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



COLONIAL APARTMENTS — Facility Name
0038125 — I.D. Number

920 WEST FOURTH, CENTRALIA, ILLINOIS 62801 — Address

Reviewed By
JUNE 8, 2005 — Date of Survey
INCIDENT REPORT INVESTIGATION OF MAY 10, 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):

350.620 a) 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.

350.1060a)c)1)2) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.

There shall be written training and habilitation objectives for each resident that are:

Based upon complete and relevant diagnostic and prognostic data.

350.1060 d)e)h) Stated in specific behavioral terms that permit the progress of the individual to be assessed.

350.1210 b)
350.1230 d)1)
350.3000 d)2) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.

350.3240 a) 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.

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350.3240 a)
(Cont.)

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.

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.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) (A, B)

These regulations were not met as evidenced by the following:

Based on interview and record verification, the facility failed to implement policies and procedures that prohibit neglect of the client for one of one in the incident investigation with the potential to affect 14 of 14 other clients (Rs 2 - 15) when one client (R1) eloped from the facility without staff knowledge.

1) Based on information in the Individual Program Plan (IPP) R1 is a 41-year-old male with a diagnosis that includes Profound Mental Retardation, Encephalopathy, Autistic Disorder, Fragile X, and Severe disorder of perception and Expressive.

The IPP states that R1 is to be on one-on-one supervision due to elopement risk, usually to seek out food sources including a dumpster. The current IPP dated 8-4-04 states R1 will eat food from the trash can, will eat cooked or uncooked food, will eat food that is possibly spoiled, will eat non-food items and is to be "within eye contact, or one-on-one with a staff member at all times" (noted in the IPP under Self Direction) due to this behavior. Per the "Elopement Procedures for [R1] revised and dated 9-7-01, R1 has PICA behaviors which "fixate him on finding food and other hazardous items from dumpsters and trash cans. He will leave the facility in search of dumpsters".

The procedure states that the primary concern is that R1 will be injured by traffic or ingest a harmful substance. Potential dangers, according to the procedure, include, but not limited to: “Traffic, ditches, inedible items, food poisoning, hazardous materials in dumpsters, cuts, getting

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lost, encounters with strangers, inability to communicate injury or illness, inability to disclose identifying information... Hazards near the home: Constant traffic on Fourth Street and Brookside, several large ditches, dumpsters, outdoor equipment at school, construction sites and drainage area in backyard."

Per a report sent to the Department, on the evening of 5-10-05 at 8 PM, a staff member was returning from taking a resident shopping when the custodian from the school next door stated he had just seen a resident walking toward the back of the school. The report submitted to the Department on 5-11-05 by E4, Medical Team Leader, stated the staff went to the back of the school grounds toward the dumpster, R1 had not reached the dumpster and there was no injury and R1 had not ingested any food items. The report ended by saying R1 returned to the facility and there was no injury.

E4 said in interview on 5-31-05 at 2:10 PM that she was not at the facility on the evening of 5-10-05 and the information she sent to the Department was obtained from E2, Qualified Mental Retardation Professional (QMRP).

During the investigation, the surveyor determined per interview with the three direct care staff working on the evening of 5-10-05 (E3, E5, and E7) that it was not known for sure how long R1 was actually gone from the facility, the exact time of the incident, if he actually got and ingested something from the dumpster or if he encountered any of the identified hazards.

During observation of R1 at the facility on 5-31-05, R1 is independent in ambulation, can speak, but tends to repeat what was asked or heard. Attempted interview with R1 on 5-31-05 at 3:30 PM showed that he is a poor historian of events.

Per interview with E5, R1 must have left the building while E5, direct care staff was assisting R5 with his cell phone in the living room, E3, direct care staff, was on a shopping trip with two to three clients, and E7, direct care staff, was assisting another client with a bath.

Per the employee roster, E5 began work at the facility on 3-5-05 and has not completed her habilitation training. E5 stated in interview on 5-31-05 at 2:30 PM that she knew R1 was by the laundry room while she was helping R5 with his cell phone in the living room. E5 said that she then saw R1 walk by the medication room (next to the living room) and that she "did not see [R1] after that." There is no outside exit by the medication room. E5 said that about 2 minutes later, when E3 returned from taking 2 clients shopping, that she said a man pulled up (in a car) in front of the facility and said R1 was by the school. E5 said that by the time she got to the

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school yard to get R1, R1 was at the front door of the facility. E5 said that the staff did no body check on R1 and said there was no evidence he had been in the dumpster (food on his clothing, etc). The dumpster was not observed to see if the lid was up or down, if the dumpster was full, empty, etc. or if R1 took something from the dumpster and hid it. R1's IPP stated that R1 will hide food and eat it days later. E3 said per interview on 5-31-05 at 2:55 PM that she was assisting R8, who is blind and walks with a walker, into the facility from a shopping trip. E3 thought this was between 8 and 8:30 PM on 5-10-05. As she was assisting R8, a man in a car pulled up in front of the facility and said that "we had a resident going toward the dumpster (school dumpster)." E3 said she thought that a staff was in the kitchen preparing evening snacks when she was given this information and she called in the building for one of the staff to "run over there".

E3 thought she recognized the man in the car as a janitor at the school, but could not positively identify the individual. E3 said they checked R1's clothes and hands and had him open his mouth to see if he had ingested anything. She said in years past, R1 would leave trash all over the ground if he got into a dumpster.

E7 said in interview on 5-31-05 at 2:40 PM that she heard E3 come in and say that R1 was next door at [name of school next door], but since she was assisting R14 with a bath, she was not involved with bringing R1 back to the facility. E3 and E5 said that R1 was to be one-on-one supervision.

Throughout R1's IPP, it states he is to have one-on-one supervision / within eye contact to ensure he does not eat large quantities of food, eat inedible items and does not elope. R1 was not in eye contact or provided with one-on-one supervision when E5 was assisting another client and (per E3's interview) in the kitchen preparing the evening snack.

The procedure for R1's elopement states he is to be examined by [name of another facility] nurse for possible injuries following an elopement. There is no evidence the staff working on the evening of 5-10-05 called the nurse. There is no evidence he was examined when he returned to the facility.

R1's IPP states he does not verbally communicate that he is sick, does not usually verbally communicate his preferences and choices. Other than looking at R1's hands and mouth, there is no evidence a body check was done when R1 returned to the facility.

R1 has a formal behavior program for what is identified as PICA behavior in order to "protect his safety and to allow for a more positive public image in regards to table manners." He is to refrain from eating any food other than what is given to him. The program does not address

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that R1 eats inedibles as noted in the IPP and as documented by direct care staff. On 5-1-05 it is documented on a behavior graph sheet (for stealing and eating food) that R1 was outside with staff when he picked up rock and dirt and put it in his mouth. The staff had him spit out the rock and dirt and had him rinse out his mouth. E2 was not aware of this entry regarding ingesting inedible items. R1 had an elopement procedure revised in 2001, but in spite of him needing a one-on-one supervision to prevent elopement (and identified PICA), there was no formal behavior program developed for elopement until 5-11-05, the day after he eloped from the facility. There was only an elopement procedure to follow for R1's elopement behavior.

Per observation with E2 on 5-31-05, the location of the dumpster for the school next door is not in eyesight of the facility. It is located on the other side of the school, which is the property adjacent to the facility. To reach the dumpster, one must walk through the front or back yards (or street) of the facility, across the full length of the school yards, the full length of the back of the school and go to the back of the playground / parking area. On 5-31-05, it took E2 and the surveyor longer than two minutes to reach the site of the school dumpster and longer than two minutes to return to the facility. Per observation with E2, it was verified that it would have been very difficult to travel this course to and from the dumpster in the two minutes identified by E5 interview or five minutes (7:55 - 8PM) noted on the incident report completed by E7 (who was not involved with R1's elopement). In fact, the facility staff was not aware R1 was gone from the facility until an unidentified person in a car brought this to the staff's attention.

The facility has alarms on each outside door. The kitchen, living room and dining room doors have alarms that have a soft, short chirping sound. A rear door located down the resident bedroom corridor, has a louder sustained buzzing sound. E5, who was in the living area with clients said that the door alarms were on and working on the night of E1's elopement, but she must not have heard the alarm.

Per observation at the facility on 5-31-05 and 6-1-05, the door alarm is located by the dining room area and every few seconds emits 2 soft chirps regardless if a door is open or not. If a door, other that the back corridor door is opened, the alarm makes six rapid soft chirps, instead of the two chirps emitted every few seconds. E2 did not know why the alarm made such frequent signals when no door was opened.

The facility failed to implement its policy to prevent neglect by its failure to maintain R1 in eyesight / one-on-one as directed by his IPP to prevent elopement and ensure his safety, and by failing to address his elopement and ingestion of inedible objects in a formal training program.

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