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W 295	Continued From page 24 punching individuals and staff). When R1's exhibits physical aggression, the behavior program states, "Staff should remove other residents from the area to avoid injury. (R1) should be encouraged to go to a quiet area to deescalate. If he refuses, allow him to deescalate while keeping residents away from him." Per a 3/10/11 facility behavior incident report, R1 was to have a special diet due to diarrhea and vomiting. At the a.m. meal, R1 became upset with E7, and began to chase after her. "(R2) came in to defend (E7) and held him back, (R1) then slapped (R2) in the face and was being held back by staff and was still hitting (R2)." In an interview with E1 (RSD/QMRP), on 3/14/11, at 2:30 p.m., E1 stated that E12 (DSP), was assigned as R1's one-on-one on this date. E1 further confirmed that E12, "put his arm around his (R1's) chest". E1 stated that E12 did physically restrain R1 during this behavior.	W 295		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.1060h) 350.1082e) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and	W9999		

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W9999	Continued From page 25 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 350.1082 Nonemergency Use of Physical Restraints e) A physical restraint may be applied only by staff trained in the application of the particular type of restraint. (Section 2-106(d) of the Act) Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	W9999		

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resident. (Section 2-107 of the Act)

These Requirements were not met as evidenced by:

Based on record review and interview, the facility has failed to prevent abuse and neglect when the facility failed to implement their policy for abuse and neglect, and implement a reproducible system that:

1a) provides for adequate supervision of R1 in order to ensure the physical protection of individuals from R1's physical aggression; and, 1b) to ensure that individuals of the facility reside in an environment that is free from fear, for 1 of 1 resident in the sample who was discharged from the facility on 3/16/11, due to his physical aggression (R1).

2) ensures that physical restraint is utilized only as an integral part of the Individual Program Plan, for 6 of 7 individuals who have behavior intervention programs for physical aggression (R's 1, 3, 4, 7, 11, 13).

3) provides a clear hierarchy of interventions to be implemented, for 6 of 7 individuals who have behavior intervention programs for physical aggression (R's 1, 3, 4, 7, 11, 13).

4a) provides reproducible evidence that all staff were trained regarding R1's 3/9/11 implementation of one-on-one supervision; and, 4b) that all staff are trained in crisis prevention intervention (CPI), which is a documented intervention in R2's current behavior intervention program as related to his physical aggression; for

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W9999	Continued From page 27 2 of 3 in the sample with documented behaviors of physical aggression (R1, R2). Findings include: 1. In review of an undated facility roster that validates level of functioning, there are fourteen (14) individuals in the facility. R's 1, 2, 5 and 11 function in the mild range of mental retardation; R's 3, 6, 8, 9, 12, 13 and 14 function in the moderate range of mental retardation; R's 7 and 10 function in the severe range of mental retardation; and, R4 functions in the profound range of mental retardation. An undated facility document validates that R's 5 and 11 do not have guardians; the remaining individuals (R's 1, 2, 3, 4, 6, 7, 8, 9, 10, 12, 13 and 14) have legal guardians. In a 4/14/11, 9:57 a.m. phone interview with E1 (Administrator/Residential Services Director), E1 stated that R7 requires a walker, gait belt and staff assistance at all times when ambulating. R10 is 72 years of age (undated facility document that validates date of birth for individuals), and requires a wheelchair for mobility. R10 receives maintenance mobility programming utilizing a walker, gait belt and staff assistance. In a 4/19/11, 11:45 a.m. interview with E1, E1 stated that R3 requires bilateral braces and a walker at all times when ambulating. In review of R1's 2/15/11 Individual Program Plan (IPP), R1 functions in the mild range of mental retardation, with additional diagnoses of Autistic Disorder and Psychosocial Stressors. His 2/11 physician's orders document additional	W9999		

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diagnoses of Psychotic Disorder and Attention Deficit with Hyperactivity (ADHD).

An undated facility document, received by surveyor on 4/13/11, documents that R1 has received Risperdal, Ativan and Depakote (from his admit date of 3/17/10 -through discharge date of 3/16/11), for assistance in the control of maladaptive behaviors.

R1's 12/30/10 behavior intervention program validates maladaptive behaviors of physical aggression (defined as hitting, slapping or punching individuals and staff); noncompliance; stealing; verbal aggression (defined as cursing at staff and making threats to harm others); property destruction (defined as throwing objects, pulling items off of tables and walls, and breaking items); refusing meals;snacks; self-injurious behaviors (defined as picking off his cuticles and scabs making them bleed); inappropriate touch (defined as touching staff and individuals' legs, arms, shoulders, back and face); false accusations; and refusing to participate in activities, groups or programming.

Facility incident/accident reports and behavior incident report/B-notes document the following:
2/16/11 - displayed physical aggression when he slapped (R12) on the back.
2/18/11 - threw another (R7) residents walker
2/21/22 - hit (R2) on the back and grabbed (R2's) hand.
2/18/11 - (R6) asked staff if she could sit at another breakfast table, as she was "afraid" that (R1) would hit her again. (No incident report was found for 2/17/11. E1 (phone interview of 4/15/11, at 9:57 a.m.), stated that it was 2/16/11

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W9999	Continued From page 29 when the actual incident occurred, and staff had written the wrong date on the form. 2/18/11 - (R4) was "upset," told another staff that (R1) was hitting staff and somebody needs to do something about it. Per the same note, "(R4) called on his pretend phone, the police." 2/21/22 - slapped (R2) in the back and grabbed his hands. 2/25/11 - slapped staff in the face, head butted staff and pulled the neck of her (E9) shirt choking staff by pulling at it around her neck - (R12) attempted to intervene and was also hit. 3/3/11 - R1 choked E13 (Direct Service Person - DSP) while outside for a fire drill. All other residents were redirected onto the day training transportation vehicle. R1 was taken by ambulance to the hospital and admitted to the psychiatric unit. E13 was interviewed on 4/13/11, at 1:50 p.m. E13 stated that on the morning of 3/3/11, approximately five to ten minutes before 8:00 a.m., the facility had conducted a fire drill. The day training bus came around the corner about that time. R1 saw the bus and said he was not going to the workshop. R1 "smacked" E13 in the face. R1 then came closer, his hand came up and squeezed E13's neck. "I (E13)...ran into the house...I was throwing up...sick about three hours...hard to breathe." E17 (Licensed Practical Nurse - LPN) was going to take E13 to the hospital, but decided to call the ambulance instead. E13 was still getting sick while in the ambulance and at the hospital. X-rays and a Barium Swallow were completed. E13's larynx and hyoid bone were swollen. E13 was placed on a liquid diet for one week, muscle relaxers for spasms, and three weeks of antibiotics. E13 was	W9999		

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W9999	Continued From page 30 to stay off work for one week. After one week, E13 was not better, and was sent for further testing. After a computed tomography (CT) scan and upper gastrointestinal endoscopy, E13 was told that there was internal bruising and to check back in one month. Per this interview, E13 stated that still today, her voice starts to sound "funny" by 4:00-5:00 p.m. E13 stated that she is now able to consume regular foods. In a phone interview with E1 on 4/16/11, at 9:57 a.m., E1 stated that E13 did not return to work until 4/4/11. R1's 12/30/10 behavior intervention program states that when R1 exhibits physical aggression, "Staff should remove other residents from the area to avoid injury. (R1) should be encouraged to go to a quiet area to deescalate. If he refuses, allow him to deescalate while keeping residents away from him." There are no further instructions within R1's behavior program regarding R1's physical aggression, should R1's physical aggression continue to escalate. In a 3/9/11 letter to the Department, E1 stated that R1 was released from the hospital on 3/9/11 after a psychiatric admit on 3/3/11 (3/3/11 fascimile notification to the Department). An undated document, entitled, "(R1) PROTOCOL," was given to the surveyor by E1 on 3/15/11. Per this protocol, R1 will receive "One on One Constant supervision - visual contact at all times, except when he is in his bedroom or bathroom (15 minute checks during those times must be completed and staff must stay upstairs). A hall monitor has been set up, so you can carry the other end while he is in his room. You do not have to be sitting next to him,	W9999		

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just keep your eyes on him...If he displays physical aggression or property destruction, CALL ME IMMEDIATELY...Keep other residents at A Safe Distance...." There are no further instructions in how to address R1's physical aggression, should R1's physical aggression continue to escalate (after his significant physical injury to E13).

Per a 3/10/11 facility behavior incident report, R1 was to have a special diet due to diarrhea and vomiting. At the a.m. meal, R1 became upset with E7, and began to chase after her. R2 intervened to defend E7and held him back. R1 then slapped R2 in the face and hit him a few times. R1 was being held back by staff and was still hitting R2.

In interviews with E9 (DSP), on 4/13/11 at 1:55 p.m.; E13, on 4/13/11 at 1:50 p.m.; E17 (LPN), on 4/13/11 at 2:10 p.m., and E1 (Administrator/RSD), on 4/13/11 at 2:30 p.m., each staff stated that they felt there were times when physical restraint should have been implemented regarding R1's physical aggression in order to protect individuals of the facility and themselves from possible injury and would have utilized such with R1.

In a 4/13/11, 3:42 p.m. interview with R12, R12 stated that she was "scared of him (R1) pretty good...everybody in the house afraid of him...." R12 could not recall specific dates, but stated that R1 hit her about four times in the head, chest and back area, leaving a bruise on her back. She has been hit on more than one occasion. R12 also talked about the 3/31/11 incident with E13. R12 stated when R1 hit E3, R1 "choked

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W9999	Continued From page 32 her....hit her...out of control....way out of control." R12 stated that her room is on the same end as R1's was, and that during one of R1's behaviors, he would not let her out of her room. R12 stated she did not want to go back upstairs without a staff with her on that occasion. In a 4/13/11, 3:50 p.m. interview with R5, R5 stated that she was "afraid of (R1)." R5 stated that R1 never hit her, but "came close" (specific dates could not be recalled), and "tried to hit me." R1 was "hitting everybody else," and staff also. In a 4/13/11, 3:55 p.m. interview with R11, R11 stated that one night we were about to have a pizza party and R1 hit a pregnant staff. R1 stated, "Scared the **** out of me." R11 stated that R1 slammed his fist into the door of my room one night, and R11 could not get out of his room, further stating that R1,"is strong." The police were called on this occasion. Per a 2/18/11 facility behavior incident report, at 7:00 a.m., R6 told E3 (DSP) that she wanted to sit at another table, as she, "was afraid (R1) would hit her again, like he did last nite (night)." No incident report was found for 2/17/11. E1 (phone interview of 4/15/11, at 9:57 a.m.) stated that it was 2/16/11 when the actual incident occurred, and staff had written the wrong date on the form. In a 4/13/11, 1:40 p.m. interview with E9, E9 stated that she could not remember the date, but that after one of R1's behavioral incidents, R14 was "frightened" to take her shower in the "upstairs" end of the facility where R1's room is located. E9 stated she took R14 to the	W9999		

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"downstairs" portion of the building, so that R14 could shower.

2a) A review of behavior management programs validate that R's 1 (2/15/11), 3 (1/2011), 4 (1/2011), 7 (1/2011), 11 (3/15/10), and 13 (1/2011) have current behavior management program plans that address "physical aggression," and receive medication/s to assist in behavior control (undated facility document that validates psychotropic medications for residents).

A 7/14/10 document to the facility physician from the facility states: "Occasionally when a resident has physical aggression, staff may have to use manual restraint techniques. In order for staff to be allowed to use manual restraint techniques the facility must have consent from the Primary MD and Guardian and the staff must be CPI trained. May we have consent for the following residents to be manually restrained by CPI trained staff should an emergency need arise." R's 1, 3, 4, 7, 11 & 13 are on this list.

In an interview with E1, on 3/15/11, at 9:20 a.m., E1 stated that the individual behavior intervention programs for R's 1, 3, 4, 7, 11 and 13, do not specify the type and methodology of physical restraint to be implemented, should physical restraint become necessary.

2b) In review of R1's 2/15/11 Individual Program Plan (IPP), R1 functions in the mild range of mental retardation, with additional diagnoses of Autistic Disorder and Psychosocial Stressors. His 2/11 physician's orders document additional

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diagnoses of Psychotic Disorder and Attention Deficit with Hyperactivity (ADHD).

An undated facility document, received by surveyor on 4/13/11, validates that R1 received Risperdal, Ativan and Depakote (from his admit date of 3/17/10, through discharge date of 3/16/11) for assistance in the control of maladaptive behaviors.

R1's 12/30/10 behavior intervention program validates maladaptive behaviors of physical aggression (defined as hitting, slapping or punching individuals and staff); noncompliance; stealing; verbal aggression (defined as cursing at staff and making threats to harm others); property destruction (defined as throwing objects, pulling items off of tables and walls, and breaking items); refusing meals;snacks; self-injurious behaviors (defined as picking off his cuticles and scabs making them bleed); inappropriate touch (defined as touching staff and individuals' legs, arms, shoulders, back and face); false accusations; and refusing to participate in activities, groups or programming.

When R1 exhibits physical aggression, the behavior program states, "Staff should remove other residents from the area to avoid injury. (R1) should be encouraged to go to a quiet area to deescalate. If he refuses, allow him to deescalate while keeping residents away from him."

Per a 3/10/11 facility behavior incident report, R1 was to have a special diet due to diarrhea and vomiting. At the a.m. meal, R1 became upset with E7, and began to chase after her. "(R2)

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came in to defend (E7) and held him back, (R1) then slapped (R2) in the face and was being held back by staff and was still hitting (R2)."

In an interview with E1 (Administrator/RSD), on 3/14/11, at 2:30 p.m., E1 stated that E12 (DSP) was assigned as R1's one-on-one on this date. E1 further confirmed that E12, "put his arm around his (R1's) chest." E1 stated that E12 did physically restrain R1 during this behavior.

3) A review of behavior management programs validate that R's 1 (2/15/11), 3 (1/2011), 4 (1/2011), 7 (1/2011), 11 (3/15/10), and 13 (1/2011), have current behavior management program plans that address "physical aggression," and receive medication/s to assist in behavior control (undated facility document that validates psychotropic medications for residents).

Behavior programs were reviewed regarding intervention/s for physical aggression:

R1 - "Staff should remove other residents from the area to avoid injury. (R1) should be encouraged to got to a quiet area to deescalate. If he refuses, allow him to deescalate while keeping residents away from him."

R3 - Staff and individuals are to remain out of R3's view for at least 15 minutes. If R3 is calm after 15 minutes, staff will ask R3 is she is ok. If R3 remains calm for an additional 5 minutes, individuals may rejoin the area. If R3 does not calm within 15 minutes and is being physically aggressive, staff are to notify (E1).

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W9999	Continued From page 36 R4 - R4 also experiences auditory hallucinations, and if R4's psychotic behaviors are not dealt with, R4 will escalate to physical aggression. Staff are to redirect R4, ask if he would like to go to a quiet area and make sure no other individuals come within 5 feet of R4's space. If R4 is not calm within 30 minutes, staff are to notify (E1). In a 4/19/11, 11:47 a.m. daily status meeting (per phone and fax) with E1, E1 verified that R4 weighs 206 pounds, standing 5 foot, 6 inches tall. R7 - R7 also experiences hallucinations. When R7 displays physical aggression, staff are to remove other individuals from the immediate area and discuss how to resolve R7's anger. R11 - Whoever the aggressor is in the situation, that individual should be redirected to another area, and talk with R11 regarding other methods he can utilize in dealing with his physical aggression. R13 - When R13 pulls hair, scratches someone's face, attempts to choke others, staff will ask R13 what is bothering her, and redirect R13 to her room to calm down. In review of the above behavior intervention programs, there is no evidence of a hierarchy of interventions (least restrictive to most intrusive) for staff to implement as related to an individual's increasing physical aggression. In a 3/15/11, 2:41 p.m., interview with E1, E1 stated, "all we can really do is get everybody out of the situation...cannot use physical restraint."	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G068	A. BUILDING ______ B. WING ______	C 04/27/2011

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W9999		W9999		

Continued From page 37

4a) In review of a 3/3/11 facsimile to the Department, R1 was taken to the hospital by ambulance after R1 choked a staff person (E13). Per a 3/9/11 facsimile to the Department, R1 was discharged and returned to the facility on 3/9/11. Per this same note, staff will be providing one on one supervision for R1 in order to keep residents and staff safe.

An undated facility training document entitled "(R1) PROTOCOL," was provided to the surveyor on 3/15/11. Per this document the following procedures were put in place for R1:
- one on one constant supervision - visual contact at all times, except when (R1) is in his bedroom or bathroom - 15 minute checks during those times must be completed and staff must stay upstairs - a hall monitor has been set up, so staff can carry the other end and while (R1) is in his room.
- You do not have to be sitting next to him, just keep your eyes on him.
- If (R1) displays physical aggression or property destruction, call (E1) immediately.
- keep other residents at a safe distance.
- follow the labels on the diet table for seating changes - this will give (R1) space and a clear path upstairs to take a break if needed.

This document further provides the one to one staff schedule for R1, for all shifts from 3/9/11 through 3/16/11. Per this document the following staff have been assigned (from 3/9/11 through 3/16/11) as R1's one on one: E's 1, 2, 4, 5, 6, 7, 10, 11, 12, 14 & 15. On the bottom right of this same document, staff have initialed that they have received this training.

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W9999	Continued From page 38	W9999		

Continued From page 38

In review of the document, there is no evidence that R's 5, 6, 7 and 14 (assigned as one on one staff for R1) have received the training. E16 was not scheduled as a one on one for R1, but there is no evidence of being trained regarding R1's increased level of supervision, per this document.

In a 3/15/11, 2:30 p.m., interview with E1, E1 confirmed that there is no reproducible evidence of training for these staff.

4b) R2's 1/2011 behavior intervention program documents his maladaptive behavior of physical aggression (defined as hitting others, kicking & slapping).

R2's behavior intervention program states that staff will remove all residents from the area and ask R2 to go to his room. If R2 refuses to go to his room, and R2 continues to escalate, certified staff may utilize CPI techniques to prevent harm to themselves or others. The next step if to call 911. However, in an interview with E1, on 3/15/11, at 2:41 p.m., E1 confirmed that there are currently no staff who are trained in CPI.

Facility policies were reviewed.

The 1/03 policy entitled, "Resident Protection: Abuse and Neglect Policy", states, "It is the policy of this facility to ensure residents are not subjected to any type of physical, verbal, sexual, psychological abuse, neglect or punishment. Abuse is defined as any physical or mental injury, sexual assault or exploitation of a resident other than by accidental means. Physical abuse is defined as any physical motion or action (hitting,

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W9999	Continued From page 39 slapping, biting, punching, kicking, pinching, etc.). Neglect is defined as: 1. Any failure by a facility or employee to carry out required and appropriate clinical services, habilitation, or treatment as ordered by the physician or other personnel that is the proximate cause of psychological harm or physical injury to an individual. 2. Any act or omission by a facility or employee that endangers an individual's health or safety or fails to respond to an obvious or immediate need of an individual regardless of whether or not there is an injury." The 1/25/94 policy entitled, ""Management of Inappropriate Resident Behavior", states, "The use of systematic interventions to manage inappropriate behavior shall be incorporated into the resident's individual program plan...Restraints will NOT be issued on a standing or as needed basis. (A)	W9999		