/15/10 R3's diagnoses include Moderate Mental Retardation and Behavior Disorder. According to R3's Individual Program Plan (IPP) dated 8/3/09, R3 displays physical aggression towards staff when he is told "no" or "'stop." Per review of an incident report dated 2/27/10, when E11 (DSP/Direct Support Person) was	W9999		

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assisting R2 getting dressed at 8:10 A.M. on 2/27/10, E11 noticed a bruised area on the upper back of R2's left leg just below the buttocks. E11 notified E2 (LPN/Licensed Practical Nurse) about the bruising.

E2 assessed R2 and documented in the nurse's notes that the bruise "measured 9 cm (centimeters) long by 6 cm wide. The lateral portion of the bruise had 3 dark areas 4 - 5 cm long by 6 cm wide with lighter bruising between them." E2 contacted the administrator and an "investigation started immediately." Written statements from all the staff on duty were taken.

According to the facility's investigation, dated 3/12/10, E2 called E1 (Administrator) at approximately 8:00 A.M. (on 2/27/10). E2 said "the bruise on the lower bottom looked like three finger prints." E1 came to the facility and looked at R2's bruised area with E2. E1 "did not see the other bruising as finger prints."

Per facility's investigation, E11 provided a written statement, dated 3/8/10, in which E11 states "I could see that it (bruised area) was in the shape of a handprint." E11 also confirmed that she "could see finger imprints" on R2's bruised area during an interview with surveyor on 3/8/10 at 2:48 P.M.

The investigation indicates E1 asked R2 how he got the bruises to which R2 replied "water, fell on floor." E1 also asked R2 where he had fallen but R2 did not answer.

E1 was interviewed on 3/4/10 at 8:10 A.M. E1 confirmed that he interviewed R2 on 2/27/10 and when asked what happened, R2 said that he had

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fallen. E1 said he talked with R2 for a few more minutes then asked R2 if he was afraid of his roommate (R3) and R2 said no. E1 said he initially viewed R2's fall and subsequent bruising as an incident of unknown origin.

Per further review of nurse's notes, E2 made an entry on 2/27/10, timed 3:00 P.M., stating that while conducting a follow-up assessment on R2, E2 noticed that the initial bruising on R2's left leg had darkened and a new lighter bruise was apparent on the right upper leg, right below R2's buttocks.

The next nursing entry dated 2/28/10 at 10:00 A.M. shows E2 again re-assessed R2. E2 documented that the bruising had darkened, with an additional bruise apparent to R2's left buttock.

E2 was interviewed on 3/4/10 at 1:45 P.M. E2 said he notified E1 when a new bruise was found on 2/28/10 at 10:00 A.M.. When E5 (Direct Support Person/DSP) was assisting R2 in the shower around 3:15 P.M. on 2/28/10, E5 told E2 that she saw bruising inside R2's buttocks. E2 called E1 who gave instructions to send R2 to the emergency room for evaluation.

During a telephone interview with Z1 (Physician) on 3/6/10 at 10:42 A.M., Z1 said upon examining R2 he saw bruising to R2's perineal area indicating some type of blunt force to R2's buttocks. Z1 said he did not see any evidence of tearing or bleeding in R2's anal area and no bruising to the sides of R2's buttocks which one would normally see during a sexual assault. Z1 stated he did not take rectal smears because R2 had recently showered. Z1 confirmed that he told staff (E5) the only way R2 could have gotten this

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type of injury was if he "fell on a broom handle." Z1 said the bruising pattern was "very unusual," and he was suspicious of it being a result of sexual assault. Z1 referred this incident to the Sheriff's Department.

According to the facility's investigation, E1 and E2 talked with R3 for almost 1 -1/2 hours on 2/28/10 before R3 would talk about the incident. R3 admitted that he "touched (R2) down there (pointed to his bottom) and that he wouldn't do it again." R3 indicated that R2 said "no" and R3 said "it was ok for (R2) to say no and he (R3) was proud of (R2). I can keep my hands to myself. I wasn't mad because (R2) told me no. I pushed (R2) to the floor and I punched him one time, and threw my shoe on his body (pointed to his bottom)."

Per continuing review of the investigation, R3 told E1 and E2 that R3 was wearing clothes when R3 hit R2. R3 said he did not know "what got wrong with me." R3 admitted he had hurt R2, but (R3) apologized to (R2) and said "I will keep my hands to myself." R3 said he thought R2 was not going to be his friend and that is why R3 hit R2. The report states, "When asked if (R3) did it to anyone else at (name of facility) (R3) said "No just (R2)."

Based on R2's Sexual Expression Assessment, dated 4/14/09, the Interdisciplinary Team (IDT) determined that R2 "lacks the capacity to consent to sexual activity and must be protected from abuse and exploitation."

Per continuing interview with E1 on 3/4/10, E1 confirmed that he and E13 (Assistant Administrator) interviewed R2 and R3 at

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approximately 7:00 P.M. on 2/28/10. While E1 was talking to R3, E13 interviewed R2. R2 said R3 "did it" meaning R3 had hurt him but did not give any further information.

According to the facility's investigation E14 (DSP) was R2's "assigned staff person (on 2/27/10) from noon until 11:00 P.M. (E14) said (R2) seemed reserved, quiet, and standoffish from everyone."

Review of E5's (DSP) written statement dated 3/10/10 indicates that when E5 was assisting R2 with his shower on 2/28/10, she and E2 asked R2 what happened and "he said he didn't want to live here no more." E5 asked R2 how he got the bruises and "all (R2) would say is 'on the floor.'"

E4, DSP, was interviewed on 3/4/10 at 3:20 P.M. E4 said he worked on 2/27 and 2/28/10 and noticed that R2 was not smiling like he usually does and kept to himself more.

Per interview with E5, DSP, on 3/4/10 at 3:05 P.M., E5 said she did not work on 2/27 but did work on 2/28/10 from 3:00 P.M. to 11:00 P.M. E5 said R2 "kept away from" R3 on Sunday (2/28). E5 also said she noticed R2 was cursing a lot more since R2 and R3 became roommates in January of 2010.

E7, DSP, was interviewed on 3/8/10 at 9:10 A.M. E7 said she worked from 11:00 P.M. to 9:00 A.M. E7 said R2 was not acting any differently when she saw him on her last shift the morning of 2/25/10. However, when when she returned to work on 2/28/10 at 11:00 P.M., she noticed that R2 did not want to go to bed, then at breakfast the next morning, R2 would not sit by R3.

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W9999	Continued From page 21 Continuation of interview with E1 on 3/4/10 at 3:00 P.M. confirmed that the incident probably occurred sometime in the early hours of 2/27/10 between 2:30 A.M. - 8:30 A.M. E1 stated that there were 2 staff on duty but neither one heard anything from R2 and R3's room. E1 said another peer (R8) has staff assigned to him on a 1:1 basis 24 hours per day, 7 days per week. E1 stated that, at the time of the incident, R8's room was adjacent to R2 and R3's room. However, R8 often gets up at night to go to the living room and his 1:1 staff has to go with him, so the remaining DSP may not have been in the area when the assault occurred. According to the abuse/neglect policy (undated), "the facility must ensure the residents are not subjected to physical, verbal, sexual or psychological abuse." Physical abuse is defined as the "infliction of injury on a resident that occurs other than by accidental means" and includes "hitting, slapping, kicking and punching." Sexual abuse, according to the facility's policy, includes sexual coercion which includes "any intentional or knowing touching or fondling of a nonconsenting resident...for the purpose of sexual gratification or arousal." During the daily status meeting at 3:45 P.M. on 3/8/10, E1 confirmed that R3 has a history of aggression and has been physically aggressive towards staff, as well as exhibiting property destruction. E1 said R3 admitted to assaulting R2 which really surprised E1 since R3 had not been aggressive towards any of the individuals in the facility prior to this incident. E1 also said he had not finished the investigation at this time and had not interviewed staff about the incident.	W9999		

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W9999	Continued From page 22 The facility's final investigation, dated 3/12/10, shows that R3 admitted he had touched R2 inappropriately, then hit R2 because "he didn't think (R2) liked him anymore." The facility's investigation was not completed within 5 working days after the incident. The investigation does not reflect staff's observation of R2's behavioral changes during the weekend of the incident and does not identify what safeguards, if any, were put in place to ensure R2's safety after the assault. Additionally, the investigation does not include an assessment of staffing needs, where staff were located in the facility between the hours of 2:30 A.M. to 8:30 A.M. (the time the assault may have occurred per preliminary investigation) or why staff did not hear anything when R3 assaulted R2. 3) According to the facility roster dated 3/4/10, R1 functions at the mild level of mental retardation and is his own guardian. The roster shows that R1 was admitted to the facility on 1/22/10 from a hospital psychiatric unit after attempting to commit suicide. The hospital's history and physical record dated 1/14/10 states R1 called emergency services himself "apparently after a medication overdose of unknown medication and unknown amount." R1 told the emergency room personnel that "he was tired of living and took approximately 12 pills, which is 2 days of medications." The admission notes indicate R1 "has a prior history of drug overdose with suicidal ideations." Per interview with E1, Administrator, on 3/4/10 at 9:30 A.M., E1 said they were familiar with R1's	W9999		

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behaviors, including suicidal threats, because R1 had lived at the facility a few months ago. E1 said R1 makes these threats when he wants more attention from staff.

Review of an incident report dated 2/9/10 at 4:30 P.M. indicates E4, DSP (Direct Support Person) heard R1 say he was going to kill himself. R1 took off his glasses and tried to push them into his neck. E4 took R1's glasses away. R1 then put a belt around his neck. E4 removed the belt and took it out of R1's room. E4 documented that R1 said he is not suicidal, he "just did it for attention."

According to the nurse's notes dated 2/9/10, R1 continued to express agitation, talked in a vulgar manner to staff and hit the wall with his fist. The nursing entry dated 2/10/10 at 7:40 A.M. states R1 "remains on 1:1 due to suicidal threats from last noc (night)." Sometime during the morning, the 1:1 coverage was removed and R1 went back to general supervision level.

At 11:25 A.M. on 2/10/10, nurses notes show R1 "grabbed a microphone cord et (and) wrapped it around his neck pulling tightly." The microphone cord was removed from R1 and he was placed on 1:1 with staff.

The incident reports and the nurses notes reflect that staff only removed the object that R1 had threatened suicide with and there is no indication that R1's environment was checked for any other objects that R1 might use to harm himself.

Review of a behavior plan to address R1's threats of suicide, dated 1/22/10, lists behavioral interventions staff are to implement when R1 threatens suicide. This plan states "STAFF

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MUST IMMEDIATELY ensure his safety." Staff are also to remove "any object that can be used to hurt him." The behavior plan states R1 "will be placed on increased supervision." However, the plan does not specify what criteria must be met for R1 to regain access to the confiscated items or how long 1:1 staffing is to be in effect.

Per interview with E4 on 3/4/10 at 3:20 P.M., E4 said R1 threatens to hurt himself when staff are around, hoping to get more attention. E4 stated after R1 "does this he always says he's sorry" and demands to talk with the administrator, assistant administrator or RSD (Residential Services Director).

E8, DSP, was interviewed on 3/8/10 at 10:00 A.M. E8 said she saw R1 put the microphone cord around his neck on 2/10/10. E8 said she thought R1's room had been "cleared" the night before when he made suicidal remarks but "evidently it wasn't." E8 stated R1 says he is going to kill himself for attention when staff are around, then admits he is trying to get staff 's attention after he calms down.

During telephone interview with E1, Administrator, on 3/11/10 at 1:34 P.M., E1 said staff are to follow R1's plan when he makes suicidal threats which includes removing anything from his room that he could use to harm himself.

(A)