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	14G241	A. BUILDING _____ B. WING _____	C 09/07/2006

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LYNHAVEN	1108 ENGINEER ROAD GRANITE CITY, IL 62040

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W 149	Continued From page 12 resulting in his death on 7/26/06 (R1). Findings include: Refer to W104	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.610a) 350.620a) 350.810a) 350.810c)2) 350.1060h) 350.1070 350.3240a) Section 350.610 Management Policies a) The facility's governing body shall exercise general direction of the facility, and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served. Section 350.620 Resident Care Policies 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. Section 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide	W9999		

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W9999	Continued From page 13 services that meet the total needs of the residents. At a minimum, there shall be at least one staff member awake dressed and on duty at all times. c) The number and categories of personnel to be provided shall be based on the following: 2) Amount and kind of program content, supervision, and personal care needed to meet the particular needs of the residents at all times. Section 350.1060 Training and Habilitation Services h) 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. Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. Section 350.3240 Abuse and Neglect a) 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: Based on observation, interview and record review, the governing body and management has failed to implement their own policies to prevent	W9999		

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W9999	Continued From page 14	W9999		

neglect, when they failed to provide monitoring and oversight regarding the physical safety of R1. This resulted in R1 being in a restricted production area (that was not the day training site that he attended), where he fell from a loading dock on 7/19/06, resulting in his death on 7/26/06 (R1).

Findings include:

1) In review of R1's current IHP (Individual Habilitation Plan), dated 9/2/05, R1 was a 50 year old ambulatory male who was admitted to this facility on 8/3/01. R1 functioned in the moderate range of mental retardation, with additional diagnoses of Diabetes type II and Mental Illness. His current physician's orders document a diagnoses of Bipolar Disorder, and R1 received medications to assist in behavior control. R1's mother, sister and brother were his legal guardians.

An 11/04/05 audiological evaluation documents a severe to profound sensory neural hearing loss for R1. His current IHP states that R1 refused to wear a hearing aid, and that he had been on many programs over the past years with no success. Also, per his IHP it documents that R1's mother stated that he had not worn a hearing aid for about 4 years, as he did not like the buzzing sound in his ears.

In an interview with E3 (Habilitation Technician/Cook), on 8/30/06 at approximately 8:45 a.m., at the facility, E3 stated that R1 could not hear you if you called him from behind (out of R1's vision), and that you would have to go and tap him on the shoulder to get his attention. E3 further stated that R1 could read lips. E4

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W9999	Continued From page 15 (Consulting Nurse) also confirmed that R1 could not hear you if you called to him when his back was to you (same date/time/ interview location). R1's IHP documents that R1 spoke rather infrequently and was only understood by those who knew him. When he spoke he generally used 1 -2 word sentences. His formal communication goal documents that R1 knew some sign language, gestures, said some words and made his needs known. His IHP states that R1, "thinks at a rather literal concrete level; abstract reasoning is essentially absent - there are significant deficits in social judgement, planning, perceptual-motor functioning, etc." It further states that R1 had poor pedestrian skills and did not understand most survival signs; would not ask for assistance if lost and was unable to recite his name, address and phone number; and exhibited socially inappropriate behaviors of mocking and teasing others to the point of making his peers angry. His Major Life Areas Assessment documents that R1 did not recognize and avoid dangerous situations. In review of a resident roster/level of functioning document provided by the facility on 08/29/06, there are 14 individuals who reside at this facility. In an interview with E1 (Qualified Mental Retardation Professional - QMRP), on 8/29/06 at the facility at 12:00 p.m., E1 confirmed that R1 also resided at this facility until his death, which occurred on 7/26/06. In the same interview, E1 confirmed that R's 2, 3, 4 & 6 currently attend the day training site located in Alton, Illinois. R1 also attended this day training site until his death. R's 5, 7, 8, 9, 10, 11, 12, 13, 14 & 15 attend the day	W9999		

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W9999	Continued From page 16 training production site in Granite City, Illinois. In a 7/28/06 faxed document from Residential Options, Inc., the Department was notified of an accident involving R1 at the day training production site in Granite City, occurring on 7/19/06 at approximately 8:45 a.m. In review of a document entitled, "Supervisors Accident Investigation," dated 7/19/06 at 8:45 a.m., signed by Z1 (Bus Driver), the following is documented regarding R1's accident: R1 was on the bus that Z1 was driving. Z1 had pulled up to the entry to the day training/production site in Granite City to drop off the individuals (see above) who attend this site. R's 3 and 4 indicated that they needed to use the bathroom, as did R1, who was holding himself and pointing that he needed to go to the bathroom. Z1 let them off of the bus. R's 3 and 4 returned to the bus, but Z1 was still waiting on R1 when Z2 notified Z1 that R1 had fallen off the dock. A "Supervisors Accident Investigation" dated 7/19/06, signed by Z3, documents that Z3 called 911. This report documents that the side of R1's head was bleeding, nose was bleeding and teeth were knocked out. 7/19/06 notes from Z4 document that R1 had landed on his head and face and that he had a 2 inch cut over his left temple, his nose was bleeding and at least two of his teeth had been knocked out. After arrival at the first hospital, it was found that R1 had a broken zygomatic bone as well as a broken nose and had lost three teeth instead of two. R1 was consequently transferred to another hospital for surgery, as the first hospital did not have the needed resources to care for R1. In review of a document entitled "Chronological	W9999		

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W9999	Continued From page 17 Notes" dated 7/19/06 in R1's personal chart at the facility, it documents that facility staff was notified of R1's accident, and went to the hospital. E5 gave R1's necessary papers to the hospital and asked to see R1. E5 documents that R1 was laying on a bed with a neck brace on and had blood on his head and clothes. His (R1's) eyes were swollen shut and black. His left forehead was bumped, "way out." His nose was full of blood and his left ear was full of blood. 7/19/06 notes from Z4 further document that R1 had a stroke at some time either during transport or when he arrived at the second hospital. 7/20/06 notes (from Z4) document that R1 had a blood clot on the back of his brain. Physician's tried to remove it and when they had, another clot formed again at 80%. This note also documents that R1 was on a ventilator to help him breathe. 7/21/06 notes (from Z4) document that R1 was to have angioplastic surgery to see what could be done - had another bleeder in the back of his brain - right side paralyzed - swelling because body was holding on to excess fluid - physician's placed some kind of monitor in the top of his skull to monitor bleeding and pressure caused by the blood clots - still on the ventilator, but was doing better and had reduced the amount of oxygen being administered. 7/22/06 notes (from Z4) document that R1 was off of the ventilator and breathing on his own. Additional notes on the same day document that R1's blood pressure, heart rate and breathing had stopped and he coded - family did not wish for R1 to be put on life support.	W9999		

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W9999	Continued From page 18 7/24/06 notes (from Z4) document that R1 had taken a turn for the worse - lungs were filling up with blood and had a temperature - family called - started removing all of his IV fluids and the head monitor. 7/26/06 notes (from Z4) document that R1 passed away at 6:00 a.m. on this date. On 8/30/06, at 10:30 a.m., Z4 assisted surveyor on a tour of the Granite City production site where R1's fatal accident occurred. Per Z4, the transportation bus lets individuals off at the Granite City site, then transports the remaining individuals to the Alton site. There are double doors to the entry of this building and the transportation bus parks in front of the doors. These entry doors then access a cafeteria. There is an exit to the cafeteria on the north wall which leads to a small hallway. From this hallway, there are two bathrooms with entrance from the north hallway. Following this small hallway east (right out of the cafeteria) leads one into the production area. In a phone interview with E1 on 9/5/06 at approximately 8:30 a.m., E1 estimated the production area to be approximately 23,000 square feet. On the far northeast wall there are two loading dock doors. On this morning, Z5 was observed actively operating a forklift and there was a truck parked at the far north loading dock door. There is an open space (approximately 3 feet) on the north side and to the left, where the building ends and where the truck backs up to the building. Z4 and Z5 confirmed that this was where R1 had fallen from the dock door plate. Per observation the distance from the dock to the concrete ground area is judged to be approximately 5 feet.	W9999		

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W9999	Continued From page 19 In an interview with Z4 on 8/30/06 at 10:30 a.m., at the Granite City production site, Z4 stated that only clients and staff who work here can be in the production area. (R's 1, 2, 3, 4, & 6 do not attend this day training site - attend Alton site). Z4 further stated that individuals who are to go on to the Alton site get off at this site to use the bathroom. Signed interviews conducted by Z8 and Z9 (Investigators) document the following: Z4 - "At approximately 8:25 a.m. I walked towards the production floor to check on everybody. As I went down the hallway towards the production area, I passed (R1) coming through the cafeteria and heading towards the men's rest room. It was not uncommon as (R1) occasionally left the bus to go to the rest room. I entered the women's rest room. As I exited the rest room, I heard (staff) yelling for me from the production area.....ran to the dock and ...to the accident scene." Z2 - "Around 8:15 a.m., I assisted the PRS (persons receiving services) off the bus and into the cafeteria. I checked off my list...a few minutes later (Z7) approached me saying {there's a man on the production floor}. I responded {a man?} and finished my work, which took about 3-4 minutes." I wondered what (Z7) had meant by a man on the production floor and went to investigate...looked up and saw R1...." Z5 - "I was on the forklift facing south because I was moving product around...noticed an unidentified individual walking at a fast pace...thought the individual might be (another consumer), but then noticed it was not him...(R1)	W9999		

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W9999	Continued From page 20 continued to walk quickly toward (two other staff) and thought he might be going to interact with them near the truck at the dock door...(R1) walked through the opening between the truck and the dock door." In review of a document dated 8/1/06 from Z8 and Z9, entitled "Granite City DT Accident Investigation Summary Report" the following is documented: "What is clear from the investigation is that in some instances, company communications, trainings, instructions and procedures already in place were not adhered to: * ID Badge Policy: Admittance to buildings with secure doors requires badge permitted entrance or an escorted entrance by an employee. Doors are not to be held open for anyone without authorization. (R1) was permitted to enter the building through secure doors although he had no badge to allow admittance. He was also allowed unescorted access to the cafeteria, rest room area and production. * Door Security Communication dated 4/21/05 regarding access to Admin Building and DT Centers: All visitors must (underlined and highlighted) be escorted by a staff person if they are in the building. If you are unfamiliar with any visitor who is in the lobby, please ask that person who they are in the building to see and offer to go get the staff person for them. As a visitor in the building, (R1) should have been escorted through the building. Additionally,	W9999		

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W9999	Continued From page 21 although according to witness statements the event happened very quickly, at least five employees noticed (R1) as an unidentifiable visitor in the building and only one attempted to approach him to discover his purpose for being in the building. One employee attempted to contact (R1) verbally, but according to his statement, only a few steps before the dock. * Accident Investigation Procedures/Practices: As trained in Accident Investigation Training as recent as January 27, 2006, all eyewitness accounts of any accident should be recorded, as soon after the accident as possible, individually through a manager's accident investigation interview. The initial accident reports gathered from this investigation were the results of the manager's random distribution of accident report forms, either handed out at the worker's work location, or handed out in the manager's office with instructions to complete the form and return to the manager. There was no attempt by any manager to hold interviews with any of the eyewitnesses to develop detailed accident reports regarding the accident. Additionally, all eyewitnesses should be isolated from other witnesses to maintain the independent credibility of each witness account of the accident. Eyewitnesses were allowed to arbitrarily complete the accident investigation forms at their leisure, at the location of their choosing, without regard to the possibility of collaboration or conversation on the part of the eyewitnesses. Some reports were filled out in the manager's office, others outside the office, some on the production floor, all with direct	W9999		

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W9999	Continued From page 22 accessibility to other employees. In review of a policy entitled "ID Badge Policies," revised 1/22/06, it stated, "Admittance to buildings with secure doors requires badge permitted entrance or an escorted entrance by an employee. Doors are not to be held open for anyone without authorization." Review of a memo dated 4/24/06 regarding "Door Security," states, "As you know, the Administration Building and all D.T. centers have limited access to their lobbies....All visitors must (highlighted and underlined), be escorted by a staff person if they are in the building. There have been a few recent cases of unauthorized visitors in the building as a result of staff allowing them inside the building, either by opening the door for them, or allowing the visitors to follow them in after staff have swiped their badges to gain entry. Doors are secured for a reason and when you allow someone to enter the building, all security becomes null and void." (This memo is from the Executive Coordinator). In a phone interview with E1 on 9/1/06 at 2:00 p.m., E1 confirmed that the policy entitled "Human Rights Committee Procedures - ICF/DD" is the facility's abuse/neglect policy. Under "FUNCTION" it states that the purpose of this policy it to, "ensure that all agency policies and procedures are followed regarding.....protection and advocacy (internally and externally)...."\ In review of this policy NEGLECT is defined as follows; "Any act of omission by a community agency or facility or employee thereof that	W9999		

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W9999	Continued From page 23 endangers an individual's health or safety or fails to respond to an obvious and immediate need of an individual, regardless of whether or not there is an injury; Any act or omission by a community agency or facility or employee thereof that results in any documented physical injury to an individual, the circumstances or nature of which would cause a reasonably prudent person to believe neglect by the community agency or facility has occurred. Consideration shall be given to whether the injury was repeated or preventable...." (A)	W9999		