

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2022
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NAME OF PROVIDER OR SUPPLIER BRAUNS TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1115 EAST WASHINGTON STREET GREENVILLE, IL 62246
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Z 000	<p>COMMENTS</p> <p>Complaint Investigation 2245097/IL148518 Facility Reported Incident of 5/25/22 IL148679</p>	Z 000		
Z9999	<p>FINDINGS</p> <p>Statement of Licensure Violations:</p> <p>350.620 a) 350.1230d)1) 350.1230d)2) 350.1230d)3) 350.3210o) 350.3220f) 350.3240c) 350.3240f)</p> <p>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.</p> <p>Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness.</p>	Z9999	<p>Attachment A Statement of Licensure Violations</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Z9999	<p>Continued From page 1</p> <p>Section 350.3210 General o) The facility shall immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.</p> <p>Section 350.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or registered nurse staff within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 350.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 of the Act shall immediately report the matter by telephone and in writing to the resident's representative, and to the Department. (Section 3-610(a) 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)</p> <p>These requirements are not met as evidenced by:</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>A. Based on observation, record review and interview, the governing body failed to ensure:</p> <p>Implementation of their Abuse Policy affecting 2 of 2 individuals involved in a peer-to-peer altercation (R1 and R2) and the potential to affect the other 12 individuals residing in the facility (R3-R14) when they failed to:</p> <ul style="list-style-type: none"> " Notify local law enforcement of a peer-to-peer incident, which resulted in R1 and R2 suffering serious injuries, " Investigate a peer-to-peer incident which resulted in R1 and R2 suffering serious injury, " Notify R1's family of a peer-to-peer incident which resulted in R1 and R2 suffering serious injury, " Separate R1 and R2 to prevent additional injuries and implement measures to protect the other 12 individuals residing in the facility (R3-R14), and " Immediately report the peer-to-peer incident which resulted in serious injury to R1 and R2 to the Administrator, Executive Director or the CEO (Chief Executive Officer) and <p>Implementation of their Nursing Services and Physical Injury and Illness/Individual Medical Emergency Policy affecting 2 of 2 individuals involved in a peer-to-peer altercation (R1 and R2) which resulted in serious injuries, when they failed to:</p> <ul style="list-style-type: none"> " Seek immediate medical attention (R1 and R2), " Notify physician of human bites with open area (R2), and " Ensure physician orders were followed (R1). 	Z9999		

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Z9999	<p>Continued From page 3</p> <p>B. Based on record review and interview, the facility failed to notify individual's family promptly for 1 of 3 individuals in the sample (R1) who was involved in a peer-to-peer incident which resulted in serious injury.</p> <p>C. Based on record review and interview, the facility failed to ensure allegations of abuse for 2 of 3 individuals in the sample (R1 and R2) were reported immediately to the Illinois Department of Public Health within 2 hours (per policy).</p> <p>D. Based on interview and record review, the facility failed to have evidence of a thorough investigation for 2 of 2 individuals (R1 and R2) involved in a peer-to-peer altercation which resulted in serious injuries.</p> <p>E. Based on record review and interview, the facility failed to take measures to protect 14 of 14 (R1-R14) individuals residing in the facility following an altercation between R1 and R2 which resulted in serious injury.</p> <p>F. Based on record review, observation and interview the facility failed to ensure interventions and safeguards were implemented to manage the behavior of 1 of 1 individual (R2) to prevent peer to peer abuse of 2 individuals (R1 and R4) and the potential to affect the other 11 individuals residing in the facility (R3, R5-R14).</p> <p>G. Based on record review, observation and interview the facility failed to develop a behavior program which addresses physical aggression for 1 of 1 individual (R2) who has had physical aggression towards peers affecting 2 individuals (R1 and R4) and the potential to affect the other 11 individuals residing in the facility (R3, R5-R14).</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>Findings include:</p> <p>Abuse Policy 5.24 titled Investigative Committee Revised 4/19 documents, "Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish. Procedure: Any home employee or agent who witnesses or suspects a violation of individual rights, peer-to-peer incidents, reasonable suspicion of a crime, abuse, or neglect as well as injuries of unknown source shall immediately report the matter to home management using the following protocol: 2. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: Administrator, Executive Director, Chief Executive Officer (CEO). 3. If the allegation is one of the following situations, the Administrator or designee will contact law enforcement by calling 911 or the local emergency number: When there is reasonable suspicion that a crime has been committed-Within 2 hours if the events that cause a reasonable suspicion result in serious bodily injury to an individual. C. The home administrator shall report the matter within 2 hours if the event that caused reasonable suspicion resulted in bodily injury to an individual ...and send a written report within five (5) working days to the individual's representative and the Illinois Department of Public Health. D. The administrator shall call a meeting of the Investigative Committee. The Administrator will designate a chair and the committee members. E. The committee members shall meet to review the allegations, conduct interviews and examine the information available that is pertinent to the incident. J. If the allegation is that another individual committed an act of abuse, appropriate</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>action will be taken to safeguard the other individuals."</p> <p>Resident Roster provided on 7/5/22 documents 14 individuals residing in the facility. R2, R3 and R8 function at the Mild Level of Intellectual Disability, R1, R4, R5, R6, R9, R10, R11, R12 and R13 function at the Moderate Level of Intellectual Disability, R14 functions at the Severe Level of Intellectual Disability and R7 functions at the Profound Level of Intellectual Disability.</p> <p>ISP/Individual Support Plan dated 4/1/21 and undated Individual Profile identify R1 as a 59 year old male with diagnoses including Bipolar Disorder, Anxiety and Renal Disease who functions at the Moderate Level of Intellectual Disability. R1's Individual Profile also documents R1 is his own guardian and closest relatives are Z4 (Stepmother) and Z5 (Mother).</p> <p>ISP/Individual Support Plan dated 9/30/21 identifies R2 as a 20 year old male with diagnoses including Conduct disorder and history of ADHD/Attention-deficit/hyperactivity disorder who functions at the Mild Level of Intellectual Disability.</p> <p>R2's Behavior Program dated 10/21/21 documents, "(R2's) maladaptive behaviors consist of inappropriate social behaviors (touching and standing too close), arguing, manipulating staff, bullying and non-compliance.)</p> <p>Peer to Peer incident dated 6/13/22 documents, "Last evening (R2) hit (R4) on the back of the head with an open hand."</p> <p>R1's Progress Notes dated June 16, 2022, at</p>	Z9999		

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Z9999	<p>Continued From page 6</p> <p>5:30 PM documents, "(R1) and (R2) started fighting with each other. (R1) bit (R2) twice on his left arm. (R2) was hitting (R1) and knocked him (R1) down then continued to kick him (R1) repeatedly with his (R2) steel toed boots. (R2) said (R1) was bossing and yelling at him. (R2) finally calmed down and apologized to (R1) for fighting with him. Both boys made up with each other." The report documents, "Body part affected: Top of head-cut, feet were turning purple."</p> <p>R2's Progress Notes dated June 16, 2022, at 5:30 PM documents, (R2) and (R1) started fighting with each other. (R2) was hitting and kicking (R1) with his steel toe boots. Staff had a hard time breaking them up but finally got them to stop. (R2) bite marks on his left arm. Bites 3 inches in diameter. Treat abrasions and bites cleaned wounds." R2's Progress Note also documents E3/QIDP (Qualified Intellectual Disability Professional) was notified at 7:05 PM and E1/Administrator was notified at 7:30 PM.</p> <p>R1's Nursing Note dated June 2022 documents, "(R1) and another individual had a confrontation resulting in injuries to both individuals. (R1) is noted to have an abrasion to top of his head midsection measuring 2.0 cm/centimeters L (long) x 0.5 cm W (wide). Reported to this nurse that the other individual punched him in the back of the neck and it kind of hurts. No redness or swelling noted. ROM (Range of Motion) to neck and head wnl (within normal limits). He (R1) states that he has an ache to the left abdominal quad. No redness or swelling. States it hurts but not when nurse palpated area. Left pinkie toe has bruising and redness around it. He (R1) states he can't move it or bend it. States it hurts when he walks on it. Pedal pulses present</p>	Z9999		

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Z9999	<p>Continued From page 9</p> <p>On 7/5/22 at 1:04 PM, E1/Administrator was asked to define serious injury. E1 responded, "One that required medical intervention." E1 was asked if the police had been notified of the incident on 6/16/22 between R1 and R2 which resulted in serious injury. E1 stated, "No. Well not by anyone from facility." E1 was asked when police should be notified. E1 responded, "When someone is at risk for harm."</p> <p>On 7/6/22 at 9:03 AM, Z4 stated, "Took (R1) to the police station on 6/18/22 to file a police report."</p> <p>On 7/6/22 at 9:30 AM, Z5 stated, "(R1) told me the incident between him (R1) and (R2) happened on Thursday night. (6/16/22). (R2) kicked him (R1) with steel toe boots, took him (R1) to police station on Saturday (6/18/22) to file a police report."</p> <p>On 7/5/22 at 11:45 AM, E3/RNT (Registered Nurse Trainer) stated she came to facility on 6/16/22 about 20 minutes after the altercation between R1 and R2. E3 stated, "(I) looked at (R1's) foot -complained little toe was hurting, bruising. Also, abrasion on top of head, scratches or rug burn don side of face. Saw doctor the next day and found out toe was fractured. (R2) was bit by (R1) two times on left arm. 1 bite was partial, the other was full mouth with three open areas. Small amount of bleeding." E3 was asked if she notified R2's physician due to the human bite with open areas E3 responded, "I don't recall."</p> <p>On 7/6/22 at 9:10 AM, E4/DSP (Direct Support Person) stated, "I did not see the incident start. (I) was in the med room. They (R1 and R2) were in the activity room when I heard the commotion,</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>and they came around into dining room, so I stepped out to see what was going on."</p> <p>On 7/6/22 at 9:55 AM, E1/Administrator was asked if there was an investigation into the altercation on June 16, 2022, involving R1 and R2. E1 responded, "No. It was my understanding the incident was witnessed."</p> <p>The facility was unable to provide evidence the incident between R1 and R2 which resulted in serious injuries to both individuals had been thoroughly investigated.</p> <p>On 7/5/22 at 2:10 PM, E5/QIDP confirmed on 6/12/22 R2 hit another peer on the back of his head and confirmed on 6/16/22 R2 was involved in an altercation with (R1) and kicked him repeatedly with steel toed boots. E5 was asked if R2's ISP and Behavior Intervention Plan addressed physical aggression. E5 confirmed it did not. E5 also confirmed there had been no changes to R2's Behavior Intervention Plan to address physical aggression. E5/QIDP (Qualified Intellectual Disability Professional) was asked if R1's family had been notified of R1's injuries. (R2's) family was not contacted for 2 days." E5 confirmed R1's family should have been contacted and stated, "In this situation, it was a miscommunication and family was never notified."</p> <p>On 7/6/22 at 9:03 AM, Z4 (R1's Stepmother) stated, "I first became aware of (R1's) injuries when Z5 called me after picking (R1) up for a visit and noticed the scratches on his(R1's) face and found out about fracture and (R1) being kicked with steel toe boots."</p> <p>On 7/6/22 at 9:10 AM, E4/Clerk and DSP(Direct</p>	Z9999		

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Z9999	<p>Continued From page 11</p> <p>Support Person) was asked when she notified Administrator of the incident which occurred between R1 and R2. E4 stated, "I was passing meds when it happened then we had to finish supper and cleaning up, so it was around 7:30 PM."</p> <p>On 7/6/22 at 9:30 AM, Z5 (R1's Mother) was asked how she became aware of R1's injuries. Z5 responded, "Happened on Thursday, picked him (R1) up on Saturday and saw injury to face. (R1) told me he bit (R2) to get him to stop. Z5 was asked about R1's injuries. Z5 stated, "Top of head-scratch, dried blood, left ankle bruised, left elbow bruised, left foot broken toe, bruised bad and face-left side scratched.:" Z5 stated no one from facility had contacted her or her husband. Z5 also stated, "(R1) is his own guardian but usually call me and Z4. This time no one called to tell us, and this was bad."</p> <p>On 7/5/22 at 2:10 PM, E5/QIDP(Qualified Intellectual Disability Professional) was asked what interventions had been implemented to separate R1 and R2 and to keep other individuals safe following the altercation between R1 and R2, which resulted in serious injuries. E5 responded, "No changes to Behavior Plans, yet. BMC (Behavior Management Committee) is not until July 14."</p> <p>On 7/6/22 at 9:55 AM, E1/Administrator confirmed the facility had implemented no interventions to separate R1 and R2 and/or to protect the other individuals residing in the home. E1 stated, "Felt it was an isolated incident."</p> <p>On 7/5/22 at 12:45 PM, E2/Assistant Administrator was asked to define abuse. E2 responded, "When somebody intentionally hurts</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2022
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NAME OF PROVIDER OR SUPPLIER BRAUNS TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1115 EAST WASHINGTON STREET GREENVILLE, IL 62246
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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 12</p> <p>someone-kicking hitting, pushing." E2 was asked to define immediately. E2 responded, "Once incident is calm."</p> <p>On 7/5/22 at 1:04 PM, E1/Administrator was asked to define immediately as it relates to abuse/neglect reporting. E1 responded, "As soon as situation is resolved and (it is) safe to call." E1 was asked to define serious injury. E1 responded, "One that required medical intervention."</p> <p>On 7/6/22 at 9:10 AM, E4/Clerk and DSP(Direct Support Person) was asked when she notified Administrator of the incident which occurred between R1 and R2 on 6/16/22. E4 stated, "I was passing meds when it happened then we had to finish supper and cleaning up, so it was around 7:30 PM."</p> <p>Policy 7.02 titled Nursing Services Revised 3/19 documents, "Policy: The home shall provide nursing services necessary to meet individuals' needs and to comply with licensing standards."</p> <p>Policy 5.57 titled Physical Injury and Illness/Individual Medical Emergencies Revised 5/19 documents, "Policy: Individuals served by the agency shall receive timely and effective medical services for physical injuries and illness and medical emergencies. Procedure: In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following: 2. The QIDP(Qualified Intellectual Disability Professional) shall notify the guardian and/or relative designated by the individual of the situation as soon as possible. 3. In case of abuse, neglect or injury of unknown origin the staff who witness or first became aware of the</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2022
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NAME OF PROVIDER OR SUPPLIER BRAUNS TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1115 EAST WASHINGTON STREET GREENVILLE, IL 62246
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Z9999	<p>Continued From page 13</p> <p>Incident shall report the incident according to Policy 5.24. The Administrator shall conduct any necessary interviews, inquiries or procedures according to Policy 5.24 and 5.29. 4. The QIDP/Administrator shall conduct any necessary interviews or inquiries to establish the probable cause of the injury and document the finding on the (Progress Note). 8B/ Submit a written narrative summary of each serious accident or incident occurrence to IDPH(Illinois Department of Public Health) within 5 days.</p> <p>On 7/5/22 at 11:45 AM, E3/RNT (Registered Nurse Trainer) stated, "I arrived about 20 minutes after the altercation between (R1) and (R2). By the time I got here, (R1's) left foot was bruising and (R1) was complaining of the little toe hurting. I cleaned up the scratches to his face and assessed him." E3 was asked if R1 was taken to emergency room for treatment. E3 responded, "No. (R1) was seen the next day for follow up to an abscess, thought he could be looked at then." E3 was asked if R1 should have been seen the night of the injury. E3 responded, "Probably." E3 stated, "(R2) was bit by (R1) two times on left arm. 1 bite was partial, the other was full mouth with three open areas. Small amount of bleeding." E3 was asked if R2 had been seen by his physician. E3 responded, "No." E3 was asked if R2 should have been seen by physician due to the open bite wounds. E3 responded, "Probably."</p> <p>On 7/5/22 at 11:45 AM, E3/RNT confirmed R1 had bitten R2 two times on the left arm. E3 stated the one bite had three open area with a small amount of bleeding. E3 was asked if she notified R2's physician due to the human bite with open areas E3 responded, "I don't recall."</p>	Z9999		

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Z9999	<p>Continued From page 14</p> <p>On 7/5/22 at 3:07 PM, Z3 (R2's Father) was contacted by phone and asked if the facility had notified R2's physician about the human bites. Z3 responded, "No one has contacted this office." Z3 was asked what the protocol would be for human bites causing break in skin. Z3 responded, "Physician should have been called. An appointment would be made for patient to be seen in order the doctor could assess for the need for treatment including antibiotics." Z3 was asked if human bites could cause infections. Z3 responded, "Most definitely."</p> <p>R1's MAR, Medication Administration Record for June 2022 documents, "Buddy Tape 4th and 5th toes due to fractures." There are no initials documenting R1's toes were buddy tape on June 19, 20, 22, 23, 28, 29 and 30, 2022." R1's MAR for the month of July does not document the order to buddy tape the 4th and 5th toes.</p> <p>On 7/5/22 at 12:10 PM, E6/DSP (Direct Support Person) was asked if he had been taping R1's 4th and 5th toes together. E6 stated, "No."</p> <p>On 7/5/22 at 4:00 PM, R1 was asked if staff had been taping his toes together (buddy taping). R1 responded, "They did for a couple of days but not usually."</p> <p>(A)</p>	Z9999		