

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2014
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NAME OF PROVIDER OR SUPPLIER RANDOLPH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 404 SOUTH FIRST STREET VANDALIA, IL 62471
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Z9999	<p>FINDINGS</p> <p>Statement of Licensure Violations:</p> <p>350.1210d) 350.1220j) 350.1230b)6) 350.1230b)7) 350.1230d)1) 350.1230e) 350.3220f) 350.3240a)</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:</p> <p>d) Physical and occupational therapy services for purposes of initiating, monitoring and follow-up of individualized treatment programs rendered by or under the supervision of a physician with special training or experience in the specialty or a physical therapist or an occupational therapist.</p> <p>Section 350.1220 Physician Services</p> <p>j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest</p>	Z9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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Z9999	<p>Continued From page 1</p> <p>decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.</p> <p>Section 350.1230 Nursing Services</p> <p>b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:</p> <p>6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.</p> <p>7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.</p> <p>e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities.</p> <p>Section 350.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician.</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>A. Based on interview, observation, and record review the facility failed to provide a proactive health care system including adequate supervision, nursing assessments and proactive recommendations for 1 individual in the facility with a history of frequent falls (R3) when the facility failed to:</p> <p>a. Staff in sufficient numbers for supervision and mobility assistance to prevent further falls. b. Obtain a physical therapy evaluation after R3 had seven falls in the year 2013. b. Provide nursing assessment and recommendations to prevent further falls. c. Ensure R3 is assessed by the nurse in a timely manner after each fall to ensure no serious injury. d. Evaluate plan of care for appropriate safety interventions to prevent falls.</p> <p>B. Based on record review and interview the facility failed to ensure individuals who require ongoing monitoring of blood pressure due to medications requiring evaluation and based upon physician's orders for 6 individuals in the facility. (R1, R3, R7, R10-R12).</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>C. Based on record review and interview the facility failed to obtain lab work for the year 2013 for 1 (R2) individual who had a Physician order to monitor lab values, every three months, to monitor the effectiveness of a psychotropic medication R2 was taking.</p> <p>Findings Include:</p> <p>The facility failed to put safeguards in place and ensure adequate supervision, when their failure resulted in R3 falling again on 1/18/13, 5/15/13, 7/16/13, 8/27/13, 9/14/13, and 9/23/13</p> <p>A) Review of the Facility resident roster (undated) shows R3 is an 87 year old female who functions at a level of Severe Intellectual Disability.</p> <p>Review of the Facility Incident Reports for R3 show R3 has had seven falls in the year 2013. During observation on 12/12/13, 12/16/13, and 12/17/13 during the evening and morning hours, it was observed that the facility structure is a two story building with the kitchen and dining room areas being in the basement. The dining room area is separated into two separate rooms.</p> <p>1. The Facility Incident Report dated 1/15/13 at 8:00 PM shows R3 fell in the bathroom and had a bruise on her right upper arm and left leg below the knee. The Post Incident Report Nursing Assessment dated 1/16/13 at 5:30 PM E10 (Registered Nurse) documented, "Client fell in bathroom-Ecchymosis noted to right upper arm and left lower leg. Denies any pain. AROM (active range of motion)."</p> <p>2. The Facility Incident Report dated 1/18/13 at 7:30 PM shows R3 fell while in her room and did</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>not sustain injury. The Post Incident Report Nursing Assessment dated 1/19/13 at 5:30 PM E10 documents, "Client fell in her room unobserved denies any injury. No discoloration to extremities or pain."</p> <p>3. The Facility Incident Report dated 05/15/13 at 7:00 am shows R3 "sat down on floor" with no injuries. The Post Incident Report Nursing Assessment dated 5/18/13 at 11:00 am E10 documents, "Client sat down on floor. Denies any pain. No apparent injuries noted. No abrasions or discoloration noted."</p> <p>4. The Facility Incident Report dated 07/16/13 at 3:15 PM shows R3 bent down while in the wheelchair and fell out. The Post Incident Report Nursing Assessment dated 7/18/13 at 5:30 PM E10 documents, "Client leaned forward while in wheelchair and fell out. Ecchymosis to Rt (right) knee and forehead. No other injuries noted. Denies any pain."</p> <p>5. The Facility Incident Report dated 8/27/13 at 8:00 PM shows R3 missed her chair as she plopped down. The Post incident Report Nursing Assessment dated 8/30/13 E10 documents, "Client attempting to sit in chair and sat down on floor on her buttocks. No apparent injuries. Denies any c/o (complaints of)."</p> <p>6. The Facility Incident Report dated 9/14/13 (no time) shows R3 had a nose bleed, bruise on right arm and scrape on left knee. Cause of injury was not witnessed. The Post Incident Report Nursing Assessment dated 9/15/13 at 1400 E10 documents, "Client states rolled out of bed. Had slight nosebleed at time of incident. Sm (small) abrasion noted to Lt (left) knee and sm (small) ecchymotic area to Rt (right) forearm."</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>7. The Facility Incident Report dated 9/23/13 at 10:00 PM shows R3 fell trying to get out of bed. The Post Incident Report Nursing Assessment dated 9/26/13 at 10:00 am E10 documents, "fell out of bed. Ecchymosis noted to right orbit. Lt (left) forearm and Rt (right) knee. Denies any pain. Pt. (patient) laughing with staff. Will continue to monitor."</p> <p>Review of the Facility Incident Reports for R3 for the year of 2013 documents the Physician was not notified of R3's falls.</p> <p>Review of the Facility Fall Risk Assessment dated 1/5/13 documents R3 is at risk for falls and should have the following items in place to prevent falls; wear flat shoes, continue use of walker, assist client with gait belt, assist with ambulation.</p> <p>Review of the Facility Fall Risk Assessment dated 4/1/13 documents R3 is at risk for falls and should have the following items in place to prevent falls; wear flat non-skid soles, continue use of walker, use gait belt for assistance.</p> <p>Review of the Facility Fall Risk Assessment dated 7/1/13 shows R3 is at risk for falls and continues to list the same preventative measures to reduce falls as the previous two fall risk assessments. There has been no revisions made to R3's supervision level or plan of care to ensure proactive measures are in place to prevent further falls.</p> <p>During an interview with E8 (Habilitation Aide) on 12/16/13 at 3:45 via telephone, when surveyor asked about the staffing issues E8 states, "We frequently work with 2 staff on the weekends."</p>	Z9999		

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Z9999	<p>Continued From page 6</p> <p>One staff has to be down stairs cooking, during meal time we serve 12 residents downstairs first, leaving the two others R3 and R6 upstairs unsupervised." Confirmed by interview that R3 is unable to ambulate on stairs.</p> <p>During an interview with E1 (Administrator) on 12/12/13 at 2:05 PM, E1 stated, in October 2012 a gait belt, walker, and wheelchair was put in place to assist R3. In April 2013 a bed/chair alarm was implemented as a safety measure as well.</p> <p>During interview with E1 (Administrator) on 12/16/13 at 2:00 PM, E1 stated they do have two staff on evening shift at times. When asked how the staff was able to monitor and keep R3 safe while they were serving the meal downstairs. E1 stated that was part of the reason they implemented the chair alarm. So the staff could hear if R3 got up out of her chair.</p> <p>Review of the facility "Staff Schedule dated 12/01/13 thru 12/14/13 documents on 12/01, 12/07, 12/08 and 12/14 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule dated 11/17/13 thru 11/30/13 documents on 11/23, 11/28, 11/29, and 11/30 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule dated 11/03/13 thru 11/16/13 documents on 11/03, 11/10, 11/11, and 11/6 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule" dated 10/20/13 thru 11/02/13 documents on 10/26, 10/27, and 11/02 there were two staff members on the schedule for evening shift.</p>	Z9999		

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Z9999	<p>Continued From page 7</p> <p>Review of the facility "Staff Schedule" dated 10/06/13 thru 10/19/13 documents on 10/12, 10/13, and 10/19 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule" dated 9/22/13 thru 10/05/13 documents on 9/22, 9/28, 9/29, and 10/05 there were two staff members on the schedule for evening shift.</p> <p>Review of the Nursing Quarterly Assessments for R3 dated 1/5/13, 4/1/13, and 7/1/13 shows no documentation related to R3's falls.</p> <p>Review of R3's Nurses notes for the year of 2013 show no documentation related to R3's falls.</p> <p>Review of R3's Annual Nursing Summary dated 9/24/13 shows no documentation related to the falls R3 had in 2013.</p> <p>Review of the Interdisciplinary Team Report dated 9/24/13 shows no documentation related to the falls R3 had in 2013.</p> <p>Review of the QIDP (Qualified Intellectual Disability Professional) Review of IPP (Individualized Personal Plan) dated 1/27/13, 3/27/13,5/27/13,7/27/13, and 11/27/13 all show no documentation related to the falls R3 had in 2013.</p> <p>Review of the QIDP Review of IPP dated 9/27/13 documents R3's falls on 8/27/13, 9/14/13, and 9/23/13. There is no documentation of a plan or changes to be made to prevent further falls.</p> <p>During interview with E1 (Administrator) on 12/12/13 at 2:05 PM she states a Physical</p>	Z9999		

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Z9999	<p>Continued From page 8</p> <p>Therapy evaluation had not been completed on R3 in a long time. When asked if one had been done in 2013 E1 stated "no". E1 confirmed through interview R3 had a bed alarm and chair alarm that had been implemented since April of 2013. E1 also confirmed R3 had an order in place since October of 2012 to use a gait belt, walker and wheelchair while out of the building.</p> <p>During interview with E10 (Registered Nurse) on 12/16/13 at 10:45 am E10 stated a Physical Therapy evaluation had not been completed on R3 in the year 2013. When asked if there was a nursing plan of care in place for R3, E10 stated "no there isn't one."</p> <p>During interview with E1 (Administrator) on 12/19/13 at 2:00 PM, E1 stated they only have two staff at times on evening shift. When asked how they keep R3 safe while they serve the evening meal to the other clients, E1 stated that is part of the reason we got the chair alarm. So the staff can hear if R3 gets up out of her chair.</p> <p>During an interview with E6 (Habilitation Aide) on 12/17/13 at 11:45AM, E6 also voiced staffing concerns. E6 states, "We work with 2 staff all the time on weekends." E6 continues to describe the meal time events as, "I cook and usually have 4 residents assisting me, if something happens and I'm needed upstairs I take the other residents with me. When its meal time, one staff is in each dining area downstairs assisting those residents first, then once they are finished we take trays upstairs to the two others R3 and R6 that are unable to come downstairs."</p> <p>B) 1. Review of the Physician's Order Sheet</p>	Z9999		

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Z9999	<p>Continued From page 9</p> <p>dated 12/01/13 documents R1 is a 42 year old male who functions at a Mild Level of Intellectual Disability. R1's diagnosis include Hypertension and he has an order for Vasotec 10 milligrams one tablet every morning.</p> <p>The Physician's Order Sheet states, "For patient on blood pressure medication please check blood pressure medication please check blood pressure monthly. If B/P (blood pressure) over 140 systolic, check B/P weekly for 2 more weeks, and notify Physician. Notify Physician of any B/P greater than 160 systolic or 100 diastolic.</p> <p>Review of the Medication Administration Record dated October 2013, November 2013, and December 2013, documents no record of blood pressures obtained for R1.</p> <p>2. Review of the Physician's Order Sheet dated 12/01/13 documents R3 is an 87 year old female who functions at a level of Severe Intellectual Disability. R3's diagnoses include Hypertension and her medications include; Vasotec 5 milligram in the morning and Hydrochlorothiazide 25 milligram every morning.</p> <p>The Physician's Order Sheet states, "For patient on blood pressure medication please check blood pressure monthly. If B/P (blood pressure) over 140 systolic, check B/P weekly for 2 more weeks, and notify Physician. Notify Physician of any B/P greater than 160 systolic or 100 diastolic.</p> <p>Review of the Medication Administration Record dated October 2013, November 2013, and December 2013, documents no record of blood pressures obtained for R3.</p> <p>3. Review of the Physician's Order Sheet dated</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>12/01/13 documents R7 is a 66 year old male who functions at a Moderate Level of Intellectual Disability. R7's diagnoses include Hypertension and his medications include, Cozaar 25 milligrams every morning.</p> <p>The Physician's Order Sheet states, "For patient on blood pressure medication please check blood pressure monthly. If B/P (blood pressure) over 140 systolic, check B/P weekly for 2 more weeks, and notify Physician. Notify Physician of any B/P greater than 160 systolic or 100 diastolic.</p> <p>Review of the Medication Administration Record dated October 2013, November 2013, and December 2013, documents no record of blood pressures obtained for R7.</p> <p>4. Review of the Facility Resident Roster (undated) documents R10 is an 83 year old female who functions at a level of Moderate Intellectual Disability.</p> <p>Review of the Physician's Order Sheet dated 12/01/13 documents R10 has a diagnosis of Hypertension and has an order for Atenolol 50 milligrams daily and Vasotec 20 milligrams every morning.</p> <p>The Physician's Order Sheet states, "For patient on blood pressure medication please check blood pressure monthly. If B/P (blood pressure) over 140 systolic, check B/P weekly for 2 more weeks, and notify Physician. Notify Physician of any B/P greater than 160 systolic or 100 diastolic.</p> <p>Review of the Medication Administration Record dated October 2013, November 2013, and December 2013, documents no record of blood pressures obtained for R10.</p>	Z9999		

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Z9999	<p>Continued From page 11</p> <p>5. Review of the Facility Roster (undated) documents R11 is a 69 year old male who functions at a Mild Level of Intellectual Disability.</p> <p>Review of the Physician's Order Sheet dated 12/01/13 documents R11 has a diagnosis of Hypertension and takes Verapamil 240 milligrams daily to control the hypertension.</p> <p>The Physician's Order Sheet states, "For patient on blood pressure medication please check blood pressure monthly. If B/P (blood pressure) over 140 systolic, check B/P weekly for 2 more weeks, and notify Physician. Notify Physician of any B/P greater than 160 systolic or 100 diastolic.</p> <p>Review of the Medication Administration Record dated October 2013, November 2013, and December 2013, documents no record of blood pressures obtained for R3.</p> <p>6. Review of the Facility Resident Roster (undated) documents R12 is a 57 year old male who functions at a level of Severe Intellectual Disability.</p> <p>Review of the Physician's Order Sheet dated 12/01/13 documents R12 has a diagnosis of Hypertension and takes Lisinopril 40 milligrams daily and Hydrochlorothiazide 12.5 milligrams daily to control the hypertension.</p> <p>The Physician's Order Sheet states, "For patient on blood pressure medication please check blood pressure monthly. If B/P (blood pressure) over 140 systolic, check B/P weekly for 2 more weeks, and notify Physician. Notify Physician of any B/P greater than 160 systolic or 100 diastolic.</p>	Z9999		

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Z9999	<p>Continued From page 12</p> <p>Review of the Medication Administration Record dated October 2013, November 2013, and December 2013, documents no record of blood pressures obtained for R3.</p> <p>During interview with E3 (Qualified Intellectual Disability Professional) on 12/16/13 at 1:45 PM, E3 stated the facility had not obtained blood pressures as ordered by the Physician on individuals with diagnosis of Hypertension receiving medications.</p> <p>C) Review of the Physician's Order Sheet dated 12/01/13 shows R2 is a 54 year old female who functions at a Severe level of Intellectual Disability, with diagnosis that includes, Borderline Diabetes, Anxiety, and Schizo- Affective disorder. The Physician's Order Sheet continues to document a physician order that states, "Topomax levels Q (every) 6 mo. (months)."</p> <p>Review of the medical record for R2 did not show documentation that the Topomax levels had been drawn as ordered by the Physician.</p> <p>During interview with E1 (Administrator) on 12/16/13 at 12:00 PM, E1 stated she was unable to locate the results of the Topomax levels in the record and called the laboratory to have them send the results to the facility. The laboratory staff said the Topomax levels had not been drawn on R2 for the year 2013. The facility did not obtain lab work as ordered by the physician three times in the year 2013 for R2.</p> <p>(B)</p>	Z9999		

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Z9999	<p>Continued From page 13</p> <p>350.620a) 350.1060e) 350.1060h) 350.1060j) 350.1210 350.1230b)6) 350.1230b)7) 350.1230d)1) 350.3240a) 350.3240b) 350.3240c) 350.3240d) 350.3240f)</p> <p>Section 350.620 Resident Care Policies</p> <p>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.</p> <p>Section 350.1060 Training and Habilitation Services</p> <p>e) An appropriate, effective and individualized program that manages residents'</p>	Z9999		

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Z9999	<p>Continued From page 14</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1230 Nursing Services</p> <p>b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:</p>	Z9999		

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Z9999	<p>Continued From page 15</p> <p>The DON shall participate in:</p> <p>6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.</p> <p>7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>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)</p> <p>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)</p> <p>d) A facility administrator, employee, or</p>	Z9999		

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Z9999	<p>Continued From page 16</p> <p>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)</p> <p>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)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review, this condition is not met as the facility failed to implement their own system to prevent abuse and neglect for 4 individuals (R1,R9,R10 and R13) aggressed upon by another resident (R5) when they failed to:</p> <p>1) Follow and implement their own policy and procedures prohibiting abuse and neglect while also ensuring individuals of the facility are free from peer to peer abuse.</p> <p>2) Implement safeguards to protect other (more defenseless) residents from R5 following incident/s of aggression, monitor his patterns of behavior, and make revisions (in collaboration</p>	Z9999		

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Z9999	<p>Continued From page 17</p> <p>with R5's Day Training program) to his behavior developmental plan following incidents of aggression.</p> <p>3) Ensure all allegations of peer to peer abuse are promptly reported to the administrator or designee to assist in the prevention of further potential abuse/neglect.</p> <p>4) Thoroughly investigate all allegations of peer to peer abuse to assist in the identification and prevention of further potential abuse/neglect. Task two review form 9/27/13-11/27/13 revealed five of seven incidents involving R5 had not been thoroughly investigated.</p> <p>5) Provide adequate supervision to ensure R5 does not physically aggress towards peers.</p> <p>6) Revise R5's Behavior Management plan to ensure interventions are in place to prevent further abuse.</p> <p>Findings include:</p> <p>A) The facility's undated policy entitled "Client Protection" states that: "The facility shall be responsible to ensure that no resident is subjected to physical, verbal, sexual, neglect, exploitation, or psychological abuse or punishment by an employee, staff or other agencies that service the residents, family member/guardians, volunteers, outside consultants or other individuals." This policy goes on to define abuse and neglect as,</p> <p>"Abuse refers to ill treatment; violation, revilement, malignant or exploitation of an individual whether purposeful or due to</p>	Z9999		

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Z9999	<p>Continued From page 18</p> <p>carelessness, inattentiveness or omission of the perpetrator...</p> <p>Neglect refers to any failures by facility to carry out required/appropriate services, habilitation or treatment as ordered by authorized personnel. Neglect means failure to provide goods or services necessary to avoid physical or psychological harm."</p> <p>Per the POS (Physicians order sheet) dated 11/1/2013, R5 is a 22 year old male that functions at the Profound level for Individuals with intellectual disabilities. R5 has an additional diagnosis of Autistic Spectrum Disorder. The Behavioral Clinical Summary dated 7/5/13 from The Hope Institute (for Children and Families) identifies R5's targeted behaviors include verbal outbursts (swearing/yelling), self injurious behavior (biting hand or wrist), and physical aggression towards others (hitting with hands/fist). R5's admission date to this facility is 8/16/13.</p> <p>R5's Interdisciplinary team report, 30 day review dated 9/12/13 under problem behaviors are written as; Of the eight categories of behaviors measured by the Inventory of Client and Agency Planning(ICAP), R5 demonstrates problem behaviors in 2 categories. He is hurtful to himself as evidenced by biting his wrists in a self-stimulatory manner. He is hurtful to others as evidenced by him occasionally hitting himself. This happens 1-3 times a month and is considered a moderately serious problem. He is disruptive as evidenced by yelling and screaming. This happens 1-10 times daily and is considered a moderately serious problem.</p> <p>R5's Behavior Development Plan dated 9/12/13</p>	Z9999		

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Z9999	<p>Continued From page 19</p> <p>lists Maladaptive Behaviors to be reduced and or Biting wrist, baseline data 1-10 times weekly. Physical aggression- Hits staff and peers, 1-2 times per month. Data collection methods: Staff will document all incidents of targeted maladaptive behaviors in the behavior data sheet and the statements to incidents.</p> <p>Upon review of the the QIDP review of the Interdisciplinary Plan for R5 dated 11/12/13 (2 month review) under objectives reviewed; R5 will exhibit no episodes of physically aggressive behavior in 90% of days for 6 consecutive months, Progress demonstrated show that R5 had 4 incidents, 2 peer and 2 staff.</p> <p>Per review of the facility's incident reports given to surveyor on 12/10/13 actually show 5 incidents of peer to peer aggression and 3 incidents of aggression to staff during the two month period for review.</p> <p>During an interview with E3(Qualified Intellectual Disability Professional/QIDP) on 12/11/13 at 1245pm, surveyor asked to see the Behavior data sheets for R5 from the time of implementation of the plan 9/12/13. E4 presented surveyor with blank sheets stating, " I've been using the incident reports to monitor R5's behavior. The staff should be documenting these incidents on the Behavior tracking sheets but they have not."</p> <p>During an interview with Z2 (Day training program manager) on 12/16/13 at 8:50am, when the surveyor asked to see the behavior tracking sheets for R5 from 9/12/13 until present time Z2 states " I did not get them started until this week."</p> <p>An interview was also conducted at this time with Z2(Day Training Program Coordinator) related to</p>	Z9999		

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Z9999	<p>Continued From page 20</p> <p>an incident report on 10/16/13 where R5 hit a peer at the second day training program. After looking over the incident report Z2 states, " R5 should not have been on the van, he doesn't like closed quarters. It's my fault I did not tell the staff at that day training that R5 should not be on the van."</p> <p>Review of R5's Physician order sheet dated 10/13, shows that R5 was started on Melatonin 3 mg on 10/23/13 to assist him in the sleeping hours. Facility staff had voiced concerns about R5 getting up around 2am-3 am frequently and not going back to sleep.</p> <p>During an interview with E6 (Hab Aide) on 12/12/13 at 7:50 am, when the surveyor asked E6 about R5's sleeping pattern, E6 stated, "He is up a lot during the night. Sometimes he gets up at 1:30-2:00 am with out going back to sleep. E6 continued to state, "when he's up like this he is very difficult to manage and I often need to get the downstairs staff that is primarily responsible for cleaning and food prep in the basement to come and help me."</p> <p>In an interview with E1(Administrator) on 12/12/13 at 11:30 pm , the surveyor asked if R5's sleeping issues had been readdressed by the physician related to the the Melatonin not being effective for R5's sleeping, E1 stated, " no not yet, I'm going to have to do that." When the surveyor asked E1 if R5 had been seen by a psychiatrist for his aggressive behaviors and his sleeping issues E1 stated, " He has not yet been seen by a psychiatrist, we are getting ready to lose our psychiatrist next month and I'm not sure who I'm going to get to replace him."</p> <p>On 12/20/13 the surveyor requested a copy of</p>	Z9999		

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Z9999	<p>Continued From page 21</p> <p>R5's record of sleep. Upon review of R5's sleep pattern starting 10/23/13 after Mellatonin began thru 12/17/13, there are 20 days out of 56 days of poor sleep pattern. R5 is getting up at Midnight, 2am, 3 am and not going back to sleep.</p> <p>An Interview with E3 (QIDP) on 12/20/13 via telephone to discuss R5's sleeping pattern, surveyor asked, if there was a formalized written plan to monitor R5's sleeping hours except for 15 minute checks? R3 stated "no there is not."</p> <p>In review of the facility's incident reports that were provided to the surveyor identify that R5 had seven documented incidents of aggression towards other individuals at the facility and individuals at his day training from 9/27/13-11/27/13 site which include:</p> <p>1) 9/27/13 at 2:58 PM "When R5 came onto bus he seemed to be upset, he was biting his wrist and yelling loudly. He kept yelling. I (Z12) told him it was time to be quiet, that's when he struck R9 in the neck with an open hand. I (Z12) (the driver) unhooked R9's seatbelt to move him to a different seat. That's when R5 hit me (Z12) with an open hand and forearms. Then he hit R10 three times, I (Z12) asked R10 to move up a seat. Another staff came to assist and R5 hit that staff."</p> <p>2) 9/28/13 at 11:25PM (sic) "R5 hit R13." This report also includes a staff's statement of the incident which reads: "E7 (Habilitation/Hab Aide) was in the restroom and heard a slapping noise coming from R5's room. I (E7) go in and see R5 hitting another client (R13). I get R5 away from R13 and the other staff E9 (Hab aide) tried to get R13 out of the room when R5 pushed E9 against the wall and hit her repeatedly on the arms, face, and head then tried to bite her on the head. I (E7)</p>	Z9999		

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Z9999	<p>Continued From page 22</p> <p>stepped in between them and grabbed R13 to take him to the living room. R5 then came to the living room and hit me repeatedly in the arms. R5 then ran to his room and started jumping up and down and hitting the walls..."</p> <p>Documentation within this report states that R13 was returned to the bedroom (shared with R5) for the night after 15 minutes when R5 calmed down. No safeguards or increased supervision was implemented to protect R13 from further aggression from R5.</p> <p>During interviews with E1 (Administrator) and E3 (QIDP/Qualified Intellectual Disabilities Professional) on 12/11/13 at 10:30 AM, when surveyor asked if there had been any revision to R5's Behavior plan or special interdisciplinary team meeting after the 09/28/13 incident, both E1 and E3 stated, "No."</p> <p>3) 10/15/13 at around 4:30pm - "R5 struck a peer, his roommate (R13) while in their room. Staff was present in the room when R5 walked over and hit R13 with an open hand on the side of the head. R13 was immediately escorted out of the room by staff and an incident report and neurological was initiated. The report states, procedures are being implemented and staff are being trained on these new procedures in order to prevent future occurrences. A room change is also being considered. There is no reproducible evidence as to what the new procedures to be initiated are and no documentation which states whether a room change occurred at this time.</p> <p>During interviews with E1 (Administrator) and E3 (QIDP) on 12/11/13 at 10:30 AM, both stated that the facility's staff were trained on R5's roommate protocol on 10/16/13. This protocol states, "When</p>	Z9999		

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Z9999	<p>Continued From page 23</p> <p>R5 and his roommate are home, staff should encourage his roommate to join staff and peers in the living room or downstairs when R5 is having his private time in his room. If they are in the room at the same time, for example during sleeping hours, staff must keep the audio monitor on them at all times and must respond immediately if they hear R5 become agitated." E1 and E3 both said that after the 10/15/13 incident, R13 was moved out of the bedroom shared with R5 and R9 was moved into the bedroom. E1 and E3 were unable to give dates of these bed moves.</p> <p>4)10/16/13 at 2:05 PM at Day Training during a van ride, "R5 started getting agitated and hit Z8 (peer at day training). Z7 (DSP/Direct Support Person) asked R5 to stop. Z5(DSP) then separated the clients upon return for the rest of the day.</p> <p>5)11/7/13 at 2:30AM "R9 was sleeping when R5(his roommate) hit him in the arm three times."</p> <p>The Investigative Summary for this incident reads, "While doing 15 minute bed checks staff noticed that R5 was awake but quiet. Around 2:30 am E8 heard R5 being restless. When E8 (Habilitation Aide/Hab Aide) knocked and went in the room, E8 saw R5 hit R9 in the arm three times. E8 immediately took R9 out of the room. There were no injuries or red marks. After about 30-45 minutes R5 calmed down and R9 was taken back to his room." There is no documentation which states what safeguards were put in place for R9 upon his return to the bedroom with R5.</p> <p>During interviews with E1 (Administrator) and E3 (QIDP) on 12/11/13 at 10:30 AM stated, "R9 was</p>	Z9999		

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Z9999	<p>Continued From page 24</p> <p>moved sometime after this incident to allow R5 to have his own room." When asked when this occurred, neither E1 or E3 could give the specific dates as to when R9 was moved from the bedroom shared with R5. E1 went on to state that around 10/31/13, staff of the facility were instructed to keep R5 in eyesight at all times when he is out of his bedroom. E1 also stated that this intervention had not been formalized or included within a written plan.</p> <p>6) 11/8/13, "... It was reported to E3 (QIDP) that R5 hit Z11(Female day training client) when he got off the bus. When R5 got to workshop, staff said that he was agitated. Staff asked him to sit down and work. R5 started yelling and tried to sit in the recliner. Staff again told him that he needed to work first. At this time R5 took off running and yelling in the room and hit Z11(day training peer) with an open hand on top of the head. R5 then began running around the room again. The other clients were removed from the room while R5 calmed down. After about 15-20 minutes R5 calmed down and the other clients reentered the room. The female client that he hit was not hurt or injured. ... staff will now provide transportation to and from workshop for R5 so that he arrives separately from the other clients and has an opportunity to get settled into his routine before peers arrive."</p> <p>During interviews with E1 (Administrator) and E3(QIDP) on 12/11/13 at 10:30 AM, E1 stated that the facility's staff began to provide the transportation to and from daytraing for R5, but no formalized or written revisions were made to R5's Behavior Management Plan, nor was there a special IDT (Interdisciplinary Team) meeting between the facility and the day training site.</p>	Z9999		

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Z9999	<p>Continued From page 25</p> <p>7) 11/27/13 at 9:00 am, Incident Report identifies that after staff of the facility had dropped R5 off at his Day program, "... R5 came into door agitated. The staff stated he was calm till now. R5 started running around the room yelling and biting his hands. Several staff try to redirect R5, however R5 continued to run around the room, cursing and screaming. Other clients started to arrive. Staff tried to redirect R5 back to his seat. Z10 (female client) was standing by the coat rack. Suddenly R5 ran towards Z10 with his fist raised and made contact with Z10's right shoulder. Female client (Z10) started to cry. Staff intervened and removed Z10 to a different room. The other staff tried to redirect R5. He finally sat at his seat for a few minutes."</p> <p>During observations made by the surveyor of R5 on 12/10,12/11,12/12 and 12/16/13 at the facility during the afternoon and evening hours from 3:50-6:30pm, R5 was noted to be very hyperactive with fast ambulation. R5 would frequently have loud verbal outbursts and yell out, "I Hate You." R5 was observed to make quick jerking hand movements and occasionally bite his wrist. He required frequent redirection by the staff.</p> <p>R5's Behavior Development Plan dated 09/12/13 identifies that he hits staff and peers on average of "1-2 times per month" and that he (R5) has the potential to possibly injure staff or peers if he becomes physically aggressive. Under the reactive strategies section of this plan it states,</p> <ol style="list-style-type: none"> 1. Staff should remain calm. 2. If R5 hits anyone, staff will remove other clients from the area. 3. Staff should block aggressive behaviors/attempts and minimize attention 	Z9999		

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Z9999	<p>Continued From page 26</p> <p>towards R5. Minimal attention means that staff should not talk, provide eye contact, or show emotion with R5. They should block to protect R5, themselves, or other clients.</p> <p>4. Staff will observe R5 from a distance to assure that he is calm. As soon as he appears calm, staff should use first-then language and redirect him to the activity he was engaged in.</p> <p>5. Staff will continue to observe R5 for any additional signs of agitation and repeat above procedures if necessary.</p> <p>6. Staff will document each incident of physical aggression on behavior data sheet and describe incident in the statement to incidents."</p> <p>Through review of the Behavior Management Plan there are no identified pro-active interventions, which would ensure R5 does not have the opportunity to strike or injure another individual.</p> <p>Further review of this behavior development plan does not identify that revisions have been made since this plan's initiation date of 09/12/13, even though R5 has had multiple incidents of striking other clients and continues to physically aggress against peers.</p> <p>During interviews with E1 (Administrator) and E3(QIDP) on 12/11/13 when the surveyor asked if there had been any revision to R5's Behavior plan or special interdisciplinary team meetings after these incidents both E1 and E3 voiced "No, there has not."</p> <p>B) The facility's undated policy for Client Protections identifies, "A facility employee or agent who becomes aware of abuse or neglect of a resident shall inform the Administrator/Resident Services Director... Staff will complete the</p>	Z9999		

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Z9999	<p>Continued From page 27</p> <p>"Abuse/Neglect Reporting Form" and the responsible staff will document on the "Checklist for Report of Abuse/Neglect."</p> <p>1)Upon review of an incident report dated 10/16/13 at 2:05 pm, it states that R5 hit Z8 (peer at daytraing program) while on a van ride. The staff at Randolph House was not notified of this report until 10/25/13.</p> <p>In an interview with Z1(Day training program coordinator) completed on 12/16/13 at 9:00am related to the incident report dated 10/16/13. Z1 states "Z2 (Day training program manager) was on vacation that week and the report had been placed on my desk without me knowing and I found it on 10/25/13 and sent it to Randolph house as soon as I saw it."</p> <p>An interview was also conducted at this time with Z2(Day training program manager) related to an incident report on 10/16/13 where R5 hit a peer at the second day training program. After looking over the incident report Z2 stated, "R5 should not have been on the van, he doesn't like closed quarters. Its my fault I did not tell the staff at that day training that R5 should not be on the van."</p> <p>During an interview with Z5 (Direct support staff-day training) on 12/16/13 at 1040 am, Z5 stated, "I sent the report to Z1 (Day training program coordinator) and Z2 (Day training program manager) at our other day training facility on 10/16/13."</p> <p>During an interview with E3(QIDP) on 12/18/13 at 0950, E3 stated, "I was aware of this incident on 10/25/13." Surveyor asked if the incident was investigated or reported to Department of Public Health? E3 stated, "no it was not investigated</p>	Z9999		

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Z9999	<p>Continued From page 28</p> <p>and I just reported it to the Illinois Department of Public Health 1-2 days ago."</p> <p>Per the facility's undated policy presented to the surveyor on 12/11/13, under client protections #24 reads; A facility employee or agent who becomes aware of abuse or neglect of a resident shall inform the administrator/resident service director. The administrator/designee is responsible to notify the residents's representative (guardian/family) and the Illinois Department of Public Health.</p> <p>Upon review of an incident report dated 10/16/13 at 2:05pm, the report states that R5 hit Z8(peer at daytraing program) while on a van ride.</p> <p>In an interview with Z1(Day training program coordinator) completed on 12/16/13 at 9:00am related to the incident report dated 10/16/13. Z1 stated, "Z2 (Day training program manager) was on vacation that week and the report had been placed on my desk without me knowing and I found it on 10/25/13 and sent it to Randolph House as soon as I saw it."</p> <p>During an interview with Z5 (DSP) on 12/16/13 at 1040 am, Z5 stated, "I sent the report to Z1 (Day Training Program Coordinator) and Z2 (Day training Program Manager) at our other day training facility on 10/16/13."</p> <p>On 12/11/13 an investigation began about 5:45pm when R1 came to E1 (Administrator) and informed her that R5 had hit him in the eye sometime before Thanksgiving in the hallway. In a statement written by E4 (Hab Aide), E4 stated she was approached by R1 in the kitchen one</p>	Z9999		

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Z9999	<p>Continued From page 29</p> <p>night that she was working. R1 said to her, " hey that R5 kid hit me in the eye a couple nights ago when you wasn't here." E4 then asked R1 what happened and R1 stated that he was in the hallway and R5 was upset and pacing the hallway, throwing his arms in the air and hit R1 in the eye.</p> <p>E1(administrator) asked E4 why she didn't tell herself or E3(QIDP) about what R1 had told her and E4 said that she was not at the facility when the alleged incident occurred and she assumed that the staff on duty made the incident reports.</p> <p>During an interview with E4 (Hab Aide) on 12/17/13 at 1:00pm, when the surveyor asked her if R1 had told her about R5 hitting him in the eye around Thanksgiving. R4 stated, "yes he did tell me that." The surveyor asked if E4 had reported this incident to anyone? E4 stated, "no, I thought it had been previously reported."</p> <p>2)An investigation began about 5:45pm on 12/11/13 when R1 came to E1 (Administrator) and informed her that R5 had hit him in the eye sometime before Thanksgiving in the hallway. Further review of this investigation from a witness statement written by E4(Hab Aide) reads; E4 was approached by R1 in the kitchen one night that she was working. R1 said to her "hey that R5 kid hit me in the eye a couple nights ago when you wasn't here." E4 then asked R1 what happened and R1 stated that he was in the hallway and R5 was upset and pacing the hallway, throwing his arms in the air and hit R1 in the eye. E1(administrator) asked E4 why she didn't tell her or E3(QIDP) about what R1 had told her? E4 said she was not there when the alleged incident occurred and she assumed that the staff on duty</p>	Z9999		

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Z9999	<p>Continued From page 30</p> <p>made the incident reports.</p> <p>During an interview with E4 (Hab Aide) on 12/17/13 at 1:00pm, when the surveyor asked her if R1 had told her about R5 hitting him in the eye around Thanksgiving R4 stated, "yes he did tell me that." Surveyor asked if E4 had reported the incident to anyone. E4 stated "no, I thought it had been previously reported."</p> <p>R1 was interviewed on 12/11/13 at 4:00 PM and stated that he was not afraid of R5 and had never been subject to his aggression. On 12/12/13 at 8:00 A.M., R1 approached the surveyor and stated that he had not been truthful during his interview with the surveyor on 12/11/13 (4:00-4:10 PM) R1 said he had told the administrator E1 that R5 had hit him before Thanksgiving.</p> <p>An interview was conducted with R1 on 12/12/13 at 8:00am. When the surveyor asked about the incident R1 had reported on 12/11/13 to E1 (Administrator) but had previously denied to the surveyor, R1 stated, "I lied yesterday when I told you about being hit. R5 hit me in the eye in the hallway sometime before Thanksgiving. I think he was agitated. I didn't tell any staff but I did tell my mom about it on Thanksgiving." The surveyor asked R1 to describe the hit, R1 made a fist and swung his arm describing a punch.</p> <p>The facility's investigation report for the incident reported to have occurred before Thanksgiving, identifies that Z9 (R1's guardian) was contacted and confirmed that R1 had informed her that he had been hit in the eye by R5 before Thanksgiving. This report also states that R1 had asked Z9 not to say anything because R1, "didn't want to get this guy (R5) in trouble."</p>	Z9999		

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Z9999	<p>Continued From page 31</p> <p>This report also identifies that E1(Administrator) had asked E4 why she had not immediately reported this allegation after R1 had told her and E4 said she was not there when the alleged incident occurred and assumed that the staff on duty made the incident reports.</p> <p>In review of the facility's policy and procedures, staff failed to implement the facility's policy after becoming aware of an allegation made by R1 against R5.</p> <p>C)The facility's undated policy entitled "Client Protections" states, in case of peer on peer aggression, the facility shall notify the guardian, RN (Registered Nurse) and Administrator (and Physician when outside medical treatment is needed). A Trend/Pattern Assessment shall be completed to determine risk of reoccurrence. An Administrative Summary shall be completed and sent to the Illinois Department of Public Health. While there is no way to predict human behavior, proactive measures will be taken in an attempt to prevent peer on peer aggression.</p> <p>During Task II of the survey on 12/10/13, the facility's incident reports that were provided to the surveyor on this date identified that R5 had 7 documented incidents of aggression towards individuals at the facility and individuals at the day training sites in a two month time frame from 9/27/13-11/27/13. Upon review these incidents 5 of the 7 were not thoroughly investigated which include:</p> <p>1) 9/27/13 at 2:58, "When R5 came onto bus he seemed to be upset, he was biting his wrist and yelling loudly. He kept yelling. I (Z12-driver) told him it was time to be quiet, that's when he struck</p>	Z9999		

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Z9999	<p>Continued From page 32</p> <p>R9 in the neck with an open hand. I (Z12) (the driver) unhooked R9's seatbelt to moved him to a different seat. That's when R5 hit me with an open hand and forearms. Then he hit R10 3 (three) times, I (Z12) asked R10 to move up a seat. Another staff came to assist and R5 hit that staff."</p> <p>An investigative summary is not included in this incident to monitor for possible trends/patterns to determine risk of reoccurrence.</p> <p>On 12/16/13 at 9:25am, during an interview with R10, surveyor asked if R10 remembered being hit on the bus, R10 stated "yes" but was unable to describe the incident.</p> <p>2) 9/28/13 at 11:25PM, "R5 hit R13." This report also includes a staff statement of the incident which reads: "E7 (Habilitation/Hab Aide) was in the restroom and heard a slapping noise coming from R5's room. I (E7) go in and see R5 hitting another client (R13). I (E7) get R5 away from R13 and the other staff E9 (Hab aide) tried to get R13 out of the room when R5 pushed E9 against the wall and hit her repeatedly on the arms, face, and head then tried to bite her on the head. I E7 stepped in between them and grabbed R13 to take him to the living room. R5 then came to the living room and hit me repeatedly in the arms. R5 then ran to his room and started jumping up and down and hitting the walls..."</p> <p>R13 was returned to the bedroom which was shared with R5 for the night after 15 minutes when R5 calmed down. There is no investigation summary attached to this report to monitor trends and patterns to determine risk of reoccurrence.</p> <p>During interview with E9 (Hab Aide) on 12/16/13</p>	Z9999		

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Z9999	<p>Continued From page 33</p> <p>at 4:00 pm via telephone when surveyor asked details of the above incident E9 states "it happened exactly as written." E9 further states, "R5 is very fast and unpredictable and even though he hits with an open hand, he hits really hard and it hurts."</p> <p>During interview with E7(Hab Aide) on 12/16/13 at 4:07pm via telephone when the surveyor asked for details of the above incident, E7 stated "It happened exactly as written." E7 stated "R5 is fast and unpredictable and when he hits it feels like being hit with a wet towel, it hurts and it is very scary."</p> <p>3) 10/16/13 at 2:05PM at Day Training during a vanride, "R5 started getting agitated and hit Z8 (peer from another facility) Z7 (DSP/Direct Support Person) asked R5 to stop. Z5(DSP) then separated the clients upon return for the rest of the day.</p> <p>There is no investigation summary attached to this report to monitor trends and patterns to determine risk of reoccurrence.</p> <p>An interview with Z1(Day training program coordinator) was completed on 12/16/13 at 9:00am related to the incident report dated 10/16/13. Z1 stated, "Z2 (Day training program manager) was on vacation that week and the report had been placed on my desk without me knowing and I found it on 10/25/13 and sent it to Randolph House as soon as I saw it."</p> <p>An interview was also conducted at this time with Z2 (Day training program manager) related to an incident report on 10/16/13 where R5 hit a peer at the second day training program. After looking over the incident report Z2 states, " R5 should not</p>	Z9999		

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Z9999	<p>Continued From page 34</p> <p>have been on the van, he doesn't like closed quarters. It's my fault I did not tell the staff at that day training that R5 should not be on the van."</p> <p>During an interview with Z5 (day training DSP) on 12/16/13 at 1040 am, Z5 stated " I sent the report to Z1 and Z2 at our other day training facility on 10/16/13." Z5 continued to state, " R5 was sent here for a couple weeks on a trial basis, we were not told R5 should not ride the van, we were not given any details about him."</p> <p>In an Interview with Z7 (day training direct support person) on 12/16/13 at 1040am, Z7 confirms the above interview with Z5, Z7 stated, "We were not told R5 should not ride the van and we were not given any details about him."</p> <p>During an interview with E3(QIDP) on 12/18/13 at 0950, E3 states " I was aware of this incident on 10/25/13. Surveyor asked if the incident was investigated , E3 states "no it was not investigated."</p> <p>4) 11/8/13, "... It was reported to E3 (QIDP) that R5 hit Z11(Day training client) when he got off the bus. When R5 got to workshop, staff said that he was agitated. Staff asked him to sit down and work. R5 started yelling and tried to sit in the recliner. Staff again told him that he needed to work first. At this time R5 took off running and yelling in the room and hit a female peer with an open hand on top of the head. R5 then began running around the room again. The other clients were removed from the room while R5 calmed down. After about 15-20 minutes R5 calmed down and the other clients reentered the room. The female client that he hit was not hurt or injured. ... staff will now provide transportation to and from workshop for R5 so that he arrives</p>	Z9999		

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Z9999	<p>Continued From page 35</p> <p>separately from the other clients and has an opportunity to get settled into his routine before peers arrive."</p> <p>During interview on 12/16/13 at 0900 with Z4 (Day training Habilitation Aide) who witnessed incident states" R5 hit Z11 4 times real fast" "It is very unpredictable when he will strike."</p> <p>Further review of this incident by surveyor show that Z11 was actually hit four times on top of her head.</p> <p>There is no investigation summary attached to this report to monitor trends and patterns to determine risk of reoccurrence.</p> <p>During interview with E1(Administrator) on 12/10/13/ at 2:30pm when surveyor asked to see the investigation to this incident E1 states " We don't investigate all incidents, if they are witnessed we used the incident reports."</p> <p>An interview was attempted with Z11 on 12/16/13 at 9:15 am, Z11 answered, "Yes he hit me." Z11 was unable to give any further details of event.</p> <p>5) 11/27/13 at 9:00am, Incident Report identifies that after staff of the facility had dropped R5 off at his Day program, "... R5 came into door agitated. The staff stated he was calm till now. R5 started running around the room yelling and biting his hands. Several staff try to redirect however R5 continued to run around the room cursing and screaming. Other clients started to arrive. Staff tried to redirect R5 back to seat. A female client (Z 10) was standing by the coat rack. Suddenly R5 ran towards Z10 and his fist made contact with her right shoulder. Z10 started to cry. Staff intervened and removed female to a different</p>	Z9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2014
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NAME OF PROVIDER OR SUPPLIER RANDOLPH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 404 SOUTH FIRST STREET VANDALIA, IL 62471
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(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) COMPLETE DATE
Z9999	<p>Continued From page 36</p> <p>room. The other staff tried to redirect R5.</p> <p>During interview with Z1(Day training Program coordinator) on 12/16/13 at 9:15am ,Z1 states "R5 had both hands clenched because he was biting his hands, R5 was pacing , he is very quick and unpredictable, he went towards Z10 with his fist made and made contact with her right shoulder. Z10 began to cry."</p> <p>During observation on 12/12/13,12/16/13 and 12/17/13 it was observed that the facility structure is a two story building with the kitchen and dining room areas being in the basement. The dining room area in the basement is separated into two separate rooms.</p> <p>Observations during the evening hours on 12/10/13 of R5 at the facility between 3:50 PM-6:15 PM, R5 was very hyperactive, fast paced with occasional loud outbursts. At times would raise hands and make quick flapping movements.</p> <p>On 12/11/13 at 11:00 AM E1(Administrator) was asked to provide evidence of R5's line of sight supervision level. E1 stated "I do not have anything specifically in a written plan, its just written in the communication book where staff have signed it."</p> <p>Review of the copied page given to surveyor shows an entry around 10/31/13 that reads.... "remember when R5 is out of his room to keep him insight."</p> <p>On 12/16/13 a copy of the facility's staffing schedule was observed with evidence of only two staff scheduled on weekend evening shifts. E1 stated when asked if this is the staffing pattern for</p>	Z9999		

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Z9999	<p>Continued From page 37</p> <p>weekend evening shifts, "Yes it is true."</p> <p>The surveyor then asked how two staff are able to closely monitor R5 and provide adequate supervision and care for the other 13 residents? E1 stated, "I know this has been an issue- I've put an ad in the paper for new hires."</p> <p>In an interview with E1(Administrator) on 12/10/13 at 6:00pm when the surveyor asked what R5's level of supervision was, E1 stated " He is to be in eye sight of staff at all times when he's not in his room. I keep enough staff on duty to make sure of it." E1 further states "I can't get the funding for 1:1 supervision."</p> <p>On 12/11/13 at 11:00am, E1 was asked to provide evidence of R5's line of sight supervision level, E1 stated, "I do not have anything specifically in a written plan, it's just written in the communication book where staff have signed it." Review of the copied page given to the surveyor shows an entry around 10/31/13 that reads...." remember when R5 is out of his room to keep him insight."</p> <p>On 12/16/13 a copy of the Facility's staffing schedule was observed with evidence of only two staff working on the weekends during the evening hours.</p> <p>Review of the facility "Staff Schedule dated 12/01/13 thru 12/14/13 documents on 12/01, 12/07, 12/08 and 12/14 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule dated 11/17/13 thru 11/30/13 documents on 11/23, 11/28, 11/29, and 11/30 there were two staff members on the schedule for evening shift.</p>	Z9999		

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NAME OF PROVIDER OR SUPPLIER RANDOLPH HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 404 SOUTH FIRST STREET VANDALIA, IL 62471
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Z9999	<p>Continued From page 38</p> <p>Review of the facility "Staff Schedule dated 11/03/13 thru 11/16/13 documents on 11/03, 11/10, 11/11, and 11/6 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule" dated 10/20/13 thru 11/02/13 documents on 10/26, 10/27, and 11/02 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule" dated 10/06/13 thru 10/19/13 documents on 10/12, 10/13, and 10/19 there were two staff members on the schedule for evening shift.</p> <p>Review of the facility "Staff Schedule" dated 9/22/13 thru 10/05/13 documents on 9/22, 9/28, 9/29, and 10/05 there were two staff members on the schedule for evening shift.</p> <p>During an interview with E8 (Habilitation Aide) on 12/16/13 at 3:45 PM via telephone, when the surveyor asked about the staffing issues at this facility, E8 stated, "We frequently work with 2 staff on the weekends. We can not keep R5 in sight at all times. One staff has to be downstairs cooking, during meal times we serve 12 residents downstairs first, leaving the two others R3 and R6 upstairs unsupervised."</p> <p>During an interview with E7 (Habilitation Aide) on 12/16/13 at 4:07pm, E7 confirms E8's reports by stating, "We have been working with only 2 staff on the evenings for quite a bit." E7 was asked if R5's supervision level of being within eye site could be managed with only 2 staff? E7 stated " It is very very hard to manage R5 and his behaviors and can't keep him in eyesight at all times because 1 staff has to cook and prepare</p>	Z9999		

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Z9999	<p>Continued From page 39</p> <p>the meals, leaving the other staff to manage R5 as well as 13 peers."</p> <p>During an interview with E6 on 12/17/13 at 11:45am, E6 also voiced staffing concerns. E6 stated, " We work with 2 staff all the time on weekends. "When the surveyor asked if R5 was able to be kept in eye sight E6 stated, "Not constantly but we try our best." E6 continues to describe the meal time events as, "I cook and usually have 4 residents assisting me, if something happens and I'm needed upstairs I take the other residents with me. When its meal time, one staff is in each dining area downstairs assisting those residents first, then once they are finished we take trays upstairs to the two others R3 and R6 that are unable to come downstairs."</p> <p>(B)</p>	Z9999		