STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014732	A. BUILDING: _____ B. WING _____	C 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLAND TERRACE	15175 STATE STREET SOUTH HOLLAND, IL 60473

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Z9999	FINDINGS STATEMENT OF LICENSURE VIOLATIONS: 350.620a) 350.1010e) 350.1060a) 350.1210 350.3240a) 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 350.1010 Service Programs The facility shall provide, either directly or through arrangements with an outside resource, as needed by the individual resident, all resident living services, training and guidance necessary in the activities of daily living and in the development of self-help skills for maximum independence. These services shall consist of at a minimum the following: e) Training and Habilitation Services Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. Section 350.1210 Health Services	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 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. These regulations are not met as evidenced by: Based on record review and interview, the facility failed to implement their policy of taking immediate corrective actions necessary to assure individuals' safety when they failed to remove a staff person from direct contact with individuals once an allegation of abuse was identified to have occurred to R4 and prevent further abuse from occurring when they continued to send two individuals (R1 and R3) to the day training site where the accused was still working.) R4 was removed from riding the day training van and kept home from day training for four working days while R1 and R3 continued to ride the van and attend day training after an allegation of abuse was alleged. This affected three of three individuals (R1, R3 and R4) in the sample who ride the day training van and attend day training. Findings include: Record review of the facility's policy 5.24 titled "Investigative Committee" dated 12/15 states: "The Investigative Committee shall be responsible for the following: A. To identify, review and determine if alleged violations of any individuals rights, including abuse and neglect have occurred. B. To investigate allegations in a professional and impartial manner. C. To protect individuals from further harm."	Z9999		

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Z9999	Continued From page 2	Z9999		

"Procedure" section states: "If the allegation is that an employee committed an act of abuse or neglect, the employee shall be suspended from duty until such time as the 1) Investigation is complete and, 2) The Administrator considers the report and takes administrative action."

According to the "Final Investigation Summary" dated 01/13/16 for R4, R4 is an individual whose level of functioning is in the moderate range. R4 receives medication for anxiety and agitation, however she does not require medication for hallucinations and is considered "Good with names; remembering things. The maladaptive behaviors of concern are as follows: Yelling, stealing snacks, lying about stealing snacks, elopement and self abusive behavior (biting her arm, scratching arm, banging head, kicking and slapping her face and or loudly clapping her hands)."

Review of facility's "Initial Investigation Report" dated 01/07/16 states that on 01/06/16, R4 returned home from day training and Direct Support Persons' (DSP)'s E4, E5 and E6 noticed "a bruise" underneath R4's left eye. R4 reported at that time that Z1 hit her in the eye. "In response to the allegation, immediate directive was given to keep R4 home from day training until the matter could be thoroughly investigated." However; through interview with E1 (Administrator) on 01/19/16 at 12:00pm in the dining room area of the facility, surveyor was informed that R1 and R3 continued to ride the van and attend day training but "should have been held back to safeguard them, but at the time, I was only thinking about R4's safety since she made the allegation."

Review of facility's "Final Investigation Summary"

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Z9999	Continued From page 3	Z9999		

dated 01/13/16 states as follows:

On 01/06/16; R4 returned home from day training with "A bruise" observed under her left eye by home staff. Home Administrator, Guardian and Nurse were notified and the day training site was attempted to be notified but were closed for the day. R4 was taken to the Emergency room for treatment the same night of 01/06/16. E1 began conducting interviews with (DSP)'s E4, E5 and E6 who were present in the home upon R4's return.

On 01/07/16, E1 contacted Z2 (Day Training Director) via telephone and informed her that an allegation had been alleged by R4 against Z1 on 01/06/16. E1 conducted interviews with E3; Nurse, E4 (2nd interview), E5 (2nd interview), Z1 and DT DSPs (Z4, Z5, Z6, Z7).

On 01/08/16, E1 interviewed E7 and E8 (DSP)'s and R1, R3 and R4.

On 01/11/16, R1 and R4 were interviewed a second time and their story remained consistently the same while interviewed independently of each other that Z1 " punched R4 in the eye." R1 also alleged at this time that Z1 had " threatened him at the time of the incident on 01/06/16 that if he told anyone, he too, would get the same thing."

On 01/12/16, E1 notified Z2 of the new information obtained on 01/11/16 from R1 and discussed her findings from the above interviews.

Conclusionary findings from the facility dated 01/12/16 are as follows:
1) Z1 will be suspended while the day training site conducts their own internal investigation as of 01/12/16.
2) Z2 stated that based on the findings from their

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Z9999	Continued From page 4	Z9999		

investigation, a determination will be made regarding their next course of action.
3) R4 will return to day training upon suspension of Z1.

Followup conclusionary report from the facility dated 01/13/16 "finds the matter of alleged physical abuse Substantiated."

Record review of the day training attendance sheet for R4 titled " Month: JANUARY 2016, NAME: (R4)" states that R4 was absent from day training on 01/07/16, 01/08/16, 01/11/16 and 01/12/16.

During an interview held with E1(Administrator) on 01/19/16 at 12:00pm in the dining room, E1 confirmed that R4 was held back from riding the van and did not attend day training for four days while R1 and R3 continued to ride the van and attend day training after an allegation of abuse was alleged.

Record review of the day training document titled "Vehicle Route Assigned" without a date states: "Turtle Top- (Z5./Z1.(aide) (as of 1/7/16 no longer aide, as of 1/12/16 (Z8) will be the aide)". Document does not state that Z1 is also a direct support person in the classroom. Review of a facility email dated 01/07/16 at 8:48am from Z2; Day Training Director to Z9; Vice President/Supervisor states that the day training site was notified of an allegation of physical abuse made by R4 from E1 and informed that E1 would be conducting interviews. Further conversation through email dated 01/07/16 at 9:29am from Z2 to Z9 states " (Facility) resident did accuse a staff member at (Day training)." Documents described above did not state what the status of Z1 would be once the allegation of

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Z9999	Continued From page 5 physical abuse was alleged and the facility did not inquire. An interview was held on 01/19/16 at 12:00pm in the dining room area of the home with E1. E1 stated that she notified Z2 on 01/07/16 of the allegation of physical abuse alleged against Z1 but was not told the status of Z4 in relation to working, other than Z1 "no longer being an aide on the van, and I didn't know where she was working at that point." The facility did not have knowledge of the actual working location of Z1 An interview was held with E1 on 01/19/16 at 12:00pm in the dining room area of the home. E1 stated "I did not think that I could suspend the program staff and we were just starting the investigation process, I did not know where Z1 was working." The facility failed to verify and ensure that Z1 did not continue working directly with individuals across all settings. Facility failed to take immediate corrective action necessary to assure individuals' safety and to prevent further abuse from occurring when the incident occurred on 01/06/16. Z1 was not suspended until 01/12/16 and not terminated from all duties until 01/16/16. R1 and R3 continued to attend day training where Z1 was working in the classroom from 01/07/16 until 01/11/16, thus resulting in a 6 day delay in providing safety. (B)	Z9999		