COLONIAL MANOR
Facility Name

0044610
I.D. Number

300 CHURCH STREET, ZIEGLER, 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)
350.1060e)h)
350.1230d)1)2)
350.3000d)2)
350.3240a)

The facility shall have written policies and procedures governing all services provided by the facility whiich 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.

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.

There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting of 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.

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.

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(Cont.)

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 2-07 of the Act)

These regulations were not met as evidenced by the following

1) R2 walked out of the facility and ran approximately two blocks down the street when staff attempted to get him to return back into the facility on 05/29/05. The facility neglected to investigate this incident and failed to take corrective action to prevent other potential elopement attempts. As a result of this failure, R2 eloped from the facility on 06/01/05 without staff's knowledge (even though the door alarm system was operable) during a time when five staff members were on lunch, which left only five direct care staff and one QMRP assistant to meet the direct care needs of the forty six individuals of the facility.

Per review of the pre admission information, R2 is a 46-year-old male who was admitted to the facility on an emergency basis on 05/16/05 with diagnosis of Autism.

Per review of the facility's policy and procedures on Accidents and Incidents, all incidents that occur on the facility's premise must be investigated and reported to the administrator. Further review of the policy identified that an Accident Incident Report Form is to be completed and an investigation conducted, "regardless of how minor an accident or incident may be..."

During the interview with E1 (Administrator) on 06/10/05 at 1:50 P.M., E1 stated, "... R2 had another instance prior to the 06/01/05 where he attempted elopement, but he did not get off the property. At that time I instituted close supervision for R2..."

Review of the Nurse's Noted for R2 documentation identified that on 05/29/05 at 3:45 P.M., "Res. (resident) left building. Supervised by staff at (symbol for "at" used) all times. 1 on 1 coaxing to come back in to facility. No behavior problems noted. 1 on 1 remainder of evening."

Per interview with E9 (QMRP Assistant) on 06/10/05 at 3:15 P.M., E9 confirmed that she was on duty on 05/29/05 when R2 attempted to elope from the facility. E9 stated, "... I was notified that R2 was in the parking lot. When we came out of the building, R2 took off running (off the

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(Cont.)

facility's property) and ran past the blue building to the end of the block. We brought him back to the facility and he was placed on 1 on 1 supervision..." During this interview, E9 was not able to recall if R2 remained on one-on-one supervision after the 05/29/05 incident.

Per record review, no Accident Incident Report form was located regarding R2's elopement of 05/29/05. Subsequent interview with E1 (Administrator) confirmed that the facility did not complete an investigation regarding R2's elopement of 05/29/05.

Per review of the Nurse's Notes from 05/29/05 (after R2 eloped from the facility) to 05/31/05, documentation identified that R2 remained on one on one through 05/30/05. No documentation was noted on 05/31/05 that identified the level of monitoring needed to prevent R2 from further elopement.

Per review of the Incident Accident Report dated 06/01/05 documentation identified,
"7:10 P.M. QA (QMRP Assistant) came to nurse reporting hab tech told her that res. (resident) ran out of facility. QA et (and) 3 hab techs immediately left facility to escort res. back.
7:20 P.M. QA et hab techs returned to facility with (symbol for "with" used) res. Res agitated et upset. Unable to obtain V/S (vital signs). Skin assessment done with difficulty. No redness or open areas noted. Res. escorted 1 on 1 to room. 1 on 1 with res initiated at this time..."

Interview with E1 (Administrator) on 06/10/05 at 1:50 P.M., E1 confirmed that R2 was to be closely monitored by staff after his prior attempt of 05/29/05. E4 stated, "E4 (QMRP Assistant) was to be watching him (R2) on 06/01/05. E4 assigned herself to monitor R2 on 06/01/05... E4 and the nurse were to collect staff's statements regarding this incident, but I have not received those statements..." During this interview, E1 confirmed that the facility had checked the door alarm system and the alarms were working on 06/01/05.

During this interview, E1 showed the surveyor the house where R2 was located by staff. As observed, the house is approximately one city block behind the facility.

Per interview with E4 (QMRP Assistant) on 06/10/05 at 3:05 P.M., E4 stated that prior to R2's 06/01/05 incident, "R2 was to be closely watched and staff were to know his whereabouts at all times." E4 also stated that if R2 was in his bedroom, "R2 was to be checked every five to ten minutes" by staff. During this interview, E4 confirmed that door alarms were operating on 06/01/05, but stated, "When staff go out for lunch and leave out of different doors, multiple

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door alarms go off. R20, R23 and R27 also go outside during this time and would have set the door alarms off. You would have to go to the Nurse's Station to find out which door actually had been opened. Staff may have checked the other doors, but may not have checked the end doors (bedroom doors) when they heard the alarm sound."

Observation of the facility's exit doors on 06/10/05 identified that each exit door (north wing, south wing, activity, northwest door dining room door and front door) is equipped with an audible alarm. Observation of the door alarm control box identified that a light goes off and the alarm sounds when any of the six doors are opened. However, as observed by the surveyor and as confirmed per interview with E1 who was present with surveyor during this observation, if you do not see the person leave the building and if you were not at the nurse's station, you would be unable to determine which door a person had opened and exited from. Observation at the facility's nurse's station identified that dual mirrors are installed on the northwest upper wall which are angled to provide monitoring of the north and south wing halls, which are the bedroom areas of the facility. Review of the facility layout identified that R2's room was two doors down from the north exit door.

Ten days after R2 eloped from the facility on 06/01/05, the facility completed their preliminary investigation on 06/11/05. E1 provided the surveyors with copies of staff statements regarding the incident of 06/01/05 on 06/13/05. Review of the facility's preliminary investigation, R2 eloped from the facility without staff's knowledge on 06/01/05 during staff's lunch breaks.

Documentation within the staff's statements and as confirmed per the daily staff schedule for 06/01/05 identified that ten direct care staff (E10, E11, E12, E13, E14, E15, E16, E17, E18, and E19) and one QMRP Assistant (E4) were on duty from 3:00 P.M. to 9:00 P.M.. Further review identified that five direct care staff were sent to lunch at the same time from 6:30 to 7:00 P.M. and that the other five staff were scheduled for lunch from 7:00 to 7:30 P.M.. Review of the staff's statements identified that at 7:00 P.M., E11, E12, E13, E14 and E15 were outside for their lunch break when a "man" approached them and informed them that he had one of the residents at this home. Review of E15's written statement identified, "... I came in to see what resident was gone and tell the nurse, Nurse was seating behind nursing station. I told her what had happened. I checked R2's room, he was not there. Then 4 staff came back with our resident.

Per interview with E1 on 06/10/05 at 3:25 P.M., E1 confirmed that no behavioral plan had been developed to address R2's first elopement attempt of 05/29/05. E1 stated, "I told them to closely monitor him and they were to know his whereabouts at all times." During this interview, E1 confirmed that R2 was placed on one-on-one after the 05/29/05 elopement

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350.620a) 350.1060e)h) 350.1230d)1)2) 350.3000d)2) 350.3240a) (Cont.)	incident and that close monitoring was not continued which resulted in R2 elopement on 06/01/05. E1 also stated that she had not completed her investigation and was waiting for the staff's statements from E4 (QMRP Assistant) and E20 (Licensed Practical Nurse/LPN). During the Daily Status Meeting of 06/10/05, E1 (Administrator) and E5 (Owner) confirmed that they were not aware that five staff were being sent to lunch at the same time. E1 and E5 also confirmed that five staff and one QMRP Assistant were not sufficient to manage and supervise forty-six clients in accordance with their needs.

(A)

CH:jb/AV-COLONIAL MANOR (07-25-05)

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

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