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Z 000	COMMENTS COMPLAINT INVESTIGATION SURVEY #1797633 IL00099206-W102, W104, W122, W125, W149 #1797542 IL00099106-W102, W104, W122, W125, W149	Z 000		
Z9999	FINDINGS STATEMENT OF LICENSURE VIOLATIONS: 350.620a) 350.1060e) 350.3240a)b)f) 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	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 available to administer these programs. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) 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 REQUIREMENTS WERE NOT MET AS EVIDENCE BY: Based on observation, record review and interview, it was determined that the Governing body failed to take action to identify and resolve a systematic problem of a reoccurring nature, also to ensure adequate client protections for 2 of 2 (R2 and R3) sampled residents and 12 of 12 (R4-R15) in the supplemental sampled residents. The facility failed to ensure that residents exercise their rights to not have consistent exposure to an environment of inapproprite verbal language, verbal threats of bodily harm, and	Z9999		

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exercise freedom of movement throughtout the house without restrictions. This failure impacted 2 of 2 sampleed residents (R2 and R3), and 12 of 12 supplemental sampled residents (R4 - R15) who were requireed to move to their rooms due to aggresive behvaior by another resident (R1). The facility also failed to ensure that residents were free from abuse and mistreatment when the facility failed to:

1) Failed to prevent reoccurring acts of both physical aggression and verbal aggression to 1 of 1 (R2) resident who was pulled to the ground and hit repeatedly in the face and additionally impacted 13 of 13 (R3-15) in the supplemental sample that were affected by verbal and physical aggression.

2) Failed to ensure residents were provided with sufficient safeguards to prevent injuries from physical aggression and affected by frequent episodes of verbal aggression from a peer living in the home.

3) Failed to have a procedure in place with directives to staff regarding management of residents who displayed frequent and serious acts of both physical and verbal aggression.

4) Failed to ensure individuals rights are not restricted to accommodate maladaptive behaviors displayed by a resident

1) Provide operating direction and oversight to ensure protection of resident rights.

2) Failed to develop and implement a system which in a timely manner identified and resolved acts of physical and verbal aggression to 2 of 2 (R2 and R3) sampled residents and 12 of 12 (R3-

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Z9999	Continued From page 3 R15) residents in supplemental sample who were required to go to their rooms at various times of the day to avoid both verbal and physical abuse by another resident (R1) who lives in the home. 1) Ensure that R2-R15 were protected from physical aggression, threats of physical aggression and verbal aggression by R1. 2) Ensure that all client's rights are not restricted as a result of maladaptive behaviors of a single resident. 1) Implement safeguards once resident to resident aggression resulting in injuries and consistent physical and verbal aggression to 1 of 1 (R2) sampled residents from R1 were identified. 2) Ensure residents were protected from continuous episodes of both physical and verbal aggression when 2 of 2 sampled residents (R2 and R3) and 12 of 12 supplemental sampled residents (R4-R15) received physical and verbal aggression from a peer living in the home (R1). Findings include: Facility Policy number 5.57, dated October, 2017 titled, "Physical Injury and Illness/Individual Medical Emergencies" states, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Facility Policy number 5.49, dated December 2015 titled, "Safety Committee" states, "The Safety Committee assists Administration by ensuring practices and policies regarding	Z9999		

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individual's safety meet regulatory standard and quality outcomes" #4. "The committee shall conduct any necessary interviews or inquiries to identify if patterns or trends exist." #7 "The committee will determine the cause of the injury and provide a list of considerations relevant to prevention of further incidents/accidents. This includes any issues that pose a safety risk to an individual, such as change of condition and unusual incidents (either resulting in observable injury or not resulting in observable injury). If the safety committee determines that the injury is a result of abuse or neglect, or of unknown origin, the safety committee will refer the matter on to the investigative committee."

Facility Policy number 5.29, dated December/2005 titled, "Quality Assurance Committee" states, "Quality Assurance review all incidents and accidents: including issues that pose a safety risk to an individual, such as change of condition and unusual incident (either resulting in observable injury or not resulting in observable injury.)" "Committee will implement a plan of correction when necessary to prevent future incidents or accidents."

Various observations were made of R1 on 1/17/18 from 8:30am to 10:00am. R1 is a tall female of large stature.

R1's Individual Service Program dated 5/18/17 states R1 is 21 years old with an Intelligence Quotient of 52, Mild level of intellectual function, and a Broad Independence score of 6 years and 9 months. R1 was admitted to the facility on 11/20/17. The Behavior Management Program dated August 2017 states R1 has several maladaptive behavior problems including verbal and physical aggression, putting hands on

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another person with malicious intent. The Behavior Management Program states, "3. If (R1) continues to be physically aggressive, staff will ask (R1) to remove herself from the room and go to a quiet room to calm down. If (R1) refuses to leave then staff will assist all other peers from the area to ensure safety."

The Medication Administration Record dated 11/21/17 documents R1 takes Ziprasidone 40 milligrams (mg) daily and Trileptal 300mg daily for Bipolar Disorder.

Behavior reports dated 11/27/17 to 1/31/18 for R1 indicate physical and verbal attacks from R1 impacting other residents living in the home. Incidents are as follows:

11/27/17 6:00pm "(R1) got upset rolled her eyes and called the cook a b---h this behavior continued until 6:32pm residents were present"

11/28/17 1:40pm, "(R1) yelling cursing at (R2), when staff (E3) was trying to get past R1, R1 attacked staff digging fingernails in E3's arm" "other residents were present" written by E7, House manager

11/28/17 6:40pm "(R1) is yelling and cursing at (R2)" Other residents were present" written by (E5), DSP

11/30/17 A document dated 11/30/17 addressed to Illinois Department of Public Health by (E6), previous Administrator, "On November 29, 2017, individual (R2) was involved in peer to peer altercation. Peer (R1) was displaying maladaptive behavior and struck (R2) causing scratches to face, neck and head area. Individuals were separated, (R2) was assessed per Direct Support

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Z9999	Continued From page 6 Person staff as well as taken to emergency department for further evaluation." The incident report dated 11/29/17 states, "an individual (R1) grabbed R2 by her shirt pulled her down to the ground and hit her in the face repeatedly." 12/7/17 (not timed) "false accusations, cussing, verbal aggression to others." 12/9/17 (not timed) "Profanity to staff and clients, redirected all day" 12/9/17 2:30pm "talking to mom on tablet, mom told (R1) to punch staff in the mouth." No other information documented on this report and there is no evidence presented to surveyor that a staff was actually punched in the mouth. 12/10/17 7:10am "yelling at client, telling client she was stupid and retarded and she threatened to punch her." 12/21/17 - (not timed) "(R1) was in her bedroom when she became very upset. (R1) started yelling, screaming and cursing at another individual for taking her body wash. Staff tried to calm (R1) down but she became highly upset and continued cursing and yelling until she was given more body wash. she then went to her room finally settling down." 12/28/17 6:10am, "false allegations made to another resident (R2) that she was in (R1)'s belongings." 12/31/17 6:30pm - 8:30pm," (R1)'s mom called threatening to kill all us b------s and was sending someone to hurt us" 12/31/17 6:55pm, "threats to staff and clients,	Z9999		

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Z9999	Continued From page 7 states she will punch staff in face." 12/31/17 7:15pm, "(R1)'s mom called states she is sending police over, making threats" 1/1/18 1:05pm, "(R1) on phone telling mom to get a gun and come over to (name of facility) and shoot the staff. Mom called states coming over to the home with a sledge hammer and knock staff f------g heads off." No additional information is documented on this report. No evidence presented to surveyor that (R1)'s mother came to the facility. 1/20/18 5:30pm, "(R1) was in the family room" "other residents are present" "(R1) was in the family room on her tablet trying to yell at staff to fix her g----m tablet or somebody was getting their a-- kicked" written by (E3), DSP 1/22/18 4:45am, "(R11) is yelling, hollering and cursing saying she doesn't want to live here, she got in my face and called me a liar and a black son of a b---h and is accusing other individuals of making fun of her and slamming their bedroom doors" "other residents are present" written by (E4), DSP 1/25/18 7:25am, "(R1) was at the table eating breakfast and she started to insult a resident (R8) telling her she is a dumb person and that she is retarded" "(R1) responded to staff that she can say whatever she wants." written by (E10), DSP 1/25/18 7:45am, "(R1) was in the living room" "(R1) was using the F--k word saying she want's to do it now" "(R1) continued to insult staff with bad words" "other residents were present." written by (E10), DSP	Z9999		

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1/26/18 7:00 am, "(R1) was in the living room" "She was screaming and yelling" "(R1) was back and forth insulting staff." "other residents were present" written by (E10), DSP.

1/30/18 7:55pm, "(R1) was asked to come and get ready for medicine after several times of me asking she jumped up out of her bed fully clothed and began cursing and hollering at me calling me b---h and h--s." "R1 had several other individuals scared and upset." written by (E4), DSP

1/31/17 5:45pm "(R1) became upset, yelling and cursing calling the surveyor b---h after she left." "that b---h asking questions" it was difficult to get her calm down." "other residents were present to hear." written by (E3), DSP.

Review of incident reports as follows:

12/21/17 at 9:00pm written by E3, DSP (Direct Support Person) "(R1) walked into the dining room and started cussing at (R2). Staff noticed (R1) grabbed (R2) to fight her, staff, (E3) tried to separate them then accidentally bumped (R1) in the face with elbow."
(R1) was physically removed from the home by police officers and taken to the hospital emergency department.

Review of the facility's safety committee meeting dated 11/29/17 include the incident that occurred on 11/29/17, " (R1) grabbed (R2) pulled her hair and began hitting her in her face" The safety committee recommendation were, "Staff will monitor and keep the individuals separated during activities."

Facility's safety committee meeting dated

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12/21/17 include the incident that occurred on 12/21/17 however; the statement is different from the above eyewitness account of the altercation. This meeting documents both (R1) and (R2) engaged in an altercation equally without an aggressor and the safety committee recommendations are: "consider the two individuals have had incidents of physical aggression towards each other." "staff will monitor and keep the individuals separated during activities."

The above safety committee recommendations does not give directives to staff on what policy and/or procedure to use in management of (R1)'s physical and verbal aggression. There is no evidence that the safety committee followed its policy to address (R1)'s physical and verbal aggression.

Facility's Quality Assurance Review dated 1/16/18 states, "Pattern/trend: yes: R1 has a history of physical aggression towards others both peers and staff. R1 is on a behavior plan for physical and verbal aggression" "Correction Actions: Special Support Team is involved with R1 and has assisted with behavior training for R1. Meeting with mom and guardian to discuss correction plan for appropriate language."

The facility presents documentation that SST first documented visit was 1/22/17. During an interview with E1 (Qualified Intellectual Disability Professional) and E2 (Administrator) on 1/31/18 at 12:00pm. E1 states the initial visit was on 1/17/18 but there is no documentation of that visit.

An interview was conducted with Z1, R1's guardian on 1/17/18 at 12:57pm. Z1 was asked if

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there was a team meeting or a facility plan regarding R1's verbal and physical assaults to residents in the home since R1's admission in November 2017. Z1 states "we are looking for other placement for her down in (name of town). R1 had a history of attacking residents and staff in her previous home. I don't think she will be happy unless she is with her mom. She was taken from her mom because of neglect about 3 or 4 years ago. Her mom is not fit to take care of her."

An interview was conducted with E4, DSP on 1/17/18 at 12:45pm. E4 states R1 is "very unpredictable and will focus on certain staff." E4 denied receiving any additional training or specific instructions of management of R1 when maladaptive behaviors occur. E4 states the only training she has had for dealing with aggressive clients is, "I forget the exact name of it" E4 stood to demonstrate to surveyor a body move that pivots her body in a reverse movement to protect herself from a physical attack.

An interview was conducted with E5, cook on 1/17/18 at 2:15pm, E5 stated that other residents are present when R1 exhibits episodes of aggression, profanity, yelling, screaming, threatening, and physical aggression.

A telephone interview was conducted with E3, Direct Support Person on 1/25/18 at 2:15pm. E3 states that she has worked at the facility for twenty years. E3 was asked what residents has she witnessed receiving verbal and/or physical aggression by R1. E3 states she was concerned about R16 (now expired) who stayed in the room with R1. "She gets real violent. She will go in anybody's face. She has hit R14, She has hit R2, She has cursed R3 out. She has cursed out R9,

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Z9999	Continued From page 11 She has also hit R9. The men pretty much stay in their rooms except for R10." An interview was conducted with R9 on 1/29/18 at 8:45am. It was noted that R9 utilizes a customized wheelchair for mobility. R9 states, "When I'm talking to R2, R1 will get mad and start cursing, R1 will say f--k you. She will pop off anytime and when she does there is no reasoning with her. We do have to come in our rooms so we don't get hurt. We have to go in our rooms a lot. R1 will get right in your face and you have to back down or she will hit you. I like to use the phone to call my family when I get home but R1 stays on the phone with her mom all the time and if you ask her can you use the phone she will yell f--k you. I can't use the phone because she is on it all the time. It seems there is nothing we can do about it." Surveyor asked R9 if he had reported this to staff and R9 states "yes and they will tell R1 to get off the phone but then she hangs up and dial her mom right back. She gets right back on the phone." An interview was conducted with R2 on 1/29/18 at 2:55pm. R2 was asked about R1 and states, "She mean. She hit me. Hit me in my face." An interview was conducted with E9, DSP on 1/29/18 at 9:45am. E9 states she has worked at the facility for 11 years. E9 was asked if she has ever witnessed verbal or physical abuse in the home. "R1 is verbally abusive to R2. R1 called R2 a black bald headed b---h. She is verbally abusive to R 3, R13 and R9 on a daily basis since she was admitted." "I keep the residents with me when she is having a behavior or encourage them to go in their rooms." "This has happened more than ten times. We have to hide the knives." E9 was asked if she has reported this to	Z9999		

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administration and E9 replied "yes" and states she has told E1 in the past.

An interview was conducted with Z4, clinical therapist on 1/29/18 at 1:30pm. Z4 confirms her agency received the referral on 1/4/18 and started seeing R1 last week on 1/22/18. Z4 states she started behavioral training with the staff today. This is two months after R1's physical aggression began.

An interview was conducted with E2, Administrator and E1, Qualified Intellectual Disability Professional, QIDP on 1/17/18 at 2:30pm at the residential facility, E1 and E2 was asked if the interdisciplinary team had met to discuss R1's placement at the facility. E1 states there was a telephone conversation with E11, Executive Director last week and yesterday. E1 had a discussion with E11 about a referral to the SST (Specialized Support Team) to see R1. E1 also confirmed that she was aware Z1, guardian was working on a transfer for R1. E1 was asked if the facility consulted R1's psychiatrist for consult regarding R1's violent behavior and to assess R1's psychotropic medications. E1 states the facility does not have a psychiatrist evaluation and an appointment was made for a psychiatrist but the psychiatrist did not take R1's insurance. E1 states R1's medical doctor ordered the refills on R1's psychotropic medications until the facility finds a psychiatrist. E1 states the facility is currently working on finding another psychiatrist. E1 and E2 were not able to show evidence of additional training given to staff in relation to R1's escalating behavior impacting the rights of all the residents in the home.

An interview was conducted with E2, Administrator and E1, QIDP on 1/31/18 at

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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
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9:30am. Surveyor asked why was Administrative staff such as the Administrator, Executive Director, QIDP were not notified when the facility's staff received the threats on 12/31/17 and 1/1/18 from R1's mom., coming to the facility with weapons and threats of harm. E1 and E2 were also asked why the police were not notified and if the facility currently have a reproducible system for incidents of this nature. E1 and E2 were not able to provide evidence of a reproducible system or evidence that an investigation was conducted to address if the threat were a present danger to residents at the time. E1 states she received notification of the threat a couple days later, "maybe two days". E2 states the facility met with the staff yesterday and informed the staff that in the future the police will be called and the staff is to notify Administrative staff immediately.

An interview was conducted with E1, QIDP on 2/1/18 at 10:15am, E1 was asked why was the information that R1 was removed from the home and taken to the hospital by police on 12/21/17 during the peer to peer incident not included in the incident report, safety committee meeting notes or R1's behavior report. E1 states the information was included in the Quality Assuarance Review dated 1/16/18 (more than 3 weeks later) E1 confirmed the significant information should have been included in all of the incident reports.

An interview was conducted with E2, Administrator and E1, Qualified Intellectual Disability Professional, (QIDP) on 1/17/18 at 2:30pm and again on 1/29/18 at 10:30am at the residential facility, E1 and E2 were asked if the interdisciplinary team had met to discuss R1's placement at the facility. E1 states there was a

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	IL6014732	A. BUILDING: _____ B. WING _____	C 02/08/2018

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telephone conversation with the E11, Executive Director last week and yesterday (1/16/18.) E1 states they had a discussion about a referral to the SST (Specialized Support Team) to see R1. E1 also confirmed that she was aware Z1, guardian was working on a transfer for R1. E1 was asked if the facility consulted R1's psychiatrist for consult regarding R1's violent behavior and to assess R1's psychotropic medications. E1 states the facility does not have a psychiatrist evaluation and an appointment was made for a psychiatrist but the psychiatrist did not take R1's insurance. E1 states the facility is currently working on finding another psychiatrist. E1 and E2 were not able to show evidence of additional training given to staff in the home who work directly with R1 in relation to R1's escalating behavior impacting all the residents in the home

An interview was conducted with Z1, guardian on 1/17/18 at 12:57pm. Z1 was asked if there was a team meeting or a facility plan regarding R1's verbal and physical assaults on residents in the home since R1's admission in November 2017. Z1 states "we are looking for other placement for her down in (name of town). R1 had a history of attacking residents and staff in her previous home." "I don't think she will be happy unless she is with her mom." "She was taken from her mom because of neglect about 3 or 4 years ago. Her mom is not fit to take care of her."

A telephone interview was conducted with E3, Direct Support Person (DSP) on 1/25/18 at 2:15pm. E3 states that she has worked at the facility for twenty years. E3 was asked what residents has she witnessed receiving verbal and/or physical aggression by R1. E3 states she believes it is R1's mother who encourages the maladaptive behavior by R1. E3 states she was

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concerned about R16 (now expired) who stayed in the room with R1. "She gets real violent. She will go in anybody's face. She has hit R14, she has hit R2, she has cursed R3 out, she has cursed out R9, she has also hit R9. The men pretty much stay in their rooms except for R10." E3 was asked about the residents in the home ability to use the telephone freely. E3 confirmed there are issues of restrictions regarding the telephone, "yes, she want to have the phone away from other residents. The other residents have family calling and not able to get through because R1 is on the phone. The other residents also can't always make calls when they want because R1 is on the phone. The other residents can't always make calls because R1 wont give them the phone. She targets R5. The other people are R13, R14, R3, R10 and R2."

An interview was conducted with E9, DSP on 1/29/18 at 9:45am. She states she has worked at the facility for 11 years. E9 was asked if she has ever witnessed verbal or physical abuse in the home. "R1 is verbally abusive to R2. R1 called R2 a black bald headed b---h. She is verbally abusive to R3, R13 and R9 on a daily basis since she was admitted. I keep the residents with me when she is having a behavior or encourage them to go in their rooms. This has happened more than ten times. We have to hide the knives." E9 was asked if she has reported this to administration and E9 replied "yes" and states she has told E1 in the past.

An interview was conducted with E1, QIDP on 2/1/18 at 10:15am, E1 was asked why was the information that R1 was removed from the home and taken to the hospital by police on 12/21/17 during the peer to peer incident not included in the incident report, safety committee meeting

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notes or R1's behavior report. E1 states the information was included in the Quality Assurance Review dated 1/16/18 (more than 3 weeks later) E1 confirmed the significant information should have been included in all of the incident reports.

The Medication Administration Record dated 11/21/17 documents R1 takes Ziprasidone 40 milligrams(mg) daily and Trileptal 300mg daily for Bipolar Disorder.

Review of behavior reports for R1 from 11/27/17 to 1/31/18 indicate physical and verbal attacks from R1 impacting other residents living in the home. Incidents are as follows:

11/27/17 6:00pm "(R1) got upset rolled her eyes and called the cook a b---h""this behavior continued until 6:32pm" "residents were present"
11/28/17 1:40pm, "(R1) yelling cursing at (R2), when staff (E3) was trying to get past R1, R1 attacked staff digging fingernails in E3's arm" "other residents were present" written by E7, House manager
11/28/17 6:40pm "(R1) is yelling and cursing at (R2)" Other residents were present" written by (E5), DSP
11/30/17 A document dated 11/30/17 addressed to Illinois Department of Public Health by (E6), previous Administrator, "On November 29, 2017, individual (R2) was involved in peer to peer altercation. Peer (R1) was displaying maladaptive behavior and struck (R2) causing scratches to face, neck and head area. Individuals were separated, (R2) was assessed per Direct Support Person staff as well as taken to emergency department for further evaluation." The incident report dated 11/29/17 states, "an individual (R1) grabbed R2 by her shirt pulled her down to the

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Z9999	Continued From page 17 ground and hit her in the face repeatedly." An interview was conducted with E1, Qualified Intellectual Disability Professional, (QIDP) on 1/17/18 at 2:30pm, E1 was asked if the interdisciplinary team had met to discuss R1's placement at the facility. E1 states there was a telephone conversation with E11, (Executive Director) last week and yesterday E1 had a discussion about a referral to the SST (Specialized Support Team) to see R1. E1 also confirmed that she was aware Z1, (guardian) was working on a transfer for R1. E1 was asked if the facility consulted R1's psychiatrist for consult regarding R1's violent behavior and to assess R1's psychotropic medications. E1 states the facility does not have a psychiatrist evaluation and an appointment was made for a psychiatrist but the psychiatrist did not take R1's insurance. E1 states the facility is currently working on finding another psychiatrist. (B)	Z9999		