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

COLONIAL MANOR — Facility Name
0044610 — I.D. Number

300 CHURCH STREET, ZEIGLER, ILLINOIS 62999 — Address

Reviewed By
JUNE 22, 2005 — Date of Survey

ANNUAL AND IRI OF JUNE 1, 2005 — Type of Survey
Surveyed By

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)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:

> Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. Basic skills required to meet the health needs and problems of the residents.

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:

1) The administrator did not promptly put protective measures in place prior to allowing R9 and the 19 other clients of the facility (R1, R3, R7, R8, R10, R11, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R26 and R27) to remain on the bus and to be driven to the workshop site, approximately six miles away from the facility with the bus driver who slapped R9 and the monitor who was present at the time of the incident.

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

At approximately 9:25 A.M. on 06/10/05, E1 (Administrator) informed the surveyor of an incident that had occurred at the facility at approximately 7:30 A.M.. E1 stated, "The bus driver slapped R9 this morning while they were loading the bus… R9 refused to get off the bus. I notified Z3 of the incident… E6 was the staff who witnessed and reported the abuse…" During this interview, E1 confirmed that she had not interviewed and obtained statements from all persons involved in the incident, nor had she interviewed the interviewable clients that were present on the bus, prior to the bus leaving the facility.

Per interview with E6 (direct care staff) on 06/10/05 at 9:50 A.M., E6 stated "…I put R9 in a seat as directed by the bus driver near the wheelchair lift by the window. R9 didn't want to go in that seat. The bus driver said she has to be turned this way. The bus driver was trying to get her (R9's) seat belt on and R9 hit her. R9 hit her (the bus driver) in her face. The bus driver grabbed her glasses (after R9 hit her in the face knocking off her glasses) and stated, "I don't think so!" She (the bus driver) then hit her (R9) on the left side of her face. R9's face was red and I saw tears come up in R9's eyes… Z3 was on the bus at the time of the incident and but, said he "didn't see" what happened. Z3 works for the workshop (stated name of the workshop) and is supposed to be their aide."

During this interview, E6 confirmed that she had left the bus after the incident and informed E7 (direct care staff) and that R9 had been examined by E8 (Licensed Practical Nurse). E8 then informed the administrator of the allegation of abuse.

b) The administrator failed to assure the adequacy of the bus' monitoring system prior to allowing the twenty clients of the facility to be driven to the workshop site by the bus driver who slapped R9.

Per interview with E1 at 9:30 A.M. on 06/10/05, E1 confirmed that R9 was not removed from the bus nor were the other 19 clients of the facility who were present on the bus. E1 stated, "No, I did not remove R9 from the bus because she had refused to get off. I sent them on because Z2 came over and rode the bus with Z3 to workshop." Subsequent interview with E1 confirmed that Z2 had not actually ridden on the bus on 06/10/05, but had driven his car and followed behind the bus.

The facility neglected to take immediate steps to protect the individual (R9) and 19 other clients of the facility (R1, R3, R7, R8, R10, R11, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R26 and R27) to remain on the bus and to be dirven to the workshop site approximately six miles away from the faiclity with the bus driver who slapped R9 on 06/10/05.

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Per review of the facility's policy and procedures regarding client abuse and/or neglect investigation, the policy identifies that during the investigation, the "accused individuals employed by the facility will be denied access to the resident…" No procedures were noted within the policy to identify what action the facility will take if the perpetrator is not an employee of the facility.

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