

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/24/2014
NAME OF PROVIDER OR SUPPLIER BEVERLY FARM FOUNDATION			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 HUMBERT ROAD GODFREY, IL 62035		
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W9999 W9999	Continued From page 36 FINAL OBSERVATIONS STATEMENT OF LICENSURE VIOLATIONS 350.620a) 350.1210 350.3240a) 350.3240b) 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes	W9999 W9999			

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W9999	<p>Continued From page 37</p> <p>aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.</p> <p>These Regulations were not met as evidenced by:</p> <p>1) Based on file review and interview, it was determined that the facility failed to implement their written policies and procedures that prohibit mistreatment, neglect or abuse of clients for 1 of 1 clients (R1) in the sample and 4 clients (R2, R3, R4, R5) outside the sample when they failed to:</p> <ol style="list-style-type: none"> 1. Ensure individual's are not subjected to abuse and neglect. 2. Ensure sufficient safeguards are in place to ensure satiety for all individuals on the residential campus. 3. Ensure facility staff members implement policies related to abuse and or neglect. 4. Ensure residential sites are continuously monitored to ensure all staff continue to follow policy and procedures. 5. Ensure the facility provides planning to maintain ongoing re-training and monitoring on residential units. <p>Facility received notification that R1, R2, R3, R4</p>	W9999			

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W9999	<p>Continued From page 38</p> <p>& R5 were subjected to abuse and neglect at the residential facility (time period of 4:30PM-5:00PM on 2/25/14). It was determined at that time the facility was unable to ensure the incident was not occurring campus wide (10 residential buildings located on the campus) ensuring sufficient safeguards had been put in place to address all residential buildings.</p> <p>In addition it was determined at that time the facility did not implement a plan to monitor and provide ongoing training to prevent further potential of abuse and neglect.</p> <p>2) Based on file review and interview, it was determined the facility failed to ensure clients are not subjected to neglect for 1 of 1(R7) outside the sample who sustained a fracture of unknown origin while on same room supervision.</p> <p>Findings include:</p> <p>1)R1 is identified in his IHP (Individual Habilitation Plan) dated 7/15/13 as a 36 year old male with diagnosis of Personality Change due to static encephalopathy aggressive type, Seizure Disorder and Severe Mental Retardation. Behavior modification medications are listed as Effexor, Loxapine, Clonazepam and Lamotrigine.</p> <p>IHP states R1 has maladaptive behaviors which include attempts to hit, kick, poke, bite, spit, push or pull hair of peers or staff, kicking, hitting or biting environment, slamming doors, throwing objects, head banging, hitting or biting self, dropping to the floor, crying, refusing to get off the bus to Day training and noncompliance.</p>	W9999			

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W9999	<p>Continued From page 39</p> <p>R2 is identified in his IHP, dated 8/5/13 as a 60 year old man with diagnosis of Autistic Disorder and Profound Mental Retardation. Current behavior modification medications include Abilify, Celexa, Medroxyprogesterone and Depakote.</p> <p>R3 is identified on the facility roster dated 3/3/2014 as a male resident who functions at the Severe level of mental retardation.</p> <p>R4 is identified on the facility roster dated 3/3/2014 as a male resident who functions at the Moderate level of mental retardation.</p> <p>R5 is identified on the facility roster dated 3/3/2014 as a male resident. R5's level of functioning is not listed.</p> <p>Review of facility "Abuse and Neglect Policy and Procedure" dated 5/10:</p> <p>Page 2 states, " Any employee who becomes aware of alleged abuse or neglect of an individual will immediately assist to protect the resident(s) and report the alleged event to the Executive Director or his/her designees; Assistant Executive Director, Human Rights Coordinator or Charge Nurse of the facility".</p> <p>Page 5 of the facility "Abuse and Neglect Policy and Procedure" states, " Allegations of abuse and neglect should be reported immediately. If a reporter requires assistance to protect the individuals or support while the allegation is made, the staff should inform their supervisor who the parties involved are (perpetrator and involved party) and they need to contact a</p>	W9999			

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W9999	<p>Continued From page 40 designee to make a report."</p> <p>Page 8 of the facility "Abuse and Neglect Policy and Procedure" states, "Allegations may include resident to resident, staff to individuals or other outside parties toward an individual receiving service."</p> <p>Review of facility training manual dated 1/20/12, the following was stated:</p> <p>Page 4 states, " Any employee who suspects, witnesses, or is informed of an allegation of abuse or neglect must report it immediately. 'Suspects' means you have a suspicion based upon information or an observation, 'Witness' means you saw or heard it, or 'Informed of' means you were told it (like hearsay or an anonymous letter), whether or not you think it actually happened.</p> <p>You are a required reporter 24 hours a day, seven days a week, not only when you are at work.</p> <p>For abuse/neglect, 'employee' means any person who provides services at the facility or with facility or agency. .</p> <p>For reporting purposes, you are an 'employee' 24 hours a day, seven days a week. Employees are accountable if they commit abuse or neglect on their personal time.</p> <p>Physical abuse is defined as an employee's non -accidental and inappropriate contact with an individual that causes bodily harm. Physical abuse includes actions that cause bodily harm as a result of an employee directing an individual or person to physically abuse another individual. Mental abuse is defined as the use of demeaning, intimidating or threatening words, signs, gestures,</p>	W9999			

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W9999	<p>Continued From page 41</p> <p>or other actions by an employee, about an individual and in the presence of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present. Mental abuse is still mental abuse even if the individual's mental or physical condition keeps him/her from getting upset. Mental abuse is verbal or nonverbal and includes not intervening when an individual faces an upsetting situation. Mental abuse is not always face-to-face with that individual, but at least one individual must be present at the time.</p> <p>Neglect is defined as an employee's, agency's or facility's failure to provide adequate medical care, personal care, or maintenance, and that as a consequence, causes an individual pain, injury, or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk.</p> <p>A Required Reporter is any employee who suspects, witnesses or is informed of an allegation of abuse or neglect. You must report any alleged abuse or neglect that you see, hear, read or suspect. You do not need to believe allegation is true to report it .You must report immediately".</p> <p>Review of facility incident report's dated 2/26/14 at 5:33 PM the following was stated:</p> <p>"On 2/25/14 between 4:00 PM and 5:30 PM, while in the Activity Room/Hallway of Stahl Cottage, E6 (On the Job Trainee) reported E4 (Shift</p>	W9999			

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W9999	<p>Continued From page 42</p> <p>Supervisor) grabbed R1 by his arm and dragged him to his room, smacked R1 in the face and pushed (dragged) R1 (on his)back down the hall. E6 also reported E4 poured water over R1's head.</p> <p>During a medical examination by E5(nurse), R1 was found to have the following injuries: a three inch SF(superficial) scratch to the RT (right) lower side, a two inch scratch to the upper RT(right) back, a three inch and a one and one-half inch SF (superficial) scratch to the of back neck. No bruising or redness."</p> <p>Facility incident report also states:</p> <p>"On 2/25/14 between 4:00 PM and 5:30 PM, while in the Activity Room of Stahl Cottage, staff reported E4 smacked R2. Upon medical assessment by E5, E5 stated there was no injury noted."</p> <p>In review of facility investigation dated 3/4/14 at 12:50PM the following was stated:</p> <p>"On 2/26/2014, E6, OJT (On the Job Trainee), alleged she witnessed , E4 (Shift Supervisor) smack R2 and smack, drag and pour water on R1. E6 also alleged E4 encouraged three residents to strike each other. Madison County Sheriff's Department was contacted."</p> <p>"E7 (Assistant Staff Trainer) states On February 26, 2014, E6 came into the training office a little after 12 PM. and asked to speak with her concerning a problem in which E6 had. E6 stated she needed to report some things in which she had seen in Stahl Cottage (on 2/25/14)."</p>	W9999			

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W9999	<p>Continued From page 43</p> <p>Page 2 of the facility investigation, E6 states on 2/26/14, "in regards to last night (2/25/14) around 4-5:30PM, E6 witnessed residents and staff in Activity room one. R1 was biting his arm. E4 said I'll go get some water to R1. R1 doesn't like water; if you usually offer him water he will run away. E4 smacked R1 in the face multiple times until he fell to the ground. E4 dragged him by the arm down to his room. E4 put R1 in (his) room and slammed the door. E4 came back to activity room. R1 came back to activity room and bit his arm. E4 told him to go back to his room. R6 was drinking from a water bottle, E4 told R6 to give R1 his water bottle. E4 took the bottle from R6 and poured it (water) on top of R1's head. E4 hit R1 in the head with the water bottle. E4 pushed(dragged) R1 down hallway on his back and put him back into his room. E4 told R3 to smack R4. R3 smacked R4. R4 grabbed his face in pain. E4 told R4 to smack R5. R4 smacked R5. E4 told R5 to smack R4 back and he did. E4 told R5 to hit R4 harder. R5 hit him (R4) again. E6 had a bag of chips, R2 heard E6 rustling chips, and came back from the other activity room E6 told R2 to sit down, R2 didn't go, so E4 smacked R2. R2 left to sit down on other side and didn't come back."</p> <p>Page 4 of the facility investigation states," Per staff interview with E10 (DSP), E10 states he heard a sound that sounded like a slap while others were clapping. E10 states he did witness the residents hitting each other. E4 was telling them to hit each other. All this happened on 2/25/14 on the 2-10(PM) shift."</p> <p>The facility investigation also states E10 did hear the threat of water. E10 states he did witness R1 dragged to his room by E4.</p>	W9999			

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W9999	<p>Continued From page 44</p> <p>Pages 4 and 5 of the facility investigation, state, "Per staff interview with E12(DSP), E12 states R1 is fearful of water. E12 also stated E4 had to redirect R1 physically to his room. E4 dragged R1 to his room by legs. E12 states he didn't report the incident because he saw no signs of abuse and the resident was having behaviors."</p> <p>Page 5 of the facility investigation states, "Per staff interview with E13, E13 states on 2/25/14, E6 reported she saw E4 hit R2. E13 also states R1 scared of water. E13 states, Will take not reporting as my blame."</p> <p>Pages 14-16 of facility investigation report state:</p> <p>"Analysis of Evidence: The committee found enough evidence to support mental abuse for using the threat of water against R1. Staff heard E4 threaten R1 with the use of water/water bottle. E4 states he knows R1 has a fear of water</p> <p>The committee found enough support for physical abuse. Resident and staff stated they witnessed E4 dragging R1 down the hall. R1 also had injuries to the right side of his body.</p> <p>The committee found enough evidence to support that E4 physically abused R1 by slapping him in the face. Staff reported they heard a slap which supports what was alleged.</p> <p>The committee found enough evidence to support the allegation of physical abuse for the allegation that E4 told residents to hit each other. Staff member E10 admits to hearing a slap and he heard the encouragement from E4 for the residents to hit each other.</p>	W9999			

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W9999	Continued From page 45 E10 admits to hearing the threat of water being used against R1, witnessed R1 being dragged (down the hallway), heard the encouragement of resident to resident by E4 and heard a slap (although denies seeing). E10 did not intervene or timely report what he had witnessed. E12 admits he saw E4 drag R1 to his room by his feet. Although E12 states he did not view this as abuse. E12 did not intervene with the action and did not report timely per his training or policy. E11 mentioned the water (unsolicited) but put a spin on offering the water as drink instead of a threat. E6, although trained in reporting went to another more senior staff that provided her with inaccurate information on reporting. E6 did report although not immediately. E6 breached the confidentiality of the investigation by discussing with other employees E13 failed to report immediately once provided information by E6 of a potential allegation. E13 admits to not placing the reports. E4 is terminated for physical abuse, mental abuse and not meeting reasonable standards of an employee. E10 was terminated for neglect as he failed to provide services to protect the residents even though he supports witnessing abuse. Additional discipline for failing to report abuse, interfering with the investigation, failure to meet reasonable standards and safety.	W9999			

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W9999	<p>Continued From page 46</p> <p>E12 was terminated for neglect, failure to report, interfering with the investigation, not meeting reasonable standards and safety. E12 admits that he saw E4 drag R1 down the hall.</p> <p>E11 was terminated for neglect, failure to report, interfering with the investigation, not meeting reasonable standards and safety.</p> <p>E13 disciplined for interfering with the investigation, not reporting in a timely manner, breach of confidentiality, safety and not meeting reasonable standards. E13 was transferred to a more and area and will not be allowed to work in Stahl in the immediate future.</p> <p>The committee recommended that the QIDP (Quality Intellectual Disability Professional) review the ISP (Individual Service Plan) and BMP (Behavior Plan) of R1 and R2 to ensure clearly defined behavioral approaches."</p> <p>Interview with E1 (Facility Assistant Executive Director) on 3/6/14 at 2:30PM, E1 confirmed the following:</p> <ul style="list-style-type: none"> >The incident of 2/25/14 was reported on 2/26/14. > E6 reported the allegation of physical and mental abuse late and violated facility policy. > Facility investigation resulted in the termination of E4, E10, E11, E12 & E13. > Staff members E4, E10, E11, E12 & E13 failed to ensure client safety and violated the current facility policy and procedure for abuse and neglect. 	W9999			

