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, IL 62254 — Address

1/27/05 — Date of Survey

Complaint — 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):

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350.2700d)2)
350.3240a)b)c)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 the operation of 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 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)

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

A FACILITY ADMINISTRATOR WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER BY TELEPHONE AND IN WRITING TO THE RESIDENT'S REPRESENTATIVE. (Section 3-610 of the Act)

A FCILITY 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)

Findings include:

1) Per R1's 3/19/04 Individual Support Plan (ISP), the facility's roster and 1/16/05 Medication Administration Record (MAR), R1 is a 22 year old ambulatory female who functions in the Profound range of Mental Retardation (MR), with a WAIS IQ score of 14, and a adaptive ICAP score of 2 years and 8 months.
R1 is able to speak in simple sentences, but makes most of her wants and needs known through a few words and/or gestures.

R1's diagnoses includes MR, Bipolar Disorder, Stereotypic Movement Disorder, Attention-Deficit Hyperactive Disorder, Hypothyroidism and a History of Depressive Disorder.

R1's routine medications include Geodon 40mg. b.i.d., Cogentin 1mg., Ativan 0.5mg t.i.d.+ 1mg h.s., Depakote sprinkles 500mg. b.i.d., Topamax 100mg. b.i.d., Strattera 40mg b.i.d., and Ortho-Novum 1/35-28.

The ISP states that R1 enjoys being outside, needs assistance with crossing streets, displays mood swings, (where she paces), and displays overactive behaviors such as jumping up and down, pacing through the house, eloping from the house and temper tantrums.

The ISP further states that R1 was hospitalized in June of 2003 for agitation, extreme aggression toward staff and peers and for eloping from the facility.

Per review of the facility's individual Unusual Incident Report completed by E4 and E1, it was determined that on Sunday morning, of 1/9/05, R1 eloped from the facility.

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E5 stated per 1/9/05 written statement and 1/18/05, 2:55PM interview that as she was coming up the street on her way to work she was flagged down by E4. E5 stated she told E4 to call the police while she looked for R1. E5 stated that she looked around the house, saw the van door open and looked in it then called E1, the QMRP (Qualified Mental Retardation Professional).

Z2, (a manager at a local supermarket) stated during a 1/18/05 11:30AM interview that when Z3 (supermarket checker) came in to work, at 6:45AM on Sunday, she informed Z2 that there was a girl with dark hair sitting in the front seat of her van (a white van) and that she was crying.
Z2 further indicated that the incident had to just have happened because when she went out to investigate it, three men at the adjacent gas station informed Z2 that they had just saw R1 run across the parking lot and get into the van.
Z2 said that R1 was wearing only a sweatshirt, that her legs were red because it was so cold out, that R1 was crying and saying "my mommy's gone." Then Z2 indicated that the three men assisted her with bringing R1 into the supermarket where she directed Z7, (deli clerk) to call the police and to get R1 a meat cutter's jacket.
Per surveyors observations and brisk walk, this supermarket's front/ parking lot faces and is adjacent to a busy State Highway (Route 4). This supermarket is estimated to be approximately a five minute walk and one/tenth of a mile from the facility.

Per Officer Z10's, Police Department Missing Person Incident Report, obtained from the police department on 1/18/05 by the surveyor, and per 1/18/05 11:17AM interview with Officer Z1 who accompanied officer Z10 during the search, a call was made to them at 6:48AM from the facility's staff and that R1 was found at a local supermarket at 7:04AM.
Z1 stated that somebody from the store called their dispatcher. Z1 stated that Z10 stayed at the facility while he went on the dispatcher's call. When Z1 arrived R1 was already inside the store wearing only a sweatshirt, no shoes no nothing. Z1 further stated she had no mud on her, scratches or bruises and that she was cold because it was a cold morning.

Per Z5, a weather staff, phone interview on 1/19/05, the weather in the facility's area at 5:55AM on 1/9/05 was 33.8 degrees with a South wind at 10.4 miles per hour. At 6:58AM it was 33.8 degrees with a Southeast wind at 9 miles per hour.

According to E4's 1/18/05 6:05PM phone interview, R1 was wearing a sweatshirt and sweat pants that night when he toileted her at 3AM. E4 further stated that R1 will get out of her pants all the time when toileted. Per E10's (midnight and evening staff) 1/19/05 2:35PM interview, R1 has been dressed in sweat pants at night because the bedrooms back there have been cool. E10 further stated that if you take her to the bathroom she will take her pants off. That R1 will whip those pants off fast and you have to give R1 verbal cues to keep them on.

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Per E5's 1/9/05 written statement, when R1 came into the facility after the incident she was wearing only a sweatshirt, she was cold and red. E5 wrote that she took R1 to her room got her dressed, she took her meds and ate her breakfast and seemed to be fine.

E1 stated during 1/19/05 interview that she took R1 to a nearby town's acute care service where R1 was examined by physician Z8, who documented on the discharge instructions that it was a "normal exam, no bruising, lacerations or sign of trauma."
E1 further stated when asked by surveyor whether a rape kit testing was completed stated that the physician saw no physical evidence to do one and didn't feel R1 needed to be traumatized further.
E1 also indicated that R1 is resistive to touch in certain areas and is not cooperative with Gyn exams.

2) Neglected to implement their standard procedures for searching for Missing Individuals.

Facility 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."

This policy further states "Upon return of the missing individual, follow-up activities shall be undertaken to:
~Notify appropriate parties,
~Determine the condition of the individual, and
~Consider actions necessary to prevent recurrences."

Phase I, A. 3., of the procedure states: "Notify appropriate facility staff, including the administrator or designee.

E4 failed to notify the appropriate facility staff, including the administrator or designee.
E4 stated that from 6-6:30AM he was sitting in the living room watching TV. E4 stated that he did not realized that R1 was missing until around 6:35-40AM, when he went to R1's bedroom to toilet R1 and her twin sister and roommate R2.
E4 stated he opened the door and saw that the window was wide open, there was no R1 and R2 was sitting on her bed. E4 stated all R1's clothes were out of her drawers and scattered all over the room.
E4 than indicated that he looked out the window for her, then turn off the alarm system and went out the front door. E4 stated that he was half way down the walkway when he saw the facility's van (white) door open and searched it.
About this time, per E4, he saw E5 arriving for work. E4 stated that E5 told him to call the police

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E5 stated per 1/9/05 written statement and 1/18/05, 2:55PM interview that as she was coming up the street on her way to work she was flagged down by E4. E5 stated she told E4 to call the police while she looked for R1. E5 stated that she looked around the house, saw the van door open looked in it then called E1, the QMRP (Qualified Mental Retardation Professional).

Phase IV,A.,"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.

Phase IV,C, " 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 1/18/05 review of the Unusual Incident Report there is no attached detailed summary of R1's elopement.
E2, the administrator stated during 1/18/05 9:40AM interview that his notes are in Springfield, that he was not finished with the report and would not complete it until after his today's meeting with the Union Representative for E4.

Phase IV,E.,"Depending upon the circumstances, the Administrator shall direct that an Interdisciplinary Team meeting be called to discuss the situation and determine if any follow-up action is required.

No Interdisciplinary Team Meeting had been called by the Administration until after an Immediate Jeopardy was called by the department on 1/20/05 at 9:12AM.

3) Neglected to have evidence that the elopement of R1 on the morning of 1/9/05 was thoroughly investigated.

E2, the administrator, stated per 1/18/05 9:40AM/12:10PM and 1/20/05, 12:30PM interviews that he felt he had completed a thorough investigation. E2 indicated that he had obtained written statements from the two staff involved (E4, E5) and interviewed E4. E2 also stated that he had spoke with police officer three times that morning.

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There is no evidence that E2 was aware of the following discoveries made by the surveyor during the investigation on 1/18/05 and 1/19/05.

a) R1's window locks were broken (observed at 2:30PM on 1/18/05 by surveyor),
b) Whether or not the window stops were in the lock position (allowing the window to slide open only two inches).
Per E2's interview, on 1/19/05, the window stops were in place the night before the incident of elopement(1/18/05), according to the information he had obtained from E5.
E5 stated per 1/19/05 3:40PM phone interview that she put the window stops in place that morning after the incident and not the night before. E5 further stated that a lot of times the staff open the windows to air the room out.
c) Heating vent was not functioning in R1's bedroom, that R1's furniture had been rearranged the week before because staff had complained that the room was cool and thereby a dresser had been moved away from the window and the heating vent. This furniture movement provided R1 with access to the window.
d) R1 was found by the police in the supermarket wearing only a sweatshirt.
Per 1/18/05 12:10PM and 1/20/05 12:30PM interviews, E2 stated that he was unaware that R1 was found wearing only a sweatshirt or that she had been brought into the store.
e) E2 had not obtained a copy of the Police report of the missing person incident and/or staff interviews/statements to determine the reason two staff were not scheduled on 1/9/05 midnight shift.

4) Neglected to report the results of their investigation to the Illinois Department of Public Health (IDPH) within five working days of the incident.

Fax #6185374156 sent to IDPH on 1/14/05 at 11:20AM from E3, the house manager, of the facility states:

"R1 eloped from the facility just before shift change. There was a call off and 1 person was on duty. Staff called the police department to assist in bringing R1 back.
Employee, E4 was placed on administrative leave pending termination hearing with union. Details will follow when office equipment is repaired. Thanks."

E2, the administrator stated during 1/18/05 9:40AM interview that his notes are in Springfield, that he was not finished with the report and would not complete it until after his today's meeting with the Union Representative for E4.

5) Neglected to take corrective action in response to their investigation of R1's elopement to prevent it's reoccurrence.

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The facility's actions taken in response to R1's elopement of 1/9/05 were the following:

a) Per E2's 1/12/05 memo to "FILE", E4, the midnight staff was placed on administrative leave since the incident pending the facility's investigation. This memo further states that E4 is entitled to a union hearing pending termination.

b) E1 stated during 1/19/05 interview that she took R1 to a nearby town's acute care service where R1 was examined by physician Z8, who documented on the discharge instructions that it was a "normal exam, no bruising, lacerations or sign of trauma."

c) Per E6's 1/19/05 8:55AM interview, a message was written on the dining room's black board Sunday 1/16/05. Per 1/19/05 observation and confirmed by E6's interview the written message states:

"Per E1 10:10PM
make sure alarms are on
make sure to check (checkmark) on R1(initials)
every 15-30 mins.(minutes)
R1(initials) tried to elope several times today*
Both midnight workers must call in (per administrator)
E2(name)"

Documentation in R1's chronologicals by staff for 1/16/05 states:

"1/16/05 R1 was in Bed at 11:00PM used Bathroom at 2:30AM. R1 could not sleep she was up and down most of the night. E12 (midnight staff)."

"1/16/05 R1(name) was awake when I arrived. She was sitting in the arts and crafts room coloring. She got up and start adding clothing on top of what she had on stating she wana walk. Then she would go look out all the windows, then she'd sit in the middle of the floor and scream. This kept up for up to 7PM.
During this she ate her dinner, but kept getting up from the table. Around 7:30PM she tried to get out of the door in the arts and craft room. Toileted up to 4 times this evening just to keep her mind off the doors--and tried coloring--kept her in the living room to keep an eye on her so she wouldn't get away. She had her meds for the evening."

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d) R1 had a Psychiatric Evaluation completed by Z11 on 1/17/05.
Z11 evaluation states: "Patient has indeed deteriorated.", and recommended medication changes which were initiated on 1/18/05.

e) Surveyor observed during the initiating of the complaint investigation that the facility had one to one supervision of R1 who was home from Day Training on 1/18/05 at 9:45AM.

Determined by observation, interview and record verification, the facility had failed to correct a situation which existed since R1's 1/9/05 elopement. They had allowed a situation to continue that had the potential for harm for R1 by their failure to revise R1's behavioral program, provide staff supervision, monitoring and training.

Per 1/19/05, 8:30AM interview with E1, the staff should be checking on R1 every 15-30 minutes at night and be one to one with R1 when she is awake. E1 further said that it has been that way since Sunday (1/16/05) and staff should be documenting this information in R1's chrons (Chronologicals). Per review of R1's chronological documentation for 1/17/05, there is no documentation by the staff of 15-30 minute monitoring of R1.

When asked by the surveyor on 1/19/05 at 9:50AM whether or not the facility had informed the R1's QMRP (Qualified Mental Retardation Professional) at the Day Training (DT) site of R1's incident of 1/9/05 elopement, whether or not there was a special IDT (interdisciplinary team meeting) to review R1's behavioral plan, E1stated that she did not remember whether or not the DT was informed of the incident.
E1 further stated that she did not remember if she specifically informed R1's DT QMRP of the incident but did talk to Z4 last week and inquired in general how R1 and R2 were doing.
E1also stated that she will have to change R1's behavioral plan and said that their company now has a new form.

Per 1/19/05 9:58AM phone interview with Z4, the QMRP, the surveyor was informed by Z4 that no one said anything about R1's elopement of 1/9/05 nor did she receive any paper work about it.
Z4 further stated that R1 is on floor supervision, not on a one to one supervision and is not on a behavior or elopement program, because R1 does not have any behaviors here.
Z4 identified R1's programs as identification of coins, folding clothes, time on task and communication to say words.

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On 1/20/05, at 10:48AM after the facility held a Special IDT Meeting (Immediate Jeopardy called at 9:12AM) in regard to R1, the surveyor was informed by Z4 that she was a new QMRP at the DT site, that R1 was new to her case as of 12/2004 and that R1 has a behavioral program at DT.

Per record review and confirmed by interview with E1, the QMRP on 1/19/05 at 10:30AM, gave the surveyor a copy of a new service plan for R1 and informed the surveyor that she would train staff on it when they arrived for work.
This service objective states: "1-1 staff will document on R1 every 15-30 minutes for the following (awake, sleep,overactive behavior (see behavior goal), attempting and/or eloping from the facility.
This form further states that staff are to document every day throughout the day and all night every half hour or more frequently,

The next morning (1/20/05), at 8:30AM, when the surveyor reviewed the service plan objective documentation and confirmed by interview with the QMRP, E1, there had been no documentation made by the staff from 3PM until midnight as per objective design.
E1 further confirmed that evening staff E6, E8 and E10 had been trained on R1's new service objective on 1/19/05 but failed to document on it. E1 further confirmed that the midnight staff had not been trained.

6) Neglected to provide sufficient direct care staff on the midnight shift (11PM-7AM) of 1/9/05 when R1 eloped from the facility.

E4 stated per 1/18/05 6:05PM phone interview that he was working the midnight shift alone because his co-worker was given the night off and not replaced. According to E4, the last time he saw R1 was at a 6AM bed check when R1 was in bed with the bedcovers on.

Per the facility's house manager E3's Jan. 14 2005 11:20AM Page 2, , fax #6185374156 to the Illinois Department of Public Health (IDPH) "R1 eloped from the facility just before shift change. There was a call off and 1 person was on duty. Employee E4 was placed on administrative leave pending termination hearing with union. Details will follow when office equipment is repaired".

Determined by 1/18/05 9:35AM and 3:05PM interviews with E1, the QMRP, midnight staff E10 was given the night off for her birthday otherwise stated E1, E10 would of been a no call no show.
E1 stated that its a rare occurrence that there is only one midnight staff although it had happened the night before the incident on 1/8/05 due to the staff being unable to make it in due to weather.

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Per review of the staff schedules from 12/19/04-1/15/05, and confirmed by 1/19/05 2:35PM interview with E10, it was determined that prior to posting the schedule, E10 had requested and was given the night off and had not been replaced. This left E4 alone on midnight shift of 1/9/05.
Per 1/18/05, 9:35AM and 1/19/05, 9:50AM /3:48PM interviews, E1, the QMRP, stated that she had talked to E4 that night by phone and was told the house was "extremely quiet". E1 further indicated that she asked E4 to call her if he needed help.

E4 stated per 1/18/05, 6:05 phone interview that E4 had phoned E1 when he arrived at work that night to find out where his co-worker was. At that time he was informed by E1 that the staff had requested off and was not replaced.
E4 stated that E1 asked E4 whether she should call in another staff but E1 indicated if E4 hadn't called in another staff by now, why would you call one in at the last moment.
E1 also stated that besides monitoring the clients, its the midnight staff's duty to clean up the facility.

According to E1 the duties of the night staff include major cleaning, such as vacuuming, mopping, dusting, cleaning the bathroom and they are to toilet R1 and R2.

Based on the facility roster and 1/19/05 3:48PM interview with the QMRP, E1, the functioning levels of the facility's residents are 6 Mild, 8 Moderate and 2 with Profound MR (R1,R2).
15 of the 16 individuals are on behavioral programs.
These programs include behaviors such as eloping (R1, R16) and physical aggression (R6, R9,R14,R16).

(A)