

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001853</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/15/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CLEARBROOK CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3201 WEST CAMPBELL STREET ROLLING MEADOWS, IL 60008</b>
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Z9999	<p><b>FINDINGS</b></p> <p>Statement of Licensure Violations:</p> <p>350.620a) 350.1210b) 350.1230b)6)7) 350.1230d)1)2) 350.3240a)b)</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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.</p> <p>Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.</p>	Z9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure violations</b></p>	
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Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/01/16

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Z9999	<p>Continued From page 1</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <ol style="list-style-type: none"> <li>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.</li> <li>2) Basic skills required to meet the health needs and problems of the residents.</li> </ol> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>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.</p> <p>These Regulations are not met as evidenced by: Based on record review and interview, the facility failed to ensure clients were free from abuse and neglect for 1 of 1 client in the sample who was allegedly left in the bathroom for an hour and fifteen minutes, and when discovered, was found covered in feces(R1), and for 1 of 1 client who was allegedly kicked on the right lower leg when he attempted to take a staff's beverage(R2). The facility:</p> <ul style="list-style-type: none"> <li>* Failed to ensure clients were free from abuse and neglect; R1, per review of video camera footage, was left in the bathroom from approximately 9:30am through 10:45am on 9/26/16, and was covered in bowel movement when discovered, and R2 was witnessed being kicked on the right lower leg by a direct care staff;</li> <li>* Failed to ensure the allegation of neglect involving R1 on 9/26/16, was reported immediately to the Administrator; and while investigating this allegation, discovered a second</li> </ul>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>allegation of R1 being held hostage in the bathroom on 9/12/16, was also reported late;</p> <ul style="list-style-type: none"> <li>* Failed to ensure the allegation of witnessed physical abuse inflicted on R2 was immediately reported to the Administrator;</li> <li>* Failed to ensure the allegation of neglect against R1 was thoroughly investigated;</li> <li>* Failed to ensure nursing assessed R2's bruise that appeared three days after the alleged abuse occurred;</li> <li>* Failed to ensure the governing body provided the necessary oversight to ensure sufficient staff was present to provide the necessary care to successfully care for R1 while she attended her day program;</li> <li>* Failed to ensure final investigations were completed within five working days for Public Health review, when R2 was allegedly kicked in the right lower leg by a direct care staff.</li> </ul> <p>The facility policy entitled, "Client Treatment Policy", with a revision date of 8/16 was reviewed. It reads, but is not limited to, "Under no circumstances shall any abuse or neglect of a client be tolerated...Any persons witnessing, hearing about or observing evidence of abuse or neglect of a client must report it immediately to the Administrator or Administrator's designee....Any report of abuse, neglect or exploitation of a client shall be communicated to the Administrator of the Administrator's designee for immediate and thorough investigation and proper action.</p>	Z9999		
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Z9999	<p>Continued From page 3</p> <p>Abuse is defined as : Any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility.</p> <p>Neglect is defined as : A failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition.</p> <p>1. R1, per review of her Individual Support Plan dated 8/7/16, was admitted 7/26/16. R1, under level of supervision required, is noted to be blind, and requires assistance while ambulating. R1 is unable to complete her ADL's (activities of daily living) and requires full assistance. Under special provisions, R1 for safety, needs to be monitored at all times while ambulating, and while using the bathroom.</p> <p>During an interview with R1's Qualified Intellectual Disability Professional, QIDP), E15, on 10/28/16 at 11:15pm, E15 was asked what R1's bowel and bladder protocol should be. E15 explained that staff should toilet R1 every hour. E15 stated that R1 can be left alone for a few minutes, but should be checked on frequently as she is blind, and cannot wipe by herself appropriately. E15 stated that staff should be recording the results of this program as completed. E15 stated that the data has been scare, because they have been short staffed at the day program. E15 was asked about the roll call policy. E15 stated that staff should document every 15 minutes on every client while in the day program. E15 stated she thinks this is an unwritten policy, but rather their practice.</p> <p>The Summary of Incident regarding R1, for an allegation of potential neglect on 9/26/16 was reviewed. The summary states that it was</p>	Z9999		
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Z9999	<p>Continued From page 4</p> <p>reported on 10/7/16, that R1 was left in the bathroom for an extended period of time at the facility Day Program. The staff member making the late report and the staff member assigned to R1 on 9/26/16 have been placed on administrative leave pending the investigation. E3(Quality Assurance Facilitator) is the staff member who authored this investigation. The report continues, stating that an OJT(On the job training) packet completed by E5(Client Services Manager) noted an entry where E5 needed to describe a prevention strategy she used. E5 authored the following,</p> <p>"...I discovered that a client had been isolated from a group because of her disrobing issue. Someone thought it would be best to keep this client in the bathroom for an indefinite amount of time. I was notified and came to find why no one bothered to check on the client when she had been missing for over an hour. I found the client undressed and covered from head to toe in feces. I immediately addressed this and delegated responsibility as I helped to clean her and the area. A DSP(Direct Care Staff) messaged me to let me know that she had not seen the client in some time and that she didn't want to tell on anyone to get them in trouble, but she thinks that another DSP was holding that client hostage in the bathroom and would not check on her. She explained that she was in the middle of feeding and asked me to check it out."</p> <p>During an interview with E2(Director of Nursing) on 10/27/16 upon entering this investigation at 9:10am, E2 stated that E5 was completing an OJT packet, and had just finished it, and turned it into her boss(E4, DT Program Director). E2 stated that E5 should have reported this allegation when this occurred, instead of writing it in her OJT packet. E2 explained that she has</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>been through Abuse and Neglect Training, and should realize something like this needs to be reported. E2 stated that R1 was left in the bathroom by a staff member. R1 is blind and has the behavior of stripping. E2 stated that R1 was found in the bathroom and she had stool on her. E2 stated that they have suspended the staff person who was accused of leaving her in the bathroom(E8). E2 stated that she doesn't think it is typical for R1 to smear feces. E3 stated that R1 has both eyes removed, and constantly rubs her eyes. E3 stated that R1 can feel her way to the bathroom, but that she would never get up by herself once finished, and needs assist with personal hygiene after using the bathroom. E3 stated that this DT site is one large room, and probably was not a good fit for R1.</p> <p>During an interview with E1(Administrator) on 10/27/16 at 9:30am, E1 was also asked about the allegation of potential neglect with R1 by E8. E1 stated that E8 was not assigned to R1. E1 stated that they have pulled R1 out of that program, because it was too large of a setting for her, and she needs a smaller setting. E1 stated that responsibility falls on the DT Program and Management, and not on E8. E1 stated that E8 was not assigned to R1. E1 was asked if E8 took R1 to the bathroom. E1 confirmed she was the staff member who brought her into the bathroom. E1 stated that they looked at the video camera footage, and multiple staff members went to check on her while she was in the bathroom. E1 stated that I can refer to the entire investigation for all of the details.</p> <p>Further review of the facility investigation indicates that E3 interviewed E5 on 10/13/16. E3 confirmed that this reference in her OJT packet was referring to the incident involving R1 on</p>	Z9999		
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Z9999	<p>Continued From page 6</p> <p>9/26/16. E5 explained in her interview that E10(Direct Care Staff) did not come to work that day, so she explained to all of the remaining staff working that morning that the clients who normally are assigned to E10's group, did not have their assigned staff, so they needed to pitch in, and complete the extra work. E5 stated that she received a text from E9(Direct Care Staff) at 10:57am that same day, which stated, " I do not know who put R1 in the bathroom and left her there." E5 stated that she started to walk towards the DT room, and at this time E9 sent her another text which read, "She(R1) is in her poop and no one is cleaning it." E5 continued, stating she asked three staff who were working,(E8,E9,E11) where R1 was. No one responded, so E5 then entered the bathroom and observed R1 sitting on the toilet covered in bowel movement. When E5 asked what happened, E8 responded that it was not a big deal, and went into the bathroom to assist her. E5 stated that she did not think this was neglectful because R1 has a tendency to have bowel accidents, and because E8 then said she would shower R1. E5 stated as she was completing her OJT packet, she was processing the incident, and felt that staff members were being lazy, but she didn't feel like it was neglect. E5 stated she gave the packet to E4(DT Program Director), and also called her on the phone that day, saying that R1 was found in the bathroom with bowel movement on her, and that staff were being lazy. E5 stated that E4 did not have any questions after their call.</p> <p>During an interview that E3 had with E4 on 10/14/16, E3 asked E4 if she received a phone call from E5 regarding R1 on 9/26/16, and E4 gave a written response stating during E5's performance evaluation on 9/29/16, E5 reported to E4 that she cleaned up R1 after an accident in</p>	Z9999		
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Z9999	<p>Continued From page 7</p> <p>the restroom on 9/26/16, but did not describe the severity of the situation as she did in the OJT packet that she had read on 10/7/16, before she contacted OIG. This was the extent of his interview with E4.</p> <p>During an interview E3 had with E8 on 10/12/16, E8 confirmed that she worked at the day program on 9/26/16, but stated that she was not assigned to R1. E8 stated that staff took turns taking R1 to the bathroom that day, and could not remember who took R1 to the bathroom initially on 9/26/16. E8 could not recall how long R1 was in the bathroom that day, but stated that other staff members were aware that R1 was in the bathroom.</p> <p>During an interview with E9 via the telephone by the Quality Assurance Facilitator of DT(E12) on 10/13/16, E9 stated that she was the staff person who brought R1 over to the facility based Day Program on 9/26/16. E9 stated that she could not remember who was assigned to care for R1 while at DT. E9 stated that she then went ahead with all of her job duties, including leaving the program area at approximately 10:30am to get the food trays. When she returned shortly back to the program, she witnessed all of the staff complaining of a bad scent. E9 searched for the source of the smell, and at approximately 11:00am, found R1 in the program bathroom sitting on the toilet with feces all over her feet, floor and bathroom walls. E9 asked all of the DT staff who put R1 in the bathroom, and no one responded. E9 stated she stepped out of the program area to obtain cleaning supplies, and texted E5, asking her to come to the area immediately. E9 stated that E5 took over from there. E9 was asked to clarify if she texted a message to E5, stating that a staff is "holding a</p>	Z9999		
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Z9999	<p>Continued From page 8</p> <p>client hostage". E9 stated that she was referring to an incident that happened on 9/12/16. The facility investigation states a new investigation was started regarding this allegation. E9 stated that she was not sure what R1's bathroom protocol is. E9 stated that checking in on a client who is in the bathroom should be done frequently, and an attempt should be made to have a conversation with that client, to see how they are doing.</p> <p>E3, during his investigation, verified that E10 was the assigned staff member to R1 on 9/26/16, but was absent that day. E3 also reviewed the video footage from the DT program area on 9/26/16. The following information was provided:(Video review was not available from 9/12/16, due to the server deleting video past a month old.</p> <ul style="list-style-type: none"> <li>* 9:29:32am-E8 brings R1 into the bathroom.</li> <li>* 9:32:57am-E5 checks to see if someone is there</li> <li>* 9:33:32am-E11 opens the bathroom door</li> <li>* 9:39am-E13(Direct Care Staff) opens the bathroom door</li> <li>* 9:58:13am-E11 opens the bathroom door</li> <li>* 10:44:43am-E5 and E8 check on R1 in the bathroom</li> <li>* 10:49:49am-E8 brings R1 out of the bathroom and they leave the area together.</li> </ul> <p>E11(Direct Care Staff) provided the following statement on 10/7/16, stating that she was not assigned to R1. E11 stated that she does recall seeing R1 in the bathroom when she checked to see if someone else was in the bathroom, because she needed to bring other clients in. E11 stated that she did not see anything that seemed wrong, but did not know how long R1 had been in the bathroom.</p>	Z9999		

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Z9999	<p>Continued From page 9</p> <p>E13 provided the following statement on 10/7/16, confirming that he did work on 9/26/16 in the facility based DT program, but was not assigned to care for R1. E13 explained that he is not allowed to work with the female clients. E13 did state that he did go into the bathroom that day, but came quickly out when he saw that a female client was in the bathroom(R1). E13 stated that he had no idea how long R1 had been in the bathroom, but that there are staff assigned to her.</p> <p>During E8's interview with E3, E8 stated that she did not know who took R1 to the bathroom, but the video footage indicates that E8 brought R1 in at 9:29:32am. E3's investigation did not indicate that this discrepancy existed. During an interview with E3 and this writer on 10/27/16 at 11:30am, E3 was asked if he realized what E8 stated about her not knowing who took R1 initially into the bathroom that day, was not in alignment with what the video footage revealed. E3 stated that he did not realize that. He said he asked E8 who brought R1 into the bathroom, and she stated she could not remember. E3 stated that he did have the video footage information, but did not further question E8 about the conflicting information. E3 was asked why his investigation conclusion did not consider this finding with R1 to be negligent. E3 stated that since E8 was not officially assigned to R1, they as a facility felt it was not negligent on E8's part. E3 was asked if he thinks its ok for a client to be left in the bathroom for an hour and fifteen minutes, and when discovered, was noted to be covered in feces. E3 stated that it is not ok to be left for that long, but felt staff did check on her periodically. E3 was asked if the staff that were in the video opening the bathroom door were going in to specifically check on R1, and if they asked her if she was ready to come off of the toilet. E3 stated he was not sure. E3 stated that</p>	Z9999		
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Z9999	<p>Continued From page 10</p> <p>of course if someone does not show up for work, the remaining staff are all responsible for the the clients who do not have an assigned staff person. E3 stated that he is not going to deny that what E5 did was wrong, and that she should have re-assigned all of the clients affected in R1's group. E3 confirmed that his report does not indicate that this incident was neglectful, and it also does not say that staff have been re-trained on our abuse and neglect policy. E3 stated that they thought re-training of roll call, and its changes to this procedure was sufficient. E3 was also asked about the second allegation raised about R1 being held hostage in the bathroom on 9/12/16. E3 stated that this allegation was later recanted by E9. E9 denied she ever sent a text stating R1 was being held hostage. E3 stated they reviewed both E9's and E5's phone, and neither phone had this text message. E3 stated that the issues that were discovered with this second allegation were roll call issues, and late reporting, both of which are being addressed with the incident of 9/26/16.</p> <p>During an interview with E4 on 10/27/16 at approximately 11:35am, E4 confirmed that she is E5's boss. E4 stated that she is not aware what R1's bathroom protocol is. E4 stated that R1 will stay in the bathroom until someone comes to take her out. E4 confirmed that R1 was left in the bathroom from 9:30am until about 10:45am. E4 stated that when E5 was made aware that E10 was absent, and one group was without an assigned staff, E4 should have reassigned those clients to the remaining staff working that day. R1 was part of that unassigned group. E4 stated that E5 told the staff that they needed to watch the unassigned clients, but she should have known to re-assign them. E4 stated that is what she would do if they had a staff member call in, or</p>	Z9999		

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NAME OF PROVIDER OR SUPPLIER  <b>CLEARBROOK CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3201 WEST CAMPBELL STREET ROLLING MEADOWS, IL 60008</b>
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Z9999	<p>Continued From page 11</p> <p>not report for work. E4 stated that she should also stay in the DT room, and assist in caring for the clients. E4 also stated that this is something she would do, if the same situation happened in the future. E4 stated that E5 also should have reported it, not wrote it down in her OJT packet for her to discover many days later. E4 stated that she was reviewing the OJT packet with E5, and read the paragraph she wrote regarding R1. E4 stated that she immediately reported it, once she was aware. E4 stated that both E5 and E8 were both put on leave. Then they reviewed the video, and discovered that R1 was left in the bathroom for over an hour and fifteen minutes. E4 stated that E8 did put R1 in the bathroom that morning. E4 stated that E5 should have known better, and immediately reported it, and took corrective action. E4 stated that E5 is still in her 90 day probation period, and they are in the process of terminating her.</p> <p>During an interview with both E1(Administrator) and E7(Vice President) on 10/27/16 at 12:00pm, E1 stated that they really feel like this was a lack of Administrative action, and that is why they took the following action against E5, and not E8. E1 stated that E8 took R1 to the bathroom, and cleaned her up after her accident. E1 was asked if a staff member places a client into the bathroom, whether they are assigned to them or not, is it not the facility expectation to have the staff member ensure someone is watching to see when R1 is finished, or at least let other people know someone is in the bathroom. E1 stated that other staff where aware, because they were checking on R1, which the video demonstrated. This writer informed E1 that their statements indicated they were going into the bathroom not to check on R1, but rather, to see if the bathroom was empty, so they could toilet someone in their</p>	Z9999		
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Z9999	<p>Continued From page 12</p> <p>own group. E1 stated that she would have to refer to the investigation. E1 stated that they took R1 out of the program, because they think it was too stimulating for her. E1 was asked if there is any specific policy for direction when a staff person calls in. E1 stated they do not have a specific policy. E1 stated that this was clearly a negligent act that falls on the manager, but not on the direct care staff. E1 stated that E4 is working on changing their program for roll call. Currently they are signing a check off sheet every 15 minutes, indicating all clients have been observed and accounted for. E1 stated that whoever is sitting close to the roll call board fills it out for all of the clients. E1 stated that E4 will be changing that and informing all the staff on how the roll call should be completed. E1 also stated that they noticed that data for R1's bowel program also has about two weeks of missing data, so E4 will be correcting that as well.</p> <p>Observations were conducted on 10/28/16, beginning at 1:00pm in the facility based day program site.</p> <p>E13 was observed working in this program. E13 was asked if he can show this writer their process for roll call, and if it has changed since R1 had been left in the bathroom. E13 stated that nothing has changed, it's still exactly the same. E13 stated that whoever is closest to the table where the sheets of all of the individuals are on, that person checks it off. E13 stated we are supposed to check on all of the individuals every 15 minutes. E13 stated that he really doesn't go around and check to see that each person is in the room, he just knows that they are. E13 stated that he doesn't go and check the two bathrooms, to see if anyone is in there either. E13 was asked how their staffing is today. E13 stated that they are very short today, but they are short just about</p>	Z9999		
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NAME OF PROVIDER OR SUPPLIER  <b>CLEARBROOK CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3201 WEST CAMPBELL STREET</b> <b>ROLLING MEADOWS, IL 60008</b>		
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Z9999	Continued From page 13  every day. E13 stated that today they have two staff members who work in the facility, working in their day program to help out. E13 was asked if E4 reassigned the clients who did not have a staff member assigned to them because of the staff shortage. E13 stated that did not happen, nor did it ever happen. E13 stated they just try their best, and take care of all of the clients as a team. E13 asked if E4 came down to work with them, since they were short staffed. E13 stated that she did not. E13 was asked, if on the morning of 9/26/16, E5 came down and stated that they were short by one staff, and that those affected clients need to be watched very closely. E13 stated that conversation never happened. E13 was asked if she was aware that R1 was left in the bathroom for over one hour and fifteen minutes. E13 stated the morning R1 was left in the bathroom, he did go into the bathroom, and open the door. E13 stated that he only opened the door because he needed to toilet one of his male clients. E13 explained that he cannot care for R1, because he can only care for the male clients. E13 stated that he was not aware that R1 was left alone in the bathroom for that long of a period, nor did anyone tell him she was in the bathroom, and they needed to listen for her, or help her out when she was finished. E13 was also asked if he carries out the program goals. E13 stated that he does run the goals, but to be honest, he has a hard time documenting the data. E13 stated that they used to have lap tops, but now they are not here, and have been told they should place the data on paper sheets, but he just does not have time. E13 stated all he really has time for is toileting the clients and feeding them, because they are usually short staffed, just like they were on 9/26/16, and like they are today. E13 stated that they just had a few staff people resign in the last few weeks, including E11, and he is not sure	Z9999		

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Z9999	<p>Continued From page 14</p> <p>about E8, but he has not seen her in a long while either.</p> <p>During an interview with E10 on 10/28/16 at 1:20pm, E10 confirmed that they are short staffed today. E10 also confirmed that most days they are short staffed, and everybody has everybody. E10 confirmed that she had not imported data for goals for over two weeks, because the laptops are missing.</p> <p>During an interview with E1 on 10/28/16 at 1:45pm, E1 was made aware of the above day training observation. E1 was informed that the roll call process has not changed, they are short staffed, and no clients have been re-assigned as E4 stated is the process, E4 is not present in DT, assisting with patient care as she also indicated is her practice, and staff has informed this writer that goals are still not being recorded because of lack of laptops and/or paper to record them on. E1 stated that E4 has recently given her letter of resignation. E1 stated that they are short staff frequently, and that she gave two staff of her own over to the day program this morning to cover some of the vacancies. E1 stated that she is not sure why E4 is not here assisting as their practice should be. E4 stated she is at their other day program location. E1 stated she would call E14(Director of Day Services), and have her come over to discuss this observation.</p> <p>During an interview with E14 on 10/28/16 at 2:30pm, E14 stated that she will ensure their roll call practice is changed, and also ensure that clients will be re-assigned as they should be if a staff member calls in for work. E14 stated that they do have paper documentation for the staff to document on, and she will also ensure this requirement occurs going forward. E14</p>	Z9999		
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Z9999	<p>Continued From page 15</p> <p>confirmed that E4 is leaving, as she has recently handed in her letter of resignation. E14 stated that E4 should have taken over a group, since they are short staffed.</p> <p>During an interview with E1 on 11/4/16 at 10:30am, E1 stated that after the observation at DT on 10/28/16, she met with E14. E1 stated that she identified that what occurred on 10/28/16 was a negligent practice, and didn't send her clients to day programing that following Monday, until she knew all corrective measures were in place. E1 stated that she made their assignment sheets, she wrote their policy, and did the staff training, as it still had not been implemented. E1 stated that she had to step in with the supervision of that program, because she felt if she had sent them(all the clients) on Monday, it would have been an immediate jeopardy. E1 stated that they demoted E4 to a direct care staff, until her final day of work.</p> <p>2. The Summary of Incident Report involving R2 for the incident of 10/10/16, was reviewed. This investigation alleged that E16(Direct Care Staff) kicked R2 on the right lower leg while at the facility day program. R2 was assessed by nursing after the alleged incident, and no injuries were noted. E16 was placed on Administrative leave pending the investigation. On 10/13/16, R2 presented with an injury to his right lower leg.</p> <p>The written statement authored by E17(Client Services Manager at DT site 2) states that on 10/10/16, he received a text from direct care staff member, (E18) around 5:30pm. In his text E18 stated that he needed to report something that happened that day right before the bus route. E18 stated that he saw E16 kick R2 because R2 was running in the kitchen to get a pop. After</p>	Z9999		

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Z9999	<p>Continued From page 16</p> <p>receiving the text, E17 called and spoke with E18 about what he saw. E18 explained that at around 2:15pm, E16, along with E18 and E19 proceeded to stop R2 from getting pop in the kitchen. OIG was called shortly after that.</p> <p>During an interview that E3(Quality Assurance Facilitator) had with E17 on 10/19/16, that a different staff member had been assigned to R2 on 10/10/16, but she herself did not witness the alleged incident because she was in the front of the building at the time. E17 did not know what interventions were used to direct R2 out of the kitchen at the time of the incident, and was informed of the incident from E18. E17 stated that R2 does not specifically go into the kitchen but will go places that he knows there is a pop.</p> <p>During a statement provided by E18 on 10/11/16, E18 stated that on 10/10/16, as R2 was coming out of the kitchen, he saw E16 in the kitchen, and kick R2 as he was walking out of the kitchen. When E18 confronted E16, and asked him why he just kicked R2, E16 stated that he didn't kick him, but his foot ran into him instead, but that if he did kick him, he didn't kick him hard. Then he asked him if he was going to rat on him. E18 stated that he told E16 he would not rat on certain things but something like this he would. E18 then asked R2 if he was ok, and R2 said that he was. E18 stated that he did not notice any bruising on his leg at that time. E18 stated after the incident he was afraid to report it, because he was very nervous. After about one hour after work, he texted E17, and told her that he needed to report something that happened at work.</p> <p>During an interview with E16, between E3 and E16 on 10/19/16, E16 denied that he kicked R2.</p>	Z9999		
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Z9999	<p>Continued From page 17</p> <p>Per the investigation, R2's leg was assessed by nursing on 10/10/16 and by E20(Physician) on 10/11/16, and no injuries were found. On 10/13/16, staff noticed an injury to R2's right leg. E21, direct care staff, saw the bruising between 6:45am-7:00am. She reported the bruise to be approximately 2 inches tall and 1 inch wide and it looked like additional bruising was beginning to form under the bruise she noted. E21 stated that she told E22, Licensed Practical Nurse. During an interview between E3 and E22, E22 told E3 that he was informed of the bruise to R2's right lower leg during the morning of 10/13/16. E22 confirmed that he did not view the bruise to R2's right lower leg, since he was aware E20 had examined R2's lower leg on 10/11/16.</p> <p>R2 was observed at this day training location on 10/28/16 at 10:00am. R2 was sitting calmly at a table, engaged in programming.</p> <p>During an interview with E18 on 10/28/16 at 10:20am, E18 was asked by this writer if he could explain what he observed on 10/10/16. E18 stated that R2 is not in his group, but when he saw R2 up, and sneaking around the kitchen, he got up and went after R2 when he ran into the kitchen for pop. E19(Direct care staff) was already in the kitchen, and E16 ran in and beat him into the kitchen. R2 opened the refrigerator, and as R2 was running out, E16 was running in. E18 said that he saw E16 kick R2, and when he asked him why he kicked him, E16 stated he didn't, but if he did, he didn't intentionally kick him. E18 stated this happened just as the clients were getting ready to go. E18 stated he knew he needed to report it, but didn't report it until around 5:30pm, when it occurred around 2:15 pm. E18 stated he just got nervous.</p>	Z9999		

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Z9999	<p>Continued From page 18</p> <p>The conclusion of the investigation states that based on the information gathered, the allegation of physical abuse against E16 is substantiated. The investigation also indicates that the incident was reported late, and that the nurse did not check the bruise when it was first discovered.</p> <p>During an interview with E3 on 10/27/16 at 11:30am, E3 confirmed all of the above and also stated that in addition the the above findings, he is late is completing his investigation. E3 stated that his report did not get completed in the five day requirement. E3 stated that the allegation was reported on 10/10/16, but he did not finalize his investigation, and report it to Public Health until 10/20/16.</p> <p>(B)</p>	Z9999		