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{W 149}	Continued From page 28 resident appeared afraid of R1, E4 said, "Maybe (R5) - she's (R1) so aggressive - I've seen (R5) get up and move quickly when (R1) comes in the room."	{W 149}		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.1230d)1)2) 350.3240a) 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 350.1060 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 350.1230 Nursing Services d) Direct care personnel shall be trained in, but	W9999		

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are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
2) Basic skills required to meet the health needs and problems of the residents.

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, 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.

These regulations were not met as evidenced by:

Based on interview and record review, the facility neglected to implement their policy and procedures prohibiting mistreatment, neglect and/or abuse of individuals for 8 of 13 individuals in the facility (R2, R3, R4, R5, R6, R7, R8 and R12) and potentially affects 4 additional individuals in the facility (R9, R10, R11 and R13). The facility neglected to:

1) Ensure that staff are aware of and implement the facility's policy and procedures regarding

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client to client abuse.
2) Document each incident of client to client abuse and identify the victim of abuse to maintain a system of monitoring for trends and patterns.
3) Implement a system which assures that incidents of abuse are reported and investigated and that safeguards and corrective actions are taken to prevent further incidents of abuse.

Findings Include:

On 04/04/12 at 12:05 p.m., R1 displayed physical aggression and the facility failed to identify who R1 physically aggressed and whether or not injury occurred, and failed to provide necessary supervision to prevent R1 from continuing to physically aggress towards peers. The facility's documentation states that on 01/12/12 R1 was "hitting clients," 01/16/12 R1 hit R3 in the back of the head, 01/21/12 R1 slapped R2 and on 02/10/12 "began to hit residents." The facility was unable to provide evidence that systems have been put in place to prevent R1 from continuing to be physically aggressive to her peers. Based upon interviews with staff there has been no increase in R1's supervision level and no current behavior intervention plan for addressing R1's behavior of physically aggressing her peers. Upon interviews, facility staff are not aware of the facility's policy and procedures regarding client to client abuse. Staff do not document each incident of client to client abuse or identify the victim. The facility does not investigate all reports of client to client abuse and ensure that safeguards and corrective actions are taken to prevent further incidents of abuse. The facility also failed to ensure that R1's antipsychotic medication was increased on 02/17/12 as per the Psychiatrist

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orders.

The facility's undated Policy and Procedure for Abuse states: "It is the policy of this facility to ensure that all residents of this facility be freed from abuse. Abuse is defined as any physical injury, sexual abuse, neglect or mental injury inflicted on a resident other that by accidental means. The facility will observe/monitor for any patterns or trends which may indicate a resident has been abused or neglected."

The facility's undated Abuse Prevention program states that it is the policy of the facility to, "...prohibit mistreatment, neglect or abuse of it's residents... and assure that the facility is doing all that is within it's control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by:
- identifying occurrences and patterns of potential mistreatment;
- immediately protecting residents involved in identified reports of possible abuse;
- implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making changes to prevent future occurrences; and
-filing accurate and timely investigative reports.

This policy goes on to state that the facility is committed to protecting their residents from abuse by anyone including, but not limited to, other residents of the facility.

The facility's undated Policy and Procedure for Abuse uses the following definitions:

-"Physical Abuse: Hitting, slapping, pinching,

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kicking, etc.."
- "Mental Abuse: Harassment, humiliation or threat of punishment or deprivation."

The facility's undated "Procedure for Reporting and Investigating Allegations of Mistreatment of Residents or Resident Grievances" states "...If the incident involves resident to resident (committing abuse or mistreatment), this will be evaluated and dealt with promptly. If the resident is dangerous to others, he/she will be referred for assistance with more appropriate treatment."

Upon review of the facility's Admission Sheet for R1 dated 02/01/11, R1 is a 62 year old female who functions at a Profound level of Mental Retardation

R1's Physician's Order sheet dated 04/01/12 through 04/30/12 states that R1 has diagnoses that include: Obsessive Compulsive Disorder, Anxiety, Self Injurious Behaviors and Expressive Aphasia.

Documentation on R1's current Physician's Order sheet states that R1's medications include: Seroquel XR (Antipsychotic) 300 milligrams at bedtime, Trazodone (Antidepressant) 50 milligrams at bedtime and Escitalopram (Antidepressant) 20 milligrams every morning.

R1's Interdisciplinary Team (IDT) - Individual Habilitation Plan Review (IHP) dated 02/29/12 states that R1 has an Adaptive Behavior overall age equivalent of 2 years and 11 months and has an IQ of 18.

Per review of R1's Behavior Treatment Plan

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dated 02/12/12 documentation identifies the targeted behavior as: "Non-compliance/ Physical Aggression/ SIB (Self Injurious Behavior)/ Property Destruction (slamming doors)."

Interventions identified for R1's Non compliance behavior states:

"1. Whenever possible staff will present task compliance requests using a double bind presentation i.e. you can take your bath now or you can have your bath in 15 minutes...or...you can be first on the bus or you can be last on the bus...(Both requests allow the client to 'choose' but still accomplish the requested task).
2. No special activities or extra positive reinforcers should be given for a one-hour period after any episode of target behavior."

Interventions for R1's "Verbal Aggression Leading to Physical Aggression" states:

"1. When (R1) threatens staff or peers give a verbal prompt to stop the behavior.
2. Attempt to resolve what is upsetting her.
3. If she continues to be verbally aggressive give a firm verbal prompt to "stop".
4. If she is compliant with the prompt verbally reinforce her decision to act appropriately with a social response (smile, say thank you).
5. If she remains agitated attempt to redirect to an alternative activity - if she refuses an alternative activity allow her to escape the situation by going to her room independently or give a verbal prompt for her to go to her room."

There is no evidence that the facility developed or implemented an accurate behavior plan to

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address R1's peer to peer abuse, put systems in place to prevent R1 from physically aggressing her peers or documented what staff are to do when this occurs. There is no evidence that the facility implemented their policy to prevent abuse between residents.

During interview with E1 (Administrator) on 04/03/12 at 10:05 a.m., when asked whether R1 verbally threatens peers prior to physically aggressing them, E1 said "She doesn't threaten - she just does it. I guess threatened isn't the right word." E1 stated, "(R1) is impatient, if she doesn't get what she wants immediately, then sometimes she has a behavior."

Although R1's Behavior Treatment Plan is dated 02/12/12 there is no date to indicate when the Behavior Treatment Plan is to be implemented. E1 continued to say that R1's 02/12/12 Behavior Treatment Plan has not yet been implemented but that it will be this month (April). When asked if the staff have been trained on R1's Behavior Treatment Plan, E1 said, "Going to do that tomorrow (04/04/12)." When asked if the local day training has a copy of R1's Behavior Treatment Plan, E1 said that they do not.

Upon review of the facility's Incident/Accident Reports documentation states:

01/11/12 - (no time) - (At the local Day Training Site), "(R1) hit this other client and then pushed him out of the booth causing injury to other client."

During interview with Z1 (Registered Nurse at the local day training site) on 04/03/12 at 1:45 p.m.,

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Z1 identified the client that R1 pushed out of the booth on 01/11/12 as being Z3 (a resident at another facility). Z1 stated that Z3 had hit his head on the floor when R1 pushed him out of the booth and that he had been sent to the local emergency room.

01/12/12 - 12:50 p.m. - (At the local Day Training Site), "Client hit her head on glass of door purposely. (R1) uncooperative when I tried to examine her head. She has been combative, tearing items off wall, hitting clients, hitting her head against door. Please advise."

There is no evidence to identify who R1 was hitting or whether or not injury occurred.

01/13/12 - 2:00 p.m. - (At the local Day Training Site), "(R1) pushed (Z3) (client at day training) (and) he went to (Emergency Room) (and) she head butted her head, pulled coat rack off wall."

There is no evidence that the facility identified who R1 pushed or whether or not injury occurred.

During interview with Z2 (Qualified Mental Retardation Professional) on 04/03/12 at 1:40 p.m., Z2 stated that the day training site does not have a BIP (behavior intervention program) for R1. Z2 continued to say, "I recommended a BIP for physical aggression during her ISP (Interdisciplinary Support Program) (on) (02/29/12) - they were going to integrate it into the non-compliance."

01/16/12 - 7:00 a.m. - "(R1) was having a behavior, was trying to get into the pantry. Staff told (R1) no, please stop. (R1) had a fit and went

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W9999	Continued From page 36 to her room. On her way to her room she struck (R3) in back of head." 01/21/12 - 9:45 p.m. - "(R1) came from her room, slamming chairs, hitting other (resident) (R2). Hitting staff, throwing trash cans, slamming doors. Staff tried to redirect (R1), (R1) still non compliant. Staff tried again to redirect (R1) asking (R1) what was wrong, (R1) continued to slam doors, throwing chairs, staff redirected (R1) to her room. At this time (R1) was trying to hit other residents..." 01/27/12 - 12:35 p.m. - (At the local Day Training Site), "(R1) tried to go out the door. I turned her around to come back inside. When she walked past another client she attacked them. The other client attacked back. I ran to get between them to stop the conflict." There is no evidence to identify who R1 attacked or whether or not injury occurred. 03/10/12 - 7:30 p.m. - "(R1) got up early in the evening thinking it was morning and getting up to go to (name of local day training). Trying to tell her it was nighttime to go to sleep. After a few times of this (R1) got mad and started to hit and throw chairs around. At one point...(R12) was in the way of (R1) and got pushed down. BUT no one seen it. It was heard from being in the other room. They walked around the corner and seen (R12) on the floor." Review of the facility's Behavior Tracking Log for the months of 12/2011 through 03/2012 documentation states:	W9999		

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W9999	Continued From page 37 12/14/11 - (no time documented) Behavior Tracking Log is marked as Physical Aggression but no documentation as to who R1 physically aggressed, antecedents to behavior or whether or not injury occurred. 12/17/11 - 8:00 a.m. - "Wanted lunch; slapped other resident. Staff removed purse (and) (R1) was sent to room." Duration is documented as being 5 minutes. There is no documentation as to who R1 physically aggressed or whether or not injury occurred. 12/17/11 - 10:30 a.m. - "Shook (and) slapped other residents. Bit staff..." Duration is documented as being 5 minutes. There is no documentation as to who R1 physically aggressed or whether or not injury occurred. 12/17/11 - 1:30 p.m. - "Pushed other resident...." Duration is documented as being 5 minutes. There is no documentation as to who R1 physically aggressed or whether or not injury occurred. The facility's Behavior Tracking Log for 01/2012 states: 01/23/12 - 7:00 a.m. - "Throwing chairs (and) attacking staff." Duration is marked as lasting 20 - 30 minutes. The facility's Behavior Tracking Log for 02/2012	W9999		

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states that R1 was physically aggressive on 02/04, 02/05, 02/08, 02/10, 02/14/12 with no documentation as to who R1 was physically aggressing, antecedents to behavior or whether or not injury occurred.

Documentation for 02/15/12 at 4:00 p.m. states, "Throwing chairs because she was directed out of kitchen." Duration is documented as lasting 5 minutes.

Documentation within R1's Habilitation Notes dated 02/10/12 at 7:30 p.m., states, "(Resident) thinking it's time for work, staff told her it was the weekend, (resident) began to hit (resident), staff and walls. Staff called office (Personnel) and asked what to do. Staff asked her what she wanted or needed (resident) was just wanting to go to work. (Resident) is still walking around the house, hitting walls, throwing chairs."

The facility's Behavior Tracking Log for 03/2012 states that R1 was physically aggressive on 03/12/12 and 03/28/12. The 03/12/12 incident has no documentation as to who R1 was aggressing, antecedents to the behavior or whether or not injury occurred. The 03/28/12 incident states that at 5:30 a.m., R1 was "Throwing things, clothes basket (and) wheelchair (and) slamming doors." The duration of this behavior is documented as lasting 45 minutes.

There is no evidence that the facility investigated any of these incidents or put systems in place to prevent reoccurrence.

During interview with E1 on 04/03/12 at 10:05 a.m., E1 stated that R1's Behavior Tracking Log

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should have each resident and identified who were involved in the incident. E1 continued to say that there should be documentation describing each incident but that it does not.

Per interview with E1 on 04/04/12 at 11:50 a.m., when asked whether she was notified of all incidents of peer to peer aggression, E1 said that she did not know. E1 also said that she did not know if all allegations of peer to peer abuse was investigated or not. E1 said, "Not just client to client - should be investigation after every incident." When asked how an investigation could be done when the victims are not identified, E1 said, "I can't."

During interview with R4 on 04/03/12 at 2:25 p.m., R4 stated that R1 had hit someone yesterday (04/02/12) but that she could not remember who it was. When asked what staff does to prevent R1 from hitting others, R4 said, "they don't do anything to stop her from hitting but after she hits - they say, 'go to your room.' Staff don't stay close to her to stop her." R4 continued to say that she was, "very, very afraid of her (R1)."

Per interview with R8 on 04/03/12 at 2:55 p.m., when asked if she has ever been hit by R1, R8 said, "One time." When asked if she was afraid of R1, R8 shook her hand from side to side and said, "little bit."

During interview with R7 on 04/03/12 at 2:50 p.m., when asked if he had ever been hit by any one in the facility, R7 said that he has been hit in the stomach with R1's elbow.

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W9999	Continued From page 40 During interview with E3 (Direct Support Person) on 04/03/12 at 3:05 p.m., when asked if she has observed R1 hitting her peers, E3 said, "from time to time - if they're close by when she gets mad. Whoever is close enough." When asked how staff prevent her from hitting peers, E3 stated, "try not to make her mad - very easily agitated." Per interview with E7 (Direct Support Person) on 04/03/12 at 11:45 a.m., E7 said that nothing is in place to prevent R1 from hitting her peers, but after she hits someone then R1 is taken to another room to calm down. E7 continued to say that if R1 hits a peer, she would not report it to anyone unless it was hard enough to cause a bruise. Continuing interview with E3 on 04/03/12 at 3:05 p.m., when asked if there has been any increase in R1's supervision to prevent her from hitting, E3 said, "Not as far as I know." E3 also said that she was not sure whether or not R1 has a behavior program for physical aggression. During interview with E6 (Direct Support Person) on 03/30/12 at 3:30 p.m., when asked what type of supervision is provided to R1 to prevent her from hitting her peers, E6 said, "no one is assigned to watch her - it's just whoever sees her, it's usually after she does something or hits someone." On 04/03/12 at 3:50 p.m., E6 continued to say that he had done an incident report regarding R1 hitting someone, "a week or two ago." E6 said that R1 hits a peer approximately once a week. When asked if the other residents showed fear	W9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT MANOR	**1404 SOUTH 14TH STREET** **HERRIN, IL 62948**

(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
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towards R1, E6 said, "I don't think other residents are afraid of (R1) but are aware of her actions. (R6) stays out of her way - (R1) will just come in and point to the couch where (R6) is sitting and (R6) gets up - she sits back down after (R1) sits down. She's (R1) a bully."

Per interview with E4 on 04/03/12 at 3:55 p.m., when asked when was the last time he had observed R1 hitting another resident, E4 said, "Saturday (03/31/12) - (R6) - since (R6) can't talk or hear she (R1) bullies her. Hit her on the shoulder. (R6) got up and left the room." E4 continued to say that R1 hits a peer approximately 3 times a week. When asked if any resident appeared afraid of R1, E4 said, "Maybe (R5) - she's (R1) so aggressive - I've seen (R5) get up and move quickly when (R1) comes in the room."

(A)