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W 460	Continued From page 42 Retardation. During observations on 5-10-11 from 6:15 A.M. to 8:00 A.M. this surveyor observed all clients eating breakfast consisting of cereal, scrambled eggs, toast with margarine, skim milk, orange juice, prune juice, coffee, and jelly. All clients observed dining did not have a cup of fruit. Per record review of the Dietary menu dated 5-10-11 is written 1/2 cup of fruit as part of the menu for breakfast. According to an interview with E7 (Part Time Cook) on 5-10-11 at 8:08 A.M. when asked if clients were supposed to get fruit cups as stated per menu today, E7 replied the door to the pantry is locked and I do not have a key. E7 stated that she had the bowls out for the fruit cup but could not get the fruit cups due to the door to the pantry being locked. E7 stated that the door to the pantry is to be locked all of the time. At 7:40 A.M. E16 (Maintenance) was observed opening the door to the pantry. According to an interview with R3 on 5-10-11 at 8:04 A.M. when asked if he likes fruit cups R3 replied "I do like fruit cups". According to an interview with R1 on 5-10-11 at 8:03 A.M. when asked if he likes fruit cups R1 replied "why don't people understand that I don't like cereal. I like fruit cups better than cereal".	W 460		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	W9999		

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W9999	Continued From page 43 350.620a) 350.1610b) 350.1620b)12) 350.3240a) 350.3240b) 300.3240d) 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 350.1610 Resident Record Requirements b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. Section 350.1620 Content of Medical Records b) The following information shall be obtained and entered in the resident's record at the time of admission to the facility: 12) Records of significant behavior incidents, reactions to any family visits and contacts, attendance at programs, and leaves from the facility.	W9999		

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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)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 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, 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 are not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure staff document completely and accurately incidents of peer to peer abuse, report all allegations to the Administrator, and thoroughly investigate each incdent in accordance with facility policies and regulatory requirements. In October, 2010 facility

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staff was directed to change the documentation of an allegation of peer to peer abuse by facility management staff. The resultant documentation was written utilizing words which did not describe the actual allegation and what had occurred to the client. On 12-20-10 an additional direct care staff note is documented in terms which again do not describe what the actual incident involved entailed, which ultimately was identified by the Department, as peer to peer aggression in which one client (R5) demonstrated she had been choked around the neck by her roommate. This client indicated that she was fearful of the other client, and had been afraid to sleep in her room at night. The facility had not investigated, reported or put safeguards in place in order to protect R5.

Findings include:

1) Per record review of the Facility Data sheet dated 5-9-11, R14 and R16 function in the Moderate range of Mental Retardation.

The Investigative Committee Findings dated 4-8-11 are written as follows: The investigative committee was initiated to investigate an allegation of resident to resident physical abuse against R14. The allegation consisted of R14 hitting another resident R16 in October 2010.

The Findings Report goes on to say; through out the interviews the individuals could corroborate that something happened between R14 and R16. E12 (Direct Support Person) witnessed the incident and was able to verify that an altercation took place. In conclusion the committee was able to substantiate that there was an altercation

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between the two individuals.

The Facility Investigator notes dated 4-5-11 are as follows: states E11 (Direct Support Person) stated that I think R14 hit R16 or something. E12 (Direct Support Person) stated R14 was upset that day and she whacked R16 as she was walking by her. R14 got up off her chair and whacked R16 again. E14 stated I have not seen R14 hit anybody for a long time. E8 (Cook) stated for a little while R14 was whacking R16 when she walked by.

Per interview with E12 (Direct Support Person) on 3-31-11 at 3:42 P.M. regarding the facility's documentation, E12 stated "I've been asked to reword my documentation. I would not say it falsified but it did make it extremely vague." E12 stated I was told to not include details and specifics under the direction of E9 (Nurse Trainer) in regards to R14 being aggressive towards R16.

During an interview on 5-20-11 at 9:55am, Nurse Trainer E9 said that she "asked (E12) to change his documentation to only facts as he knew them." E9 said that E12 had added opinions and she "asked (E12) to omit any subjective data because it wasn't pertinent." E9 went on to say she would never tell anyone to change their documentation to something more vague.

During an interview on 5-20-11 at 10:09am Administrator E2 said that he has "had to tell people to change documentation to remove subjective statements, just stick to the facts." E2 went on to say that he would never tell someone to change a document to something more vague.

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Per interview with E2 (Administrator) on 5-10-11 at 11:37 A.M. when asked if this was reported to Public Health back in October 2010, E2 replied "no." E2 acknowledged that this should have been reported immediately when the incident occurred back in October 2010.

During a review of an Investigative Committee Findings form dated 5-4-11, the facts of the allegation noted above were reviewed. E11 and E14 were suspended and the investigation was conducted and the Department was notified.

Per record review of the facility policy number 5.57 revised 9-09, it states: the facility shall notify the Department of any incident or accident, which has come up or is likely to have a significant effect on the health, safety, or welfare of an individual or individuals. The policy states that within 24 hours to notify the Illinois Department of Public health by a telephone call or a fax to the regional office. Submit a written narrative summary of each serious accident or incident occurrence to the Illinois Department of Public Health within five days. The frequency shall be upon any occurrence of physical injury or illness.

Per record review of the facility policy number 5.24 revised 11/08 states under procedure any facility employee or agent who witnesses or suspects a violation of resident rights, abuse, or neglect as well as injuries of unknown source shall immediately report the matter to facility management using the following protocol. In order for the incident to be considered reported the employee agent must speak directly to one of the following managers: Administrator, Executive

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W9999	Continued From page 48 Director, or Director of Operations. The employee will document a brief note regarding the incident on a progress note prior to leaving the shift. 2) According to an undated client roster supplied by the facility, R5's diagnoses include Downs Syndrome and Moderate Mental Retardation. R10's diagnoses include Cerebral Palsy and Mild Mental Retardation. During a review of an Investigative Committee Findings form dated 12-20-10, it states that there was an allegation of inappropriate interaction made by R10 in that she had inappropriately touched R5. RSD E15 said that the inappropriate interaction identified by R10 to E15 is that she had choked R5. During an interview completed during this survey on 3-30-11 at 5:30pm, DSP E13 said that she thought R10 was having problems adjusting to her new life in the house. E13 said that R10 had problems adjusting to R5 as a roommate. E13 said that she was present when E15 asked R5 if R10 had done anything to her. R5's response was to put her hands on her throat and state her neck hurt. E13 said that she thought that had really scared R5 and R5 spent most of her time in the living room, she would not go down to her room at all. During an interview on 5-9-11 at 6:43pm, Direct Support Person (DSP), E10 said that she suspected that R5 was afraid of R10. E10 related one incident when R5 was sitting at a table with E10, and they were painting fingernails. R10 sat down and without a word R5	W9999		

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W9999	Continued From page 49 began sobbing, R5 stood and walked to the far end of the table where nobody was sitting and sat there crying. The investigative report notes that "The Investigative Committee also interviewed all staff members...Staff interviewed all concurred that they had never witnessed, or been told by (R5 or R10) about any inappropriate interaction....All staff members present at the time of the alleged incident could not corroborate the alleged report of inappropriate interaction." On 3-31-11 at 3:42pm DSP E12 said that he had not been interviewed, and had not participated in any investigation regarding this situation involving R5 and R10. E10 also said that she had not been interviewed, she had not participated in any investigation regarding this situation involving R5 and R10. per interview on 5-9-11 at 6:43 P.M. On 3-30-11 at 1:20pm Head Cook E8 said that she had not been interviewed, and had not participated in any investigation regarding this situation involving R5 and R10. On 3-31-11 at 11:25am DSP E14 said that she had not been interviewed, and had not participated in any investigation regarding this situation involving R5 and R10. On 5-9-11 at 6:28pm DSP E11 said that he had not been interviewed, and had not participated in any investigation regarding this situation involving R5 and R10. On 5-11-11 at 11:55am, Regional Trainer E6 who	W9999		

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submitted the 12-20-10 Investigative Committee Findings, said that her notes regarding this investigation were at a Freeport facility and she would retrieve them. These investigative notes were not presented to the surveyor during the course of the survey.

On 5-11-11 at 12:01 pm Administrator E2 confirmed there were no actual interviews. He said E6 had a list of people that she talked to but there were no actual statements available. E2 said that he could not find the documentation at the facility.

3) Per record review of the Individual Service Plan dated 2-18-11, R4 is a 70 year old female. R4 functions in the Severe Range of Mental Retardation and her diagnoses include Epilepsy and Bipolar with Delusions.

Per record review of the Individual Service Plan (IPP) dated 7-27-10, R5 is a 29 year old female. R5 functions in the Severe Range of Mental Retardation and her diagnoses includes Downs Syndrome and Graves Disease. R5's IPP does not identify that this client has behaviors of physical aggression.

During observations on 5-10-11 from 6:15 A.M. to 8:00 A.M. the following occurred. At 7:47 A.M. in the living room area R5 was observed sitting in a chair and R4 was walking and stopped next to R5 where they subsequently hit each other. E7 (Part time Cook) stated to both R4 and R5 "we don't hit other people." Per interview with E7 (Part Time Cook) on 5-10-11 at 8:40 A.M. when asked if R5 hit R4, E7 replied "I think she did, but

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R4 hit her harder back." It was observed that E7 soon left the facility without any observed conversation with the Administrator, reporting this incident.

Per interview with E2 (Administrator) on 5-10-11 at 9:37 A.M. when asked whether E7 had reported this incident between R4 and R5, E2 replied "Obviously if you are the first telling me then it was not reported by staff." When asked whether E7 followed the facility policy on reporting abuse, E2 replied no she did not follow the policy and that is why she will be retrained and inserviced.

According to the record review of the Behavior Management Resident Rights Committee dated 12-28-10, it is written R4 exhibits the following maladaptive behaviors: Physical Aggression (hitting and kicking) and Inappropriate Statements (references to death, vulgar language, threatens other residents with violence).

The record review of the current Behavior Management Resident Rights Committee dated 4-6-11 states R4's behavior program identifies symptoms of Bipolar. Examples of this include yelling, swearing, inappropriate verbal interactions, social isolation, oppositional behaviors, and excessive crying. R4 receives follow up psychiatric care. There is no documentation of physical aggression.

Per record review of the Behavior Program Form for R4 dated 3-1-11, R4 uses inappropriate language and behaviors around others. R4 persists with the inappropriate language/behavior

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W9999	Continued From page 52 when other residents ask her to stop. R4 usually stops when staff intervenes. The behavior program under programing and methods of instruction writes when R4 is observed using inappropriate language or behavior, staff will attempt to redirect her thought process. According to the Maladaptive Behavior Recording Form dated 5-1-11 through 5-31-11, maladaptive behavior disruption and bad language with the dates 5-4-11 and 5-6-11. There is no accurate or complete documentation of the witnessed physical aggression of hitting, which was observed by the surveyor on 5/10/11 for R4. Per interview with E2 (Administrator) on 5-1-11 at 2:49 P.M. when asked if her physical aggression on 5-10-11 should have been documented on the maladaptive form, E2 replied "it must have been dropped off the form." When asked what is R4's behavior program, E2 replied it is inappropriate behavior. When asked if it addresses physical aggression, E2 replied for R4 it stops at verbalization. (A)	W9999		