Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008577	A. BUILDING: _____ B. WING _____	R 07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELTERED VILLAGE	600 BORDEN WOODSTOCK, IL 60098

(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
Z 000	COMMENTS FIRST FOLLOW UP TO ANNUAL SURVEY OF 11/1/18	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1060e) 350.1060j) 350.1210 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. j) Appropriate records shall be maintained for each resident functioning in these programs.	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 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. 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. (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. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on record review and interview, the facility neglected to develop and implement interventions to: a) Prevent 1 of 1 client (R1) from being physically aggressive to 4 clients in the sample (R2, R4, R7 and R8) and 10 clients outside the sample (R13, R14, R18, R19, R20, R21, R22, R23, R24 and	Z9999		

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R25) by either biting, pinching, pulling hair, hitting or scratching them;
b) Prevent 1 of 1 client (R2) from being physically aggressive to 3 clients in the sample (R1, R3 and R4) and 13 clients outside the sample (R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20 and Z1) by pulling their hair and punching them in the back; and
c) Ensure that 1 of 1 client in the sample (R3) was supervised while in the residential facility to address recurrent falls that required medical attention.

R2's behavioral reports from 2/27/19 to present date, were reviewed. R2 had the following behavioral incidents, targeting the following 15 clients who reside in the facility, and (Z1) one outside client who attends the same day training location as R2:

3/2/19 - R2 pulled R9's hair. Appeared agitated when he approached R9, and pulled her hair. Redness noted to R9's scalp.
3/6/19 - R2 pulled R1's hair.
3/16/19 - R2 punched R19 on his back as he walked by him for no reason.
3/20/19 - R2 grabbed and pulled on R18's hair. Red marks on head where hair was pulled.
3/21/19 - R2 started hitting a peer at facility owned day training location(Z1). Redness noted to Z1 's left hip.
3/23/19 - R2 struck R17 on her back.
3/25/19 - R2 pulled R10's hair. Redness was noted to the top of her scalp.
4/8/19 - R2 pulled R12's hair. R2 refused to let go of R12's hair, so staff used a CPI technique to disengage his hold on R12's hair.. R2 continued to try and grab and hit peers, so he was restrained to protect those around him. Redness

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noted to R12's scalp.
4/11/19 - R2 hit R11 on his back.
4/13/19 - R2 pulled R9's hair. Redness noted to the top of R9's scalp.
4/16/19 - R2 walked up to R19 and pulled his hair.
4/23/19 (6:00am) - Fire alarm sounded. Seemed to agitate R2, and he pulled R12's hair. Redness noted to R12's scalp.
4/23/19 (8:00am) - R2, unprovoked, pulled R9's hair. Redness noted to R9's scalp.
4/23/19 (8:06pm) - R2, unproved, punched R4 on the leg.
4/24/19 - R2, unprovoked, pulled R13's hair.
5/9/19 - R2 became aggressive, and attempted to aggress on staff and peers. No peers hit, but R2 needed to be restrained.
5/11/19 - R2 hit R20 on the head.(Client had recently had a craniotomy for a subdural hematoma). No injury noted.
5/22/19 - R2 pulled R9's hair. Redness noted to the top of R9's head.
6/3/19 - R2 pulled R10's hair. Redness noted to the top of R10's head.
6/4/19 (8:55am) - R2 grabbed and pulled R15's hair.
6/4/19 (10:00am) - R2 kicked R16 on the shin.
6/5/19 (9:30am) - R2 became anxious, and bit himself, and pulled R13's hair.
6/5/19 (3:20pm) - R2, unprovoked, kicked R15 on his buttocks. Redness noted to R15's buttocks.
6/11/19 - R2 pulled R10's hair. Redness noted to R10's scalp.
6/12/19 - R2, unprovoked, came up to R10 and pulled her hair.
6/15/19 - R2 attempted to pull R3's hair. Due to R3's hair being short, R2 ended up scratching R3's scalp.

R2's Behavior Program dated December 12,

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Z9999	Continued From page 4 2018, was reviewed. R2's program addresses the targeted behaviors of Conduct Disorder, which includes refusals, physical aggression and mimicking. For R2, this often manifests into self-injurious behaviors. Most of R2's self injurious behaviors occur when he is agitated. The proactive procedures for R2 are to give R2 positive reinforcement and staff attention if he is engaging in adaptive behavior. Verbal prompts should be given in a positive and friendly manner. If escalation is occurring, it is imperative that staff prompt R2 to engage in self-soothing coping strategies. R2 is able to cope with negative emotions by vacuuming, cleaning and helping. R2 experiences sensory relief when wearing sunglasses or a mask. During an interview with E2(Social Services Director) on 6/25/19 at 10:15am, E2 was asked if she is aware of the above behavioral incidents, which targeted 15 clients who reside in the facility, and (Z1) 1 client who attends their day training location, but resides out of their facility. E2 stated that she is aware. E2 was asked what interventions (if any) they put into place, after a pattern was emerging, with R2 pulling other clients's hair, punching their back, and kicking different areas on his fellow peers' bodies. E2 stated they discussed R2 in their status meeting on June 4th, because they noticed that there was an increase in R2's behaviors. E2 stated that they talked about several people during this meeting, so it was not a meeting set up just to discuss R2. E2 stated that they noticed that R2 can at times become aggressive if he witnesses another client having a behavior. E2 stated that they talked about in-servicing the staff on his Behavior program. E2 stated that they reviewed the Behavior program with the staff, and discussed that R2 likes to vacuum or wear his	Z9999		

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sunglasses when he is escalating. E2 stated that R2 also has a personal fan that he likes to hold, and all of these techniques are calming to him. E2 was asked if R2 is on increased supervision, as he has had many aggressive behaviors during the past four months. E2 stated that R2 is not on increased supervision. E2 was asked if any changes have been made to R2's Behavior program, as what they are doing currently is not effective, as verified by the 25 above aggressive behavioral incidents. E2 stated that they have not changed anything, but rather, just went over his current program with staff on June 4th. (R2 has had five more incidents of physical aggression since the June 4th meeting, and no additional meetings have been conducted to address this continuing pattern of peer targeting abuse).

The following incident reports involving R3 and his recent falls were reviewed:

4/18/19 (8:30pm) - R3 was in his closet in his wheelchair with staff. Staff looked away, and R3 got out of his wheel chair and fell on the floor. The staff statement elaborates, and states that R3 did not want to sit in his chair, so staff told him to walk, grabbing the chair. R3 went in his closet, and when staff checked on him, he was noted on the floor. Nursing assessed R3, and was noted to have a pink area on his buttocks.

4/23/19 (10:00pm) - R3 was found sitting on his buttocks, on the floor of his bathroom by direct care staff. R3 was assessed for injuries, but none were noted by nursing.

4/28/19 (11:15am) - R3 was found by staff on the floor in his bathroom R3 was assisted up by staff. R3 denies hitting his head.

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4/29/19 (8:25pm) - R3 was found sitting on the floor in his bedroom. No marks of bruising noted upon assessment. Attached to his incident, E2(Social Services Director) wrote a short paragraph which states that R3 has fallen 3 times over a 7 day period. Currently R3 is using a wheelchair due to complaints of pain in his knees. Z2 (Orthopaedic Physician) has reviewed physical therapy reports and x-rays, and believes that R3 is suffering from arthritis. All falls have occurred in his personal living quarters, and have not been witnessed. Previously, R3 had been walking with the assistance of a walker, and did not require assistance of staff. R3, when questioned, was unable to give specifics. R3's roommate has also not been able to provide statements regarding the three falls (the three falls are not mentioned in this report). Precautionary measures include using the wheelchair, shower chair, assistance to toilet every 2 hours, and a floor alarm as needed for safety are all in place.

5/12/19 (6:30am) - R3 found on buttocks in front of his bed. R3 was assisted to his feet with staff. Mild redness was noted to his buttocks. Regarding interventions, the incident states that staff are to use a wheelchair that has a seatbelt, and that R3 needs assist with transfers and toileting. It is unclear with this incident if R3 had a seatbelt, or if R3 had been toileted every 2 hours as dictated. There is no investigation regarding this incident.

5/19/19 (12:00pm) - R3 was found sitting on the floor in bedroom, along side of his bed, sitting on his buttocks. No injuries noted. The incident states that there is no indication or reason to believe that someone pushed or hit him. He was alone in his bedroom. Most of the other clients

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were at lunch. R3 already has a floor mat in his room, but it was under his bed at the time the incident occurred.(There is no investigation attached to this incident to address the floor mat not being in use. There is no indication that R3 had been resting in bed, or what R3 may have been doing in his bedroom prior to his fall).

5/20/19 (8:50pm) - R3 was found sitting on the floor in the hallway. An abrasion and small bruise was noted on his right thumb. An x-ray was completed on R3's right hand on 5/21/19 which indicates that R3 sustained a Chip Fracture to his right thumb, to which a splint was applied. An investigation was completed after this fall. E2(Social Services Director) was the staff member who authored this report. The report indicates that R3 (per review of their facility video surveillance camera) was witnessed coming out of his bedroom using his rolling walker, wearing only his brief. After a few minutes, R3 turns around with his walker, and re-enters his bedroom. Only a partial view of his walker can be seen, and then seconds later, R3 appears to lose his balance and falls backwards. During the fall, his right hand appears to be caught on his walker or doorframe. No other injuries were noted other than his right thumb. R3's roommate (R26) was interviewed on 5/21/19, and he stated that his roommate fell. R26 stated he fell in his room, and that R3 was wearing only his underwear. R26 stated that he could not help him because he was in his bed, R26 stated that he yelled for help for R3. R3, per E2's investigation, states that R3 is defined as 10% intelligible according to his speech assessment, making it difficult to provide answers. The investigation concludes, stating it is uncertain why R3 fell. The investigation notes that they are aware of R3's recent fall pattern over the past few weeks, and R3 has been using a wheel

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chair at most times, due to his complaints of pain contributed to his diagnosis of arthritis. R3, per this report, was evaluated by an ortho doctor on May 14th, and per this doctor, has been encouraged to use his walker for short distances to be up and moving. Staff are to continue to to monitor R3, and keep all precautionary measures in place to help ensure for his safety.

6/9/19 (4:55pm) - R3 was found on his stomach on the floor of his bedroom with his face down resting on his right hand. A bruise was noted to his left hand, but that could possibly be from a recent blood draw. The fall was unwitnessed. A staff statement indicates that R3's seatbelt had half of the belt dislocated from his chair, and was found on the floor.(There is no investigation present with this incident to determine what happened to R3's seatbelt).

6/17/19 (10:20pm) - R3 was found on the floor in his room face down with his face resting on his arms. No injuries noted.

During an interview with E2(Social Services Director) on 6/25/19 at 10:15am, E2 was asked what the mobility status is regarding R3; should R3 be using a walker or a wheel chair? E2 stated that R3 used to walk with a walker. R3 now has arthritis which is really causing him pain in his legs. R3 is being referred to a bone surgeon. E2 was asked if R3 has any special supervision checks. E2 stated that R3 is not in the watch group (which can either be every 5 minute checks or every 15 minute checks). E2 verified that R3 is not a 1 :1. E2 was asked if R3 uses or should use a gait belt. E2 stated that she thinks R3 doesn't use a gait belt. E2 was asked if R3 should have assistance when up. E2 stated that the majority of these falls occurred while in

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his bedroom. E2 was asked, on the incident of 4/18/19, when staff turned away, if that was acceptable. E2 stated that staff should not have turned away. When pointed out that the staff statement and the incident report give conflicting information, E2 stated that she was not aware that staff had encouraged R3 to push his wheel chair into his closet, and that is when and how he fell. E2 stated that staff should not have encouraged R3 to ambulate by pushing his wheelchair. Regarding the incident of 5/12, there is indication that it is questionable that R3 may not have had a seatbelt in his wheelchair. E2 stated she does not know if R3's wheel chair had a seatbelt, but she assumes he did, because most of their wheel chairs have seatbelts attached. For the incident of 5/19, there are questions regarding R3's floor mat; the floor mat was found under R3's bed, not next to it should he fall out of his bad, or get up without calling for staff assistance. E2 stated that the mat should have been next to R3's bed. E2 offered that for the fall that occurred on 5/20, E2 used the camera footage, and discovered that R3 was up in only a pull up brief. E2 stated during this fall, R3 fractured his right thumb, and also needed to wear an controlled ankle movement boot as he had foot swelling from his fall as well (This information regarding the boot and additional injury to his foot, (which foot is unclear), is not mentioned in the investigation report). E2 stated that R3 at first had a splint to his right hand, but later needed to be changed to a cast, so with both the cast and the boot, R3 should not be using a walker. E2 was asked if the walker has been removed from R3's room, as R3 still has the cast in place at this time. E2 stated that she is not sure, but will check. Regarding the incident of 6/9/19, E2 was asked if she is aware that R3's seatbelt failed, and one half of the seatbelt was

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found on the floor, instead of attached to the wheel chair. E2 stated that she is aware, but did not investigate to see how this occurred. E2 stated that she has no official clear picture of what happened with the seatbelt, and did not investigate, and put this in writing. E2 was asked if any special staffing's had been conducted after any of the 9 falls R3 had over a three month period. E3 stated that they just discussed R3 during their status meeting yesterday (6/24/19). E3 stated that they are getting R3 a special alarm for his bed, because they discovered that R3 was able to shut the alarm off on the floor mat. E2 also stated that they are getting a seatbelt that alarms when it is unbuckled. E3 confirmed that R3 is not on any special supervision, and not part of the watch group. E2 stated that R3 should only be up with assistance of staff. E2 confirmed that this was the first meeting they conducted regarding all of the falls R3 was experiencing.

R3's Physician Order Sheets dated 6/1/19 through 6/30/19 were reviewed. Under fall/safety, the order reads that R3 can use a wheelchair with a safety belt as needed (it does not indicate that R3 should use a special seatbelt that alarms when unbuckled),and may use a walker(it does not indicate that R3 should not use a walker, as he is still casted on his right hand).

REPEAT

Based on record review and interview, the facility failed to implement their neglect policy when the facility neglected to develop and implement interventions to:

a) Prevent 1 of 1 client (R1) from being physically aggressive to 4 clients in the sample (R2, R4, R7

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and R8) and 10 clients outside the sample (R13, R14, R18, R19, R20, R21, R22, R23, R24 and R25) by either biting, pinching, pulling hair, hitting or scratching them;
b) Prevent 1 of 1 client (R2) from being physically aggressive to 3 clients in the sample (R1, R3 and R4) and 13 clients outside the sample (R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20 and 21) by pulling their hair and punching them in the back; and
c) Ensure that 1 of 1 client in the sample (R3) was supervised while in the residential facility to address recurrent falls that required medical

Findings include:

The facility's Policy / Procedure Directive: Abuse/ Neglect dated 2/10/16 was reviewed. Under definitions it includes; "Neglect: 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 of possible injury, harm or death."

Behavior reports from 2/27/19 through 6/24/19 were reviewed. The reports showed that R1, who has Profound Intellectual Disability and physical aggression, was physically aggressive to her peers 35 times during this time period. R1's program record showed that she is currently on a behavior program dated 2/27/19. Problem behavior lists physical aggression which includes: hitting, biting punching and tripping. Reactive strategies includes: verbal redirection/praise, and for escalation of physical aggression, redirection

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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	Continued From page 12 to quiet area for counseling. The following behavior reports of R1 being aggressive to the following clients were reviewed further and showed that R1 bit R4 16 times, hit R23 5 times and hit R20 3 times for the period starting 2/27/19 through 6/24/19. R1 's physical aggression incidents against her peers are as follows: R4, who has Profound Intellectual Disability, had been aggressed by R1 on the following dates: 3/5/19 at 3:06pm in the hallway: R1 just grabbed R4's arm and bit it, R4 sustained a bite mark in the left forearm, 8 small punctures are noted 5/6/19 at 6:10pm in the living room: R1 bit R4, left hand redness noted. No broken skin. 5/11/19 at 7:10pm in the living room: R1 bit R4 on her left arm. Bite mark on the left arm. No areas of broken skin noted. 5/18/19 at 5:45pm in the living room: R1 bit R4 on forearm x 2. Two bite marks with indent of teeth, 3 open areas when teeth broke skin. Incident from two bites 5/25/19 at 8:09pm in the living room: R1 bit R4 on her right arm. Small red mark noted on R4's right arm, no skin perforation noted. 5/27/19 at 5:55pm in the living room: R4 came to R1 and gave her arm twice, so the second time R4 did it, R1 bit her on the wrist. Bite mark, bruise, redness noted on her left wrist. No skin perforation noted. 5/28/19 at 8:15pm in the living room: R1 bit R4 on her right arm. Bite mark indentation on right arm with 3 punctures with minimal bleeding and 4 small bruised areas. 5/30/19 at 8:06pm in the living room: R1 bit R4 on her left and right hand (wrist). Bite marks evident on her left and right hand/wrists. Left wrist:	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008577	A. BUILDING: _____ B. WING _____	R 07/03/2019

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Z9999	Continued From page 13	Z9999		

redness, bruises, superficial open skin without blood. Right wrist: redness noted
6/2/19 at 9:00am in the living room: R1 bit R4 on the right wrist.
6/2/19 at 5:32pm in the living room: R4 was sitting on chair in living room. R1 came to her. R4 lifted her arm. R1 bit R4 on her right wrist causing wound to bleed slightly.
6/3/19 at 4:00pm in the lobby: R1 bit R4 on both arms very hard. Very deep bite marks on left and right arms. Left arm skin perforation noted
6/4/19 at 12:00pm in the big group room: R4 approached R1. R1 bit R4. Bite mark, didn't draw blood
6/4/19 at 5:50am in the dining room: R4 seeked R1. R1 bit R4 x 3 in 30 mins. Bite marks to left forearm x 2, and right forearm x 1 no bleeding
6/5/19 at 4:12pm in the living room: R4 approached R1. R1 bit R4 on her arm. Teeth impressions, no open area, cleansed with iodine
6/10/19 at 2:20pm in the big group room: R4 walked up to R1. R1 bit R4 on right arm. Bite marks on right arm
6/17/19 at 7:54pm in the living room: R4 encouraged R1 to bite her arm. R1 refused to bite and walk away, but R4 followed her and offered her arms 3x before she was bitten by R1 . Deep dental indentation with small open skin noted, scant bleeding noted R23, who has Moderate Intellectual Disability, had been aggressed by R1 on the following dates:
5/8/19 at 3:40pm in the dining room: R1 hit R23 on the face, no injuries noted
5/9/19 at 8:45pm in the living room: R1 tried to sit on R23's lap. R1 then pinched R23 on left side of abdomen. No injuries noted
5/11/19 at 7:00am in the hallway: R1 slapped R23, no marks , no redness or bruising
5/20/19 at 8:00am in the living room: R1 was told not to throw living room decorations, R1

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Z9999	Continued From page 14	Z9999		

pulled R23's hair.
5/21/19 at 6:10am in the living room: R1 pinched R23 on left cheek.

R20, who has Profound Intellectual Disability, had been aggressed by R1 on the following dates:

3/1/19 at 7:05am in the living room: R20 was pinched by peer and yelled out of pain. Some redness noted on her left lower leg.
3/17/19 at 6:32am in the living room: R1attempted to sit on R20's lap. When R1 was told "No", R1 pulled R20's hair.
5/11/19 at 7:10am in the living room: R1 pulled R20's hair

The following clients were also aggressed by R1 on the following dates:
R2 (has Profound Intellectual Disability)

3/8/19 at 3:00pm in the bus: R1 scratched and hit R2. R2 sustained scratch on right middle finger, red marks on the right wrist and right neck, also right chest, left shoulder and left back

R7 (has Moderate Intellectual Disability)
3/22/19 at 8:35pm in the dining room:While sitting at breakfast, R1 became upset and kicked R7 on the left leg

R8 (has Mild Intellectual Disability)
4/12/19 at 7:20pm in the lobby: R8 in wheelchair when R1 walked by and pulled her hair

R13 (has Severe Intellectual Disability)
5/16/19 at 1 :55pm in the lounge at day training: R13 was standing by couch in lounge area. R1 was on couch, sat up and hit R13 on her chin.

R14 (has Severe Intellectual Disability)

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Z9999	Continued From page 15 5/11/19 at 7:00am in the hall: R1 slapped R14 on the side of head R18 (has Profound Intellectual Disability) 4/7/19 at 6:54am in the living room:R1 scratched R18 on her chest R19 (has Severe Intellectual Disablity) 3/15/19 at 12:45pm in the lounge room: R1 bit R19 on the left middle R21 (has Severe Intellectual Disablity) 3/5/19 at 3:12 pm in the living room: R1 bit R21 R22 (has Profound Intellectual Disability 4/26/19 at 9:35am in the lounge room: R1 bit R22 on his left upper forearm R24 (has Moderate Intellectual Disability) 5/28/19 at 8:00pm in the living room: R1 bit R24 on left forearm. Bite indentation on left arm, no open areas or redness R25 (has Mild Intellectual Disability) 3/17/18 at 6:30am in the living room: R1 pulled R25's hair Closer review of R1's behavioral incidents showed that R1 was physically aggressive 16 times towards R4, 5 times towards R23 and 3 times towards R20. Review of R1's program record showed that she is currently on a behavior program dated 2/27/19. Problem behavior lists physical aggression which includes: hitting, biting, punching and tripping. Reactive strategies includes: verbal redirection/praise, and for escalation of physical aggression, redirection to quiet area for counseling. E2, Director of Social Services, was interviewed	Z9999		

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Z9999	Continued From page 16 on 6/25/19 at 11 :07pm. E2 stated, "Both R1 and R4 are on group watch." E2 then added R4 is on 5 minutes check since 2/7/19 for elopement. The 5 minutes check is still on going for R4. R1 was on 5 minutes check due to being a new admit to the facility and has now been changed to 15 minutes check. Surveyor asked when R1 was changed to 15 minute checks. E2 wasn't sure when. Surveyor asked E2 if the facility has done any interventions to prevent R1 from biting R4 and being physically aggressive to other clients in the facility. E2 stated the facility had a status meeting for R1 and R4 where they discussed the incidents between R1 and R4. E2 read the status meeting report which includes; "An inservice will be held for the staff of the facility and the day training site on R1 and R4's current behavior programs and staff will be instructed to help R1 and R4 find alternative activities to participate in during their free time. Staff will be instructed to be aware of the 2 clients' proximity to each other and assist in preventing any incidents of physical aggression as able." Surveyor informed E2 that after the 6/4/19 status meeting, R1 bit R4 3 more times. E2 verified that the interventions the facility had in place failed to prevent R1 from biting R4. (B)	Z9999		