Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011969	A. BUILDING: ______ B. WING ______	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLE LANE TERRACE	1641 CAROLE LANE SAUK VILLAGE, IL 60411

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Z 000	COMMENTS ANNUAL CERTIFICATION - FOCUSED FUNDAMENTAL SURVEY, EXTENDED TO FULL CERTIFICATION SURVEY INSPECTION OF CARE	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1060e) 350.1060j) 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 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observations, record review, and interview, the facility failed to implement their written policy to protect residents from abuse and neglect when they failed to prevent R1 from hitting his peer (R2) with a metal object, hitting R2 and R5 multiple times, biting R5, and breaking the glass out to obtain the fire extinguisher and throwing glass at R2 through R13. This failure affected 2 of 3 (R2 and R3) residents in the sample and 10 (R4-6 and R7- R13) outside the sample. As a result, R2 required hospitalization. Diagnoses of nondisplaced left sixth costal cartilage rib fracture, head injury of intraparenchymal hemorrhage of left parietal lobe of brain. (Accumulation of blood on left side of brain) Findings include:	Z9999		

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1. R1's Facility's incident reports, behavior reports, behavior management reports, behavior Incident data, Individual Habilitation Plan and R2's hospital records document the following:

Incident report dated 6/28/21 at 3:05am written by Z2, Direct Support Person (DSP) states, R1 was outside pacing, and I was with him. R1 grabbed a metal stick and walked into the house. R2 was sleeping on the couch. At first, R1 walked by him (R2) then R1 darted back and hit R2 with the stick. R1 was sent to emergency room (ER) for forehead bleeding.

6/28/21 - Emergency Medical Service note dated 6/28/21 at 3:13am: R2, a 31-year-old male, battery victim was assaulted. R2 was sleeping on the couch when another resident of the group home (R1) began hitting R2 over the head, with a piece of window trimming.

6/28/21 - Local hospital emergency department notes written by Z5, Physician regarding R2: The Computerized Axial Tomography (CAT) scan is being read as hyper-density right lobe and is most suggestive of a cavernous venous malformation however given the history of trauma, hemorrhage should be considered. We plan to transfer the patient to a higher level of care.

6/28/21 to 6/29/21 - Hospital records of R2 from Hospital B where R2 was transferred for a higher level of care: Z11, Medical Doctor (MD) documents R2 diagnosis as nondisplaced left sixth costal cartilage rib fracture. Shoulder pain status post assault with injury to head. Small intraparenchymal hemorrhage of left parietal lobe of brain.
Z11, Medical Doctor states, R2 was admitted to the floor for every 4 hours neurological checks.

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Neurosurgery and Neurology Intensive Care Unit were consulted given the concern for intra-cranio-pressure. Physical and Occupational therapy cleared R2 for discharge back to his group home.
Z11, MD orders discharge instructions for R2 as follows:
a. "repeat head CAT in 1 month.
b. Complete Keppra for Seizure prophylaxis for one week
c. Continue with incentive spirometry use and deep breathing exercises.
d. Look out for symptoms of fever, persistent above 100.4, headache, weakness, numbness, severe uncontrolled pain, uncontrolled bleeding, persistent nausea and/or vomiting. If any of these symptoms call 911.

2. The following information is documentation regarding R1's behavior:

3/4/22 - IDPH (Illinois Department of Public Health) letter dated 3/4/22 written by E1, Administrator states, "R1 became extremely agitated" "unable to be directed emergency services called, R1 to ER."

3/3/22 - IDPH letter dated 3/3/22 written by E1, Administrator. R1 returned from his psychiatrist appointment and became extremely agitated. He was unable to be directed and emergency services was called. R1 was taken to ER.

2/20/22 - Letter to Illinois Department of Public Health (IDPH) written by E1, Administrator. "R1 tried to attack staff called 911, sent to ER. R1 returned from ER and within minutes became aggressive towards staff and began destroying the homes property. Emergency medical services (EMS) returned and transported R1 back to ER."

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2/19/22 - Behavior Progress Note written by E7, DSP "R1 came out of R3's room yelling." "Broke the thermostat." staff called 911. Police came and picked R1 up.

2/14/22 - Referral to SST (Support Service Teams) by E1, Administrator. The referral describes R1's behavior, "Since his behaviors have been more severe and the destruction/harm caused has been more severe. We have tried everything." "R1 will act out towards his peers when he is not the center of attention. R1 will not allow anyone to celebrate a birthday or visit with their families."

1/16/22 - 1/20/22 - Psychiatric Hospital note written by Z9, psychiatrist documents for R1 "other risk assessment formulations Homicidal/Violence. R1 was discharged on 1/21/22. Z7, psychiatrist documents on discharge progress note that R1 Risk Assessment Formulation is 'Homicidal/Violence".

1/13/22 - Psychiatric hospital note written by Z8, Medical Social Worker at 11:24pm, R1"Patient has been increasingly aggressive and easily triggered. Hospitalization is recommended to avert harm to others and further exacerbation of his symptoms."
"Patient is 32 years old male with history of Autism, Attention Deficit Disorder, Moderate Intellectual Disability, Schizophrenia Disorder"

1/12/22 - Psychiatric hospital note written by Z7, Psychiatrist, R1 "Long history of psychiatric illness with multiple hospitalizations" "Severity of Illness Criteria: Homicidal/violence/destructive threats, gestures or behaviors."

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11/4/21 - Letter to IDPH written by E1, Administrator states, "R1 was transported to local hospital after becoming increasingly agitated and verbally aggressive to staff.

10/10/21 - Record note written by E7, DSP states, R1 was using profanity and yelling trying to fight resident R3. R1 went outside and beat on the window and door.

10/3/21 - Incident report written by E14, DSP (Direct Support Person) states "R1 starts throwing things (sic) go into R10's room to break his television. Staff intervene and R1 start biting staff. Police called."

9/21/21 - Record note written by E6, DSP states R1 became physically aggressive, sent to local hospital emergency department for psychiatry evaluation and treatment discharged same day. Watching television then got up ran toward the doors and tried to attack staff. Ran towards the door trying to bust fire extinguisher glass out and trying to hit the individuals R2 through R13 with the glass. R1 then went outside climbed into his bedroom window and attacked E7, DSP. Police arrived, R1 to ER.

Behavior Program Plan dated 9/1/21 written by E18, Qualified Intellectual Disability Professional (QIDP) list several of R1's maladaptive behaviors including:
a. "verbal aggression - screaming, threatening others"
b. "physical aggression - hitting, slapping, biting, kicking, shoving or striking others."
c. "property destruction - throwing, breaking or damaging items in his surroundings"
d. "elopement - leaving the facility without

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Z9999	Continued From page 6 informing staff, states he is running away or leaving this place." E18, QIDP then documents, "due to severity of R1's behaviors, the CST (Community Staff Team) and BMC(Behavior Management Committee) Team have determined that a behavior program is needed for R1." E18 continues with program methods to address R1's aggression, "redirect R1 to a quiet place" "encourage R1 to take 10 deep breaths" "staff to repeat until R1 is calm." 8/20/21 - R1's Individual Service Plan (ISP) dated 8/20/21 written by E19, QIDP includes, "R1 was born with prenatal exposure to cocaine." "In school he was known to have temper tantrums, hurt others" " R1 spent 12 years in a foster home, but the family asked to have him removed because R1 was exhibiting sexual behaviors with younger children. R1 was then moved to a facility for individuals with intellectual disabilities where he touched the breast of a staff. R1 moved into this current facility on 4/4/17. 8/10/21 - Incident report and Behavior progress note written by E12, DSP states R1 "tried to attack R2 and I." "He picked up the fire extinguisher in the living room and tried to break the TV before he broke the windows." "I saw traces of blood in the living room" "called 911". Letter notification to IDPH of the same incident dated 8/12/21 written by E1 states R1 attempted to put his head through the same broken windowpane. 8/9/21 - Behavior Progress Note written by E12, DSP states R1 was "hollering" at R5 that R5 stole his money and stormed into R5's room. R1 started slamming R5's door.	Z9999		

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Z9999	Continued From page 7 8/5/21 - Behavior Progress Note written by E12, DSP states R1 started yelling getting angry because R7 walked in dining room. Taken outside to cool down. 8/2/21 - Letter to IDPH written by E1, Administrator states R1 became physical aggressive when staff tried to redirect, he began punching walls. 911 call to ER. 7/28 - 7/31/21 - Behavior recording Form data tracking list R1 demonstrated VA (verbal agression), PA (physical agression), Property destruction and uncooperative. Staff initial illegible. 7/25/21 - Incident report dated 7/25/21 at 5:30pm written by E11, DSP states R1 became physically aggressive when staff tried to redirect his behaviors, he began punching the company vehicle. R1 sent to Emergency Department. 7/21 to 7/26/21 - Behavior recording Form data tracking list R1 demonstrated VA, PA, Property destruction and uncooperative staff initial illegible. 7/18- 7/21/21 - Behavior recording Form data tracking list R1 demonstrated VA, PA, Property destruction and uncooperative staff initial illegible. Telephone interview with E1, Administrator on 3/9/22 at 3:32pm. Surveyor informed E1 the residents at the facility were in danger, based on record review and hospital records received for R1. R1 was evaluated and determined to be homicidal, during hospital stay 1/12/22-1/21/22. E1 states she will contact her management and meet with surveyor today and confirmed R1 is not in the home today. At 5pm E1, Administrator informed surveyor that facility management was	Z9999		

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formulating involuntary discharge forms for R1's guardian which will be hand delivered to guardian.

Interview with R5 on 3/8/22 at 1:55pm. R5 states R1 hit him on his body, "he hit R2. I haven't done nothing to him. I don't say nothing to him. He hits R2 and sometimes R2 hits him back. He bit R2 three or four times. He bit me right here, about a week ago. R5 points to his 5th finger where a dime sized purple colored bruise is there. The surveyor noted on 3/8/22 at 1:55pm a bruise to R5's 5th finger of left hand. The bruise 2 centimeters in height and 2 centimeters in width. The surface of the skin was not opened but had evidence of trauma by disruption of the natural skin lines to bruised area.

Interview by telephone with Z6, licensed Behavior Specialist on 3/16/22 at 12:20pm. Z6 stated, "our job is to support the facility as additional support on the outside and if the resident is at crisis level, we want to know about it. I know R1 very well. I have worked with him. He responds. We provided services to him at that facility from 8/13/18 to 6/27/19.
There is no reason why the facility could not have reached out to us before December 2021, that is when we got a new referral to start seeing him again." "I heard about the resident he put in the hospital, if he was targeting a resident or having homicidal ideation, he needed a plan. Also, communication was poor with the facility, it was difficult getting information about R1 and we would go to the facility and R1 would not be there sometimes."

Interview with E1, Administrator by telephone on 3/9/22 at 3:15pm. E1 was asked if she had reviewed psychiatrist evaluation of R1's inpatient

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hospital record from 1/21/22 which states R1 is homicidal. E1 states, she was not aware and would make some calls to address this matter.

Interview with E7, DSP on 3/9/22 at 11:15 am E7 states, R1 did approach the door of the dining room on 3/4/22, residents R2 through R12 had just eaten breakfast when R1 used profanity against the residents in the dining room and against E7. R1 was in the door of the dining room screaming and cursing for at least 10 minutes. E7 states she tried to de-escalate R1. 911 was called and R1 was taken to the ER and came back.

Interview with E8 house Manager on 3/8/22 at 11:20am E8, states a couple weeks ago R1 was throwing stuff, slamming doors, and walking up and down the street. Residents were in the living room and other residents were at lunch, It was around lunch time.

Interview with E11, DSP on 3/8/22 at 10:45am states, "R1 will fight. I saw him hit R2. He targets R5. He bit R5. He punched a window out."

3/8/22 - Interview with E1, Administrator on 3/8/22 at 11:42am. E1 was asked what has the facility done regarding R1's physical and verbal abuse to other residents and himself. E1 states, we met in August and October 2021 and discussed R1's medication mainly his Clozaril, his medications were changed in late January (2022). R1 family visits were canceled as that exacerbates his behaviors. I have met with the QIDP (E18) and spoken to the nurse. We did have at least two meetings regarding R1. In February this year (2022) we wrote a referral for a specialty behavior team. I have tried everything.

Interview with E18, Facility Trainer and Qualified

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Z9999	Continued From page 10 Intellectual Disability Professional (QIDP). E18 was asked what has the facility done to meet the R1's behavior needs regarding physical, psychological and verbal abuse to other residents in the home and to himself. E18 states a referral was sent to SST (Service Support Team) on 2/13/22 and E18 has had discussions by "telephone with E1, Administrator about R1's behaviors. E18 states R1 has had a follow up appointment with Z3, psychiatrist. E18 did not give surveyor any evidence of support the facility has provided for R1 regarding Physical and Verbal abuse to other residents, and self from 6/28/21 to 3/4/22. Interview with Z4, Behavior Analyst by telephone on 3/7/22 at 1:35pm. Z4 is assigned to R1. "R1 could benefit from a smaller house, a 4 bed or 6 bed home. I have made these recommendations to the facility" Facility Policy number 5.57, title, "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." "Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in harm, pain, or mental anguish." (A)	Z9999		