STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

ASPIRE ON EASTERN
Facility Name

0020438
I.D. Number

105 EASTERN AVENUE, BELLWOOD, ILLINOIS 60104
Address

MARCH 7, 2005
Date of Survey

IRI OF DECEMBER 22, 2004
Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.620a)
350.1230d)1)
350.3000d)2)
350.3240a)

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 operation by the facility and shall be reviewed at least annually.

Direct care personnel shall be trained in, but are not limited to, the following:

Basic skills required to meet the health needs and problems of the residents.

All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24-hour-a-day supervision of the door, a signal is not required.

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 the following:

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350.1230d)1)
350.3000d)2)
350.3240a)
(Cont.)

1) Based on review of the facility's incident investigations, interviews and record verification, the facility neglected to provide adequate supervision for one individual, R1. R1 eloped from the facility on 9/16/04 and was found walking down the street (unclear how far from the facility). On 10/22/04, R1 was left unsupervised in a movie theater while staff went to get refreshments and was found outside the theater. On 12/22/04 R1 was found at a local convenient store after eloping from the facility.

Per the clinical record, R1 is a 50-year-old male diagnosed with Severe Mental Retardation, Down syndrome, and Hypothyroidism. Per the 6/13/03 Psychological evaluation, "He appears to be oriented to his immediate residential environment but he is unable to have unrestricted community mobility due to lack of street survival skills."

The Communication assessment indicates R1 has moderate-severe communication impairment. He is non-verbal. R1 attempts to communicate in the following ways: "vocalizes, eye gaze, facial expressions, touching, common gestures and made up gestures and signals."

The activity assessment states R1 requires verbal guidance walking through parking lots and crossing streets.

The Comprehensive Functional Assessment states: "Over the past years instances of unusual behaviors have increased, such as moving all his furniture into the bathroom/conference room, moving clothing elsewhere throughout the building and increased incontinence. This year there has been an increase of R1 falling to the ground and lying on the floor. He will often do this if prompted to remove layers of clothing or others are bothering him."

The Maximum Growth Potential Plan identifies R1's needs for supervision in the community in several different areas. The Interdisciplinary team (IDT) determined "that significant deficits exist in the following life areas: Self Care, Language, Learning, Self Direction and Capacity for Independent Living." He does not demonstrate survival/safety skills."

2) An incident report dated 9/16/04 at 1:40 p.m. details an incident where R1 was found walking down the street near the facility. Staff driving a bus (E10) with participants stopped the bus and tried to redirect R1 without success. Per the report, "As I got off the bus I noticed a staff from (the facility) was coming down the street." Two-person escort with staff (E11) from the facility was used to get him on the bus.

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E13's (receptionist) statement reads as follows: "(E11) called from the B wing, she observed (R1) walking away from the great room area passing the B wing; she called and asked did I see him, then she called and asked me to take the alarm off of B wing, so she could go find him. The construction guys were outside eating lunch told (E11) he went to the end of driveway and made a left."

During interview with E10 on 3/2/05, she said that she saw R1 walking down the street. He was in the middle of the block. At first she did not see any staff behind him. When E10 got off the bus, she saw E11 coming down the street. They got R1 on the bus and then took him to the facility.

During interview with E11 on 3/2/05, she said she could not remember all of the events since it was a long time ago. She wasn't sure if the alarm went off or she noticed R1 walking by the window. E11 said R1 was walking fast paced and she realized it was him because of his red hair. She immediately went looking for him.

There is no evidence of a special team meeting or change in R1's level of supervision. Per his clinical record R1 is on 24-hour supervision. Per interview with E1, administrator on 2/28/05, she said 24-hour supervision depends on individual needs. Individuals are allowed to be independent in their rooms and have independent mobility in the facility.

3) Review of an incident report dated 10/22/04, indicates R1 was taken on an outing to a movie. One staff was in attendance. The report does not note the number of residents attending the community outing. Per the report, written by E14, "He walked out of the movies no reason. Movie hadn't started yet and (E14) went to get popcorn for other residents. Upon return, (R1) was not in seat." Staff went in mens/womens bathroom - (R1) was not there. (E14) found that (R1) had gone outside & was standing in front of the theater. Went to go get him, still did not come back into the movies. (E14) asked usher to keep an eye on (R1) while she got the rest of the participants. We all got on the bus and came back to the job."

Per the disposition written by E1 (administrator) "Incident reported to QMRP and activity director. Activity Director will ensure (R1's) activity outing schedule always includes (2) staff to ensure his safety. (R1) has been evaluated and assessed at the Adult Down's clinic over the past year to (rule out) (signs and symptoms) of (Alzheimer's disease) and continues to demonstrate subtle change in demeanor as evidenced by above incident. He will continue to be monitored closely."

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(Cont.)

There is no evidence that a special team meeting was held, nor was R1's level of supervision increased except during activity outings. Facility staff was not notified of the need to increase monitoring of R1.

4) Incident report of 12/22/04 indicates R1 eloped from the facility at approximately 9:10 p.m. R1 exited the building from a side door near the kitchen. An alarm sounded, staff coordinator (E2) and training specialist (E6) went to the door and looked outside. Per interview with E2 (2/28/05) she went all the way around the building and did not see anyone.

Per the incident report and confirmed by interviews with E1 (administrator), E2, E3 and E5 (shift coordinators) and E7 and E8 (training specialists), E3 immediately initiated a census. As the facility was in the process of taking the census, the police called and said there was someone at the convenient store who might be a resident of the facility.

Review of the police log reads: "M/W Gray shirt, Blue pants/empl stated subj possibly from (facility)/desk called (facility)/upon ofcs arrival, someone from (facility) had already picked him up." The time listed is (9:21 p.m.) dispatch and (9:24 p.m.) arrival.

E1 and E2 went to the convenience store and found R1 drinking a soda. He was dressed in five layers of clothing but was not wearing a coat per interview with E1. R1 was returned to the facility and examined by the facility nurse. There were no injuries.

Per interviews with E2, E3 and E5 (shift coordinators) on 2/28/05, R1 was observed pacing from one end of the facility to the other prior to eloping on 12/22/04. The interviews disclosed that when R1 is pacing he walks very fast and it is a sign that he is agitated.

During interviews with E7 and E12, they stated that the elopement on 12/22/04 was the first time they were aware of R1 attempting to leave a program area. E12 stated rounds are made on individuals who are not participating in activities every 15-20 minutes. Per E12, R1 was able to get outside in between 15-minute checks.

Per interviewed staff, E2, E3, E5, E6, E7 and E12, the facility has instituted an informal procedure. When an alarm goes off, one staff goes outside and another looks for R1. Other than this informal procedure the level of supervision for R1 remains unchanged.

The disposition, written by E1, states: "QMRP informed of the incident & asked to schedule a special IDT (meeting). All supervisory staff informed of the need to physically locate (R1) anytime a door alarm goes off (without) just cause and actively walk to end of property to ensure (R1) has not left the premises until the IDT can meet to discuss this incident."

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5) Per incident report, on 12/26/04, R1 walked out of the building at 7:40 p.m. Three staff responded to the alarm on door one (side door near the kitchen). "When staff opened the door we saw (R1) about 100 feet away in the parking lot. Staff (E5) gave verbal prompts for (R1) to return to the building, when this failed. (E5) went to (R1's) side and verbally redirected (R1) to the front door."

A special IDT meeting was held on 12/28/04. The team recommended to continue the procedure that was implemented on 12/22/04 "that is if the door alarm is heard staff are to immediately determine R1's whereabouts by physically locating him. Other staff are also to simultaneously walk to the end of (facility) property to ensure that (R1) has not left the premises. The door alarm policy will be reviewed with staff across all shifts. The team felt that this behavior can be documented and monitored through incident reports, and therefore, no additional baseline tracking was necessary at this time."

Per interview with E1, E2, E3 and E5, all staff have been in serviced on this procedure. There are two other individuals in the facility who exhibit elopement behavior. This procedure does not ensure all residents are immediately checked for elopement. Surveyor interviewed E11 on 3/2/05 and she stated she did not routinely work with R1 and had not been inserviced on the policy. There is no signed in-service record indicating which staff have been inserviced. Surveyor was given staff meeting records which discuss the importance of not disarming the alarms but do not mention the need to immediately locate R1 when alarms sound.

Per interview with Z1 on 3/3/05, she said R1 displayed the eloping frequently when living at home. "He would go out of the house and walk around the neighborhood. Everyone knew him." Per Z1, she is sure the facility knew he had the behavior when he was admitted in 1981.

Per interview with E8 on 3/2/05, vocational trainer, R1 was found outside last year by a day-training door that is not alarmed. There is no corresponding incident available (date unknown).

Review of facility policies indicates a census of all residents is taken at scheduled times using designated forms. Examples are:
"A. Weekdays (3 p.m. - 11 p.m.)
1. Arrival to the facility) from Developmental Training sites as residents deboard bus
2. Meal census for first, second, third and fourth dinner seating
3. 10:00 p.m.
B. Weekends (7:30 a.m. to 3:30 p.m. Saturday and Sunday)

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1. Meal census for all breakfast seating
2. 10:00 a.m.
3. Meal census for all lunch seating
4. 2:00 p.m."

Review of facility policy for Personnel Cover Plan/Staff to Participant Ratio states: "Purpose to provide adequate staff coverage for a safe environment and effective skill training."

Observation at the facility on 2/28 and 3/1/05 indicates distinctive programming areas located at the ends of the building. The programming areas are separated by two bedroom wings and a closed unit designated as the Alzheimer's unit. Per the facility floor plan there is over 365 feet between the main program areas. R1 is not currently visually supervised when he is not in the programming and dining areas. Staff depend on the alarm system and 15-20 minute rounds to ensure that he is in the building. There is no assessment identifying the elopement behavior and no written plan in place to monitor and collect data on the behavior.

(A)