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

LEBANON TERRACE
Facility Name

0038430
I.D. Number

221 EAST THIRD STREET, LEBANON, ILLINOIS 62254
Address

02/15/2005
Date of Survey

INCIDENT REPORT INVESTIGATION
OF JANUARY 27, 2005
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)
350.1060h)
350.2700d)2)
350.3240a)d)

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.

There shall be available sufficient, appropriately, qualified training and habilitation personnel, and necessary supporting staff to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.

All exterior doors shall be equipped with a signal that will alert the staff if a patient 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 twenty-four (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)

A FACILITY ADMINISTRATOR, EMPLOYEE, OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL ALSO REPORT THE MATTER TO THE DEPARTMENT. (Section 3-610 of the Act)

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These regulations are not met as evidenced by:

Findings include:

1) Per Individual Support Plan (ISP) of 8/27/05, Physician Order Sheet of 1/15/05 and R1's 10AM interview of 2/7/05, R1 is a 23-year-old ambulatory, verbal female who functions in the Mild range of Mental Retardation (MR). Additional diagnoses include Adjustment Disorder, Attention Deficient Disorder, Obsessive Compulsive Disorder and Bipolar Disorder with a pre-occupation with sex.

This ISP states that R1 has a full scale WAIS-3 IQ of 63, an ICAP overall adaptive age of six years and eight months, and has "a need for regular personal care and/or close supervision." It also states that R1's medications include Ortho Tri-Cyclen 28, Celexa 40mg o.d., Tenex 1mg b.i.d., Ritalin 30mg b.i.d. and Loxitane 25mg b.i.d..

Per 4/28/04 Psychological Evaluation, R1, graduated from high school in Special Education, had lived at home until her placement, February 2004, in a-16 bed ICF/MR facility. This evaluation further states that this placement was lost on 4/14/05 after R1 was hospitalized for behaviors of threatening other residents, attempting to kick out a glass door, using vulgar language and "flashing" others. R1 was then transferred from this hospital to a Mental Health Center.

R1's 8/27/04 Individual Behavior Support Plan states that R1 "has a history of inappropriate" sexual comments to male peer/staff and false sexual allegations about staff and peers. There have been several episodes at home and DT (day training). All of the episodes of sexual behavior seem to be an effort to shock the people that she is targeting. R1 (name) is also very impulsive (i.e., says whatever she is thinking, flashes people without warning, will agitate peers/staff without warning, etc.)."

Per the facility's Individual Unusual Incident Report of 1/27/05, completed by staff, E5, R1 eloped from the facility on 1/27/05 at around 5:30PM and was brought back at around 6:15PM by the police.

Per interviews with Z1, DT's Qualified Mental Retardation Professional (QMRP) and DT staff, Z2, Z3 and Z4, R1 was brought home early on 1/27/05 by Z1 due to having behaviors and attempting to elope from Building 122 to the main road twice, making it once. Z1 also stated that R1 has a lot of behaviors on the bus that are very dangerous, acting out and saying "really ugly negative things" to their consumers.

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Per surveyor's odometer reading, the main road from Building 122 is a half a mile away.

Per 2/7/05 interviews with Z2, Z3 and Z4, R1 did complain of her right hand hurting on 1/27/05, but there was no swelling or sign of injury and she did do contract work with it that day.

E1, the QMRP during a 3PM 2/8/05 interview, stated that Z1 brought R1 home early on 1/27/05 due to behaviors and that E1 followed her to her room to ask R1, what was wrong. At that time, R1 showed E1 a "small bruise" on the side of her right hand. E1 further stated there was no swelling, she could move her fingers and when asked, R1 stated it didn't hurt. E1 stated that at first R1 said that R5 kicked her hand, and then denied it.

R5, who functions in the Mild range of MR, during a 3PM 2/7/05 interview, stated that R1 "tried to hit me before she had the cast on, hit (the) chair (instead), (and) fell on the floor cussing and stuff. R5 further denied kicking R1's hand.

Per staff, E5, E8 and E9's, 1/27/05 -- 1/28/05 written statements, R1 came home from DT in an upset mood, made nasty remarks, pulled down her clothing and stated she was leaving.

R1's chronological of 1/27/05 by staff E8 state that R1 ran out of the facility at 4:25PM and was brought back after getting almost a block away by E9. This record then states, that at approximately 5:30PM, R1 eloped from the facility after stating to staff she was going to bed.

According to E5's written statement, R1 spoke with her mother per phone about 5:15PM and that the last time he saw R1 was in the bathroom on the ladies' wing. R1 had said to E5, that she was going to take a shower. E5 further stated that when he walked back to the ladies wing a few minutes later, he noticed the bathroom light was not on so he began to search for her.

Z13, per 2/10/05 10:59AM interview, stated he just happened to see R1 standing on his porch in front of his door (East McAllister Street, .1 mile east of 606, .7mile from the facility, on the edge of town across from the sewer plant), barefoot, wearing nothing but panties and a short sleeve shirt. R1 asked if she could stay here. Z13 told her no and dialed 911. Z13 further revealed that he saw R1 walk to Z10 and Z11's trailer.

Z10, per 2/10/05 10:50AM interview, said that there was a knock at the door and he said there was a young little girl there, with no pants or shoes, in her stocking feet, no coat, just shirt, underwear and socks. Z13 further stated that she said "Can I stay with you?"

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Z10 indicated that his fiancée Z11 invited her in because it was freezing outside.

According to the National Weather Service Forecast Office, the weather in St. Louis on 1/27/05, at 5:55PM was 31 degrees with an East wind at 10 miles an hour and a Wind Chill Factor of 22.

Z10 then stated that he left to use his brother's phone that lives down the street and across the street from Z13, to call the police. It was at this time Z10 met Z13 who was coming towards his place with the police. Then the ambulance arrived.

According to Z10, Z11 was asking R1 questions while he was gone. Z10 stated that R1 told Z11 that she was from California, had been beat up by some male and had been dropped off in the country by a 32-year-old Z15. Z10 further stated that R1 gave a fake name of Kimberly.

Z10 stated there were two police officers, a female paramedic (Z14), and my brother at the trailer. While the police were writing down information given by R1 and Z11, the paramedic examined R1 on his sofa. R1 had a swollen hand and the paramedic thought she recognized R1 from the facility, so the police phone to see if the facility was missing anyone. Then the police asked R1 if she was R1and she responded, oops you got me.

Z10 further revealed that R1 besides giving false information would flash her breast and drop her drawers when people came in the door asking if they wanted to see something. Z10 stated, "In this neighborhood there are some shady characters and she could of got raped and hurt real bad."

Confirmed by Z8's, dispatch manager, 2/9/05 10:25 AM phone interview and record review of the trip details, a 911 call was made at 6PM, with an ambulance arrival time at 606 McAllister Street of 6:05PM. The call was cancelled at 6:10PM and that there was no patient contact made.

This report states that the police department was on the scene, there was a naked female with unknown problems.

Per facility's 1/31/05 investigation and the hospital's 1/28/05, 2:30AM emergency discharge instructions, R1 denied sexual assault, had a gynecological exam, with no evidence of sexual activity but had two broken fingers (fractures of the third and fourth proximal phalanges) which were placed in a soft cast.

2) Neglected to keep their door alarms on.

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Per the facility's mandatory staff training records of 1/21/05, 2/8/05 written statement by E2 and confirmed by E2's, 2/9/05 11:25AM interview, all staff were instructed to keep the door alarms on at all times and to contact the police immediately upon discovery of an elopement. Per written statements of E3 and E8, R1's 2/7/05 10AM interview and per written disciplinary action taken against E5 the door alarms were not on at the time of the elopement as required.

3) Neglected to implement their standard procedure for searching for a missing individual (contacting the local police) on 1/27/05 when R1 eloped from the facility.

Facility's Missing Individual Policy Number P-1200.02.7 states that the facility, "shall assure that when an individual served is reported missing from the facility, staff follow standard procedures to search for the individual and to notify appropriate parties."

Policy Phase I, B) 5. states:
"Within thirty (30) minutes of having been notified of an individual's disappearance, and when a reasonable and thorough search in the immediate vicinity does not locate the individual, the Administrator or designee shall notify local authorities.

Per E3's, the house manager, 1/28/05 written statement, E4 staff, called her at home at approximately 5:30PM and reported R1 missing. E3, after inquiring if staff were out looking for R1, then drove around in her car about 20 minutes looking for R1.

Per the administrator's, E2, written statement of 2/8/05, E2 conducted a staff training session on 1/21/05. This statement states "notification of the police should be made, in the event of an elopement, as soon as it was discovered." E2, the administrator, stated at 9:20AM on 2/9/05 interview that he sent a draft of the revised policy to his company and did not have a copy of this draft.

Determined by E3, the house manager's 2/8/05 8:30AM interview, the staff did not contact the police; the police contacted the facility by phone inquiring if the facility had someone missing around 6:05PM.

Per E2's 10AM interview on 2/8/05 the staff have not as yet been retrained on the facility's Abuse/Neglect and Missing Persons policies due to the QMRP being scheduled for other training (QMRP school), but training is scheduled for this week.

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Policy Phase IV, A. states, "When the individual returns to the facility, the Administrator shall make a precise determination of where the individual was found and the probable route taken to arrive there. The probable route shall be communicated to facility staff and shall be documented in the individual's record." Per record verification, there is no documentation by the administrator of probable route taken. Report of 1/31/05 states R1 "ran to a mobile home a few blocks from" the facility.

Surveyor was able to identify R1's location as .7 mile from the facility, at the edge of town at Z13's home across from the sewer plant at 6PM prior to going to Z10's home, by the 911 record, called in by Z13.

Policy Phase IV,C states, “The Administrator shall verify that the Unusual Incident Report was completed, and the detailed summary of events shall be attached to the Report. The notes of the Administrator or designee shall be the basis for a summary report.

Per review of the 1/27/05 Individual Unusual Incident Report there is no detailed summary of events attached to the report.

4) Neglected to have evidence that the elopement of R1 on the evening of 1/27/05 was thoroughly investigated.

Per 1/31/05, E2’s investigation summary, R1 ran to a mobile home a few blocks from the facility, dashing out the door, after loudly announcing to the staff, that she was going to take a shower. This investigation further states that R1 was gone “only 15 minutes or so.”

This investigation fails to identify the following details:
a) Female wing door alarm (East side) was not on.
b) Staff were unaware R1 had eloped and her location was unknown for at least 35 minutes.
c) Police were not contacted by the facility staff as per policy.
d) R1 eloped in only a T shirt, underwear and socks.
e) R1, had a bruise on hand upon her return from DT on 1/27/05 and complained of it hurting during the day at the DT site on 1/27/05
d) A 911 call was made by Z13 prior to R1 going to the mobile home of Z10 and Z11.
e) Z13's home is .7 miles away from the facility, across from the city's sewer plant on the southeast edge of town.
f) R1 was examined by Paramedic Z14 and upon her return to the facility by the police had a swollen hand.

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350.620a) 350.1060h) 350.2700d) 3503240a)d) (Cont.)	g) Probable route taken by R1 per investigation was, East down and to the end of Third Street from the facility, then South, down a country road with woods on the left and a field on the right, to East McAllister Street, to 606 East McAllister.

(A)

CH:jb/AV-LEBANON TERRACE (03-11-05)