STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G205	A. BUILDING _____ B. WING _____	C 08/15/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANNER PLACE	**321 CHESTNUT STREET PARIS, IL 61944**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 46 LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1230b)2) 350.1230b)3) 350.1230b)5) 350.1230b)6) 350.1230b)7) 350.1230c) 350.1230d)2) 350.1230e) 350.3240a) 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 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 2) Evaluation study, program design, and	W9999		

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W9999	Continued From page 47 placement of the resident at the time of admission to the facility. 3) Periodic reevaluation of the type, extent, and quality of services and programming. 4) Development of discharge plans, and the referral to appropriate community resources. 5) Training in habits in personal hygiene and activities of daily living. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. 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) Based on observation, interview and record review, the facility has failed to implement their system to prevent neglect for R1 when: 1a) The facility failed to take sufficient steps to reduce the probability of further	W9999		

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W9999	Continued From page 48 falls/fractures/injuries, for an individual with a known history of falls/fractures/injuries (R1). 1b) The facility failed to take sufficient steps to reduce the probability of further purposeful falls, for an individual with documented purposeful falls (R1). 1c) The facility staff failed to consistently implement R1's informal toileting schedule and R1's 15 minute checks when R1 has documented incontinence, a history of falls (recent fracture 5/06 from slipping in own urine), documented non-compliance with accepting ambulation assistance, and documented purposeful falling. The facility has also failed to implement their system to prevent neglect for R2 when: 2a) The facility failed to adequately monitor and intervene in a timely manner regarding R2's physical safety and level of supervision given his documented behaviors of leaving the day training building and/or property. (2b) The facility failed to ensure that the facility's Human Rights Committee reviewed and approved R2's day training behavior plan, which includes restrictive techniques. (2c) The facility failed to ensure reproducible documentation for notification and/or prompt notification to R2's guardian regarding R2's leaving the day training building and/or property. (2d) The facility failed to report R2's elopements from the day training property to the Department. (2e) The facility staff failed to provide sufficient	W9999		

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W9999	Continued From page 49 monitoring regarding R2's physical safety at the residential site. Findings include: 1a) The facility failed to take sufficient steps to reduce the probability of further falls/fractures/injuries, for an individual with a known history of falls/fractures/injuries (R1). In review of a resident roster that validates level of functioning, R1 functions in the severe range of mental retardation. R1's current physician's orders document that R1 is a 45 year old female with additional medical diagnoses of Seizure Disorder, Anoxic Encephalopathy, and Psychosis. These physician's orders further document that R1 receives the following medications to assist in seizure control: Dilantin 100 mg. caps, l capsule two time a day; Keppra 750 mg. tabs, l tablet two times a day (may cause drowsiness - per Medication Administration Record {MAR}); and Depakote 500 mg. tabs, 2 tablets 3 times a day. R1 also receives Risperdal .5 mg tabs, l tablet a.m. and 2 tablets at bedtime for her Psychosis. R1 receives Benztropine .5 mg tabs, l tablet every a.m. for the effects of Risperdal (may cause drowsiness - per MAR). There is a 6/27/06 facility nursing note documenting an increase in R1's Risperdal to l mg in the a.m. and 2 mg at hs (bedtime), due to R1's increase in yelling, screaming, being moody and irritable. R1's current IPP (Individual Program Plan) of 2/17/06 documents that R1 has a state guardian. In further review of R1's current IPP, the following is validated: R1's, "motor skills are very limited to negligible;	W9999		

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W9999	Continued From page 50 her performance is comparable to that of the average individual at age 3-7." (R1), "demonstrates marginally serious problem behaviors...needs frequent support, much more than others her age, primarily because of very limited to negligible adaptive behavior." (R1's), "toileting skills are very limited to negligible...does require staff assistance in bathing, but this (is)related to unsteadiness and her seizure disorder not to hygiene related issues...continues to use a walker for proper ambulating...continues to (be) incontinent and requires verbal prompting to make it to the restroom on time...on a formal program for toileting...prompted through the night to use the restroom to avoid bed-wetting." "Her major needs are social behaviors and safety...safety for mobility....is on a formal behavior program...exhibits verbal and physical aggressive outbursts...." A nurses quarterly health status of 10/25/05 documents a "shaky gait." A nurses health history and assessment dated 1/30/06 documents, "weak grasp (and) ankle strength - unsteady gait." Observations were made at the facility on 6/16/06, 6/20/06 and 7/12/06 in the p.m., after R1 returned from her day training site. R1 was observed to utilize a roller walker, helmet and gait belt, with staff assist at all times. In review of R1's personal chart and her most current IPP, R1's most current occupational therapy evaluation (OT) is dated 10/27/2004. Per this evaluation it states that R1's caregiver reported that R1's balance and walker safety have decreased; reported recently adjusted seizure medications, but has not impacted and	W9999		

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W9999	Continued From page 51 R1 continues to fall. Caregiver stated that R1 continues to fall, but stated that her ability to complete activities of daily living at home or work has not decreased. No further skilled OT was recommended at this evaluation. In review of R1's personal chart and her most current IPP, R1's most current physical therapy evaluation (PT) is dated 12/29/05. Under recommendations it states to continue use of the gait belt and staff assist for ambulation and activities; no further skilled PT needed. In review of R1's Individual Performance Evaluation Form, completed by the day training site on 8/16/06, it documents the following: "(R1's) overall health has declined some - she becomes sleepy & repetitive in her motions which slows her down...mobility limitations, slow due to decline health issues...has incontinence issues...often does not use walker safely." Safe ambulation is listed as a goal at the day training site. Review of R1's current facility programs document that R1 has a current safe ambulation program (3/1/05 - revised 11/7/05 - revised 4/1/06). Per this program, R1 asked her physician for a gait belt during a medical appointment. The physician was in agreement. R1 is to use the gait belt when she rises from a seated position and upon ambulation from one place to another and staff are to physically assist R1. Additionally, R1 is to always use her walker. When R1 gets up out of bed she will sit on the edge of the bed, call for staff assistance and wait until she feels steady before getting up. Staff are to document each day that R1 informs staff before attempting to ambulate on her own without	W9999		

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W9999	Continued From page 52 assistance. R1 also has a current toileting program (3/1/05 - revised 11/7/05 - revised 4/1/06). This program states that R1 is sometimes incontinent due to lack of self awareness that she needs to go to the bathroom. This program further documents that R1 also has a seizure disorder and limited mobility skills and that R1 requires physical assistance with the use of a walker and gait belt when she is ambulatory to minimize any falls. Per the program, staff are to ask R1 if she needs to use the restroom if R1 does not report having to use the restroom after a period of one hour. Staff are to observe R1 every 15 minutes and inquire if she needs to use the restroom. In review of R1's 2/17/06 IPP, seizure report documents, accident reports from the day training site, bed checks and facility progress notes (P-15's), falls/fractures/injuries and seizures for R1 are as follows: 8/20/05 - emergency room visit due to fall with a cut to back of head that was bleeding - 2 staples to scalp - saw physician on 8/30/05 for increase in loss of coordination - Ditropan discontinued - increased Dilantin level thought to be reason for shakiness and increased falling. 9/16/05 - was seen in the emergency room after a fall and head injury - bruised face and sprained left thumb - wear splint, apply ice pack to head and thumb and follow up with physician in 5 days. 9/20/05 - saw physician for follow up - recommended CT scan of facial bones - CT was completed - results showed fracture of left nasal bone and left sinus fracture.	W9999		

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W9999	Continued From page 53 1/3/06 - at the day training site at 3:00 p.m. - getting ready to go home - reaching for her coat with one hand on the walker - lost balance - walker tipped over - R1 fell backwards into cab (cabinet) drawer - staff unable to prevent fall - ice pack to lower left back - recommend to review walker rules with R1. 3/14/06 nursing notes document an occasional bruise on leg from hitting/bumping on bed or chair. 4/22/06 - seizure report documents a seizure at 12:05 a.m., discovered by direct care staff - no injuries. 5/3/06 - 8:55-8:57 p.m. - this report describes a seizure where R1 fell and lost consciousness - no injuries reported. 5/5/06 - Nightly bed checks document, "(R1) RR {restroom} 12:00 wet at bedroom door." 5/20/06 - Per facility progress notes (P-15's), it documents that at 2:40 a.m. E12 (direct staff person) went to assist R1 to the restroom. As R1 got near the restroom door, she urinated on the floor, slipped and fell. R1 complained of her left ankle hurting. (A 5/22/06 radiology report documents a hairline fracture of the lateral malleolus. There is a physician's order for a wheelchair with elevating leg rests (5/22/06) and a 5/23/06 physician's order which states that R1 may return to work as long as she is non-weight bearing. Nurses notes of 5/23/06 also document an ankle length boot for support. A physician consult report of 6/6/06 documents that R1 may walk with walker and wear a regular shoe, but to keep foot elevated when sitting. On 6/23/06 a	W9999		

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W9999	Continued From page 54 radiology report states that the previously noted fracture of the lateral malleolus cannot be appreciated in the foot x-rays). 6/3/06 - 3:43 a.m. - Facility progress notes (P-15) document an approximate 4 minute seizure, (discovered when direct care staff went to check on another individual). 6/6/06 - Nightly bed check at 2:15 a.m. documents that R1 was, "starting to the RR (restroom) by herself WET." 6/7/06 - 8:30 a.m. (at the day training site) - As R1 stepped off the van, her knees appeared to buckle and she fell on to the ground - no injuries, but R1 was very shaky and unsteady, so staff had R1 transfer to a wheelchair - facility notified 6/7/06. 6/8/06 - 11:00 a.m. - Per a facility P-15 progress note, it states that E5 (direct service person) heard R1 yell for help in her bedroom. E5 found R1 sitting on the floor with her recliner tipped towards her. R1 stated that she got up to go to the bathroom. E5 asked why R1 did not ask for assistance. R1 stated that she didn't want to, that she wanted to fall. E5 assisted R1 to her feet and assisted R1 to the restroom. 7/4/06 - 7:27 a.m. - Per a facility P-15 progress note, it states that E5 (direct service person) heard E8 (direct service person) yell for E7 (direct service person), to help with R1, as R1 had fallen. E5 observed R1 lying on her right side on the floor. R1's right buttock and right leg were under the bed. The right side of R1's head was resting on the lower shelf of the night stand. There was a documented abrasion similar to a	W9999		

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W9999	Continued From page 55 rug burn on R1's left knee (one inch long by 1/2 inch side). On the upper right side of R1's scalp where her helmet would rest, there was a light pink area (2 inches long and 1 inch side). 7/7/06 - 2:30 p.m. - Per a facility P-15 signed by E13 (direct service person), it documents that E13 observed a bruise on R1's right foot at the base of her great toe, running to the third toe, brown in color. When asked, R1 stated that it was from her fall on 7/4/06. R1 later told E4 {on 7/12/06 while E4 was waiting with R1 in the physician's office}, that she had not hurt her toes on 7/4/06, but that she had gotten up at night and kicked her cabinet, without calling for assistance. No one knew of this new information until this doctor visit. When asked, R1 further clarified that she kicked the cabinet that her television sets on. E4 stated that R1 told the physician the same story about, "getting frustrated with myself," and kicking the cabinet. When further questioned R1 stated that she had gotten up the night before the lady came - referring to the physical therapy appointment of 7/11/06 - would have occured on 7/10/06). E4 shared R1's new information with surveyor on 7/12/06 at 6:15 p.m., after R1 and E4's return from the physician's office. An x-ray taken on 7/11/06 (per nursing notes of 7/12/06) documents a non-displaced fracture - surgical boot on - in wheelchair - non-weight bearing. Radiology report documents undisplaced fracture lateral aspect base of the proximal phalanx 2nd toe. Nurses notes of 7/13/06 document an additional impaction fracture of the right large toe - R1 is to continue to wear the surgical shoe for 3 weeks, may return to work and use walker and gait belt.	W9999		

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W9999	Continued From page 56 In an interview with E1 on 6/20/06 at the facility at 10:30 a.m., E1 confirmed that R1's current IPP of 2/17/06 was the most current IPP for R1 and that there have been no special IDT's held regarding R1's falls/injuries/recent fractures. The last revision to R1's toileting program is documented as 4/1/06 (5/5/06 - up in night, wet, without calling for assistance; fell on 5/20/06 in own urine, resulting in fractured ankle; 6/6/06 up at night, wet, without calling for assistance); and the last revision to her safe ambulation program is documented as 4/1/06. (An emergency IDT was held on 7/13/06 after the Department called an Immediate jeopardy on 7/12/06). In an interview with E7 (direct service person) at the facility on 6/23/06 at 11:42 a.m., E7 stated that she has worked here for about 5 years and has worked all shifts, including the night shift. E7 stated that she does not hear R1 get up in the night if she is at the other end of the facility folding clothes or doing laundry. E7 stated that there is always work to be done on the night shift, such as cleaning the kitchen, laundry as well as completing rounds to check on individuals during the night. E7 stated that sometimes R4 (R1's roommate) will call out when R1 gets up out of bed on her own. E7 further stated that R1 does not always call for staff help (getting up at night) as she is supposed to and that when she does get up on her own in the night she does not use her helmet or walker. E7 also stated that by the time she gets to R1, R1 will already have been incontinent. Since R1's 2/17/06 IPP R1 has experienced the following: a) 3/14/06 - occasional bruise on leg from hitting/bumping bed or chair; b) 5/3/06 - seizure/fell/lost consciousness; c) 5/5/06 -wet at	W9999		

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W9999	Continued From page 57 bedroom door (12:00 a.m.); 5/20/06 - urinated on floor - slipped and fell - left ankle fracture requiring ankle boot/wheelchair/non-weight bearing; d) 6/3/06 - 4 minute seizure at 3:43 a.m.; e) 6/6/06 - 2:15 a.m. -starting to bathroom by self - already wet; f) 6/8/06 - unobserved fall to floor with recliner tipped towards her - stated wanted to fall; g) 7/4/06 - unobserved fall in room - neurological checks implemented; h) 7/11/06 - two right toe fractures - stated kicked cabinet out of frustration. Per record review, R1's most recent occupational therapy evaluation is dated 10/27/04. Since the 10/27/04 evaluation, R1 has experienced the following: a) 8/20/05 fall requiring 2 staples to the head; b) 9/16/05 fall and head injury resulting in a bruised face and sprained thumb (requiring a splint), a fracture of the left nasal bone and left sinus fracture; c) 1/3/06 fall at the day training site resulting in a back injury; d) 3/14/06 nursing notes that document R1 receiving occasional bruising from hitting bed or chair; e) 5/3/06 - seizure/fell/lost consciousness; f) 5/5/06 - wet at bedroom door at 12:00 a.m.; g) 5/20/06 fall at the facility resulting in ankle fracture; h) 6/17/06 - fell to knees exiting the bus at daytraining - shakey, unsteady, - weelchair utilized; i) 6/8/06 fall at the facility with recliner tipped towards R1; j) 7/4/06 fall with neurological checks implemented; k) 7/11/06 x-ray diagnosing two toe fractures (R1 stating that she kicked her cabinet). Per record review, R1's most recent physical therapy evaluation is dated 12/29/05. (See paragraph above for falls/injuries/fractures/seizures since 12/29/05). When surveyor requested of E1, the most current	W9999		

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W9999	Continued From page 58 occupational and physical therapy evaluations for R1, no additional evaluations were presented. R1 has not had an occupational therapy reassessment since 10/27/04 and has not had a physical therapy assessment since 12/29/05; and has continued to experience falls, injuries and fractures. R1 has not been reassessed regarding the possible need for additional adaptive equipment in her various environments and has not been reassessed regarding the possible adaption of her environments to increase her physical safety (residential setting/bathing/living/sleeping areas - day training site - transportation - community). Additionally, on 6/16/06 at 3:15 p.m. at the facility, surveyor requested further documentation on R1's bruises (3/14/06 nursing notes) regarding R1, which state that R1 will have an occasional bruise noted on her leg or thigh from hitting or bumping her bed or chair. When reviewing R1's incident/accident information (documented on facility P-15's), no documentation was found for bruises related to hitting herself on her bed or chair. No further information was presented to surveyor as of exit date. An observation of R1's room was made on 6/23/06 in the a.m. with E6 (direct service person). As one enters the room, on the left wall is a sliding door closet for R1 and her roommate. Per observation, R1's night stand is to the left of R1's bed at the head of R1's bed, both of these pieces of furniture placed against the next right angle wall. The night stand is square in shape, with a square edged top. R1's bed has four raised posts that are also square in shape and the top of the posts approximate the height of the surveyors upper thigh. There is a space between R1's bed and R1's roommates night stand and bed which are also placed	W9999		

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W9999	Continued From page 59 against this wall. The wall parrallel to the closet wall has a window. Against the wall parallel to the beds/nightstands wall, two chest of drawers with a television on top of each and a small cabinet in between the chests of drawers. R1's night stand, bed and chest of drawers are situated closest to the entry door to the room. The room allows for a path to the closet, a path in between the beds, a path to R1's roommates bed between the bed and the window wall, and a path into the room to access the chest of drawers, with no further space available. When asked, E6 stated that R1's bedroom has not been rearranged or changed in a long time and could not recall the furniture being resituated after any of R1's falls or accidents in her room (in order to possibly increase R1's safety and prevent further bruises/falls). Per surveyor observations since 06/16/06 through 08/03/06, R1's room has not been rearranged. Per review of facility progress notes (P-15's) for R1, R1 experienced a fall in her room on 7/4/06 in the a.m. and her head was resting on the lower shelf of her night stand. Neurological checks were initiated. 1b) The facility failed to take sufficient steps to reduce the probability of further purposeful falls for an individual with documented purposeful falls (R1). R1 has a diagnosis of Psychosis,(see example 1a for additional diagnoses and history), and receives medication to assist in behavior control. A 6/27/06 note documents an increase in R1's Risperdal to 1 mg in the a.m. and 2 mg at bedtime, due to an increase in R1's yelling, screaming, being moody and irritable. Per her current IPP, R1 "demonstrates marginally serious problem behaviors ...needs frequent support,	W9999		

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W9999	Continued From page 60	W9999		

much more then others her age, primarily because of very limited to negligible adaptive behavior...major needs are social behaviors...is on a formal behavior program...exhibits verbal and physical aggressive outbursts...."

R1 also has a behavior management program (most current revision is documented as 3/7/06), that is to be implemented at the residential facility and at the day training program. Per this program, R1 can be observed on a weekly basis crying, yelling, cursing others, throwing her walker and other aggressive type behaviors. R1 often describes herself as sad and ugly and states that no one wants her. Per the program, R1 will make positive statements about herself and will inform staff when she is feeling sad and participate in an activity that makes her feel good.

In review of a facility progress note (P-15) dated 6/8/06 at 11:00 a.m., after R1 experienced a fall in her room (recliner tipped towards her), E5 asked R1 what she was trying to do. Per this note, R1 stated, "get up and go to the bathroom." When E5 asked R1 why she didn't ask for assistance, she stated she didn't want to, she wanted to fall. There is an additional note at the bottom of this same progress note signed by E1. Per this note E1 documents that she talked with R1 about her not requsting assistance when she wants to ambulate. Again, informed R1 that she could get hurt if she falls.

R1's 8/16/05 Individual Performance Evaluation form, completed by day training staff, documents that R1 is an attention seeker and may fall on purpose and is easily frustrated and gives up.

In an interview with E1 at the facility on 6/20/06 at

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W9999	Continued From page 61 10:30 a.m., E1 stated that she has counseled R1, as some of R1's falls are intentional. When asked if she wants to fall, R1 states that she does. E1 stated that when R1 falls, she gets attention (medical and staff). In an interview with E8 (direct service person) at the facility on 6/23/06 at 8:30 a.m.., E8 stated that R1 tells staff that she wants to hurt herself, that R1's intentional falling is an attention getting issue and that R1 is, "doing this more" (intentional falling). In review of R1's current IPP of 2/17/06, there is no reproducible documentation that R1's purposeful falling has been tracked or further assessed and this behavior is not mentioned in R1's IPP. Additonally, review of her current behavior management program does not address her purposeful falling. 1c) The facility staff failed to consistently implement R1's formal toileting schedule and R1's 15 minute checks, when R1 has documented incontinence, a history of falls; documented non-compliance with accepting ambulation assistance and documented purposeful falling. R1 (see diagnosis in example 1a) has a current IPP dated 2/17/06 that documents her toileting skills as limited to negligible. R1 has a formal toileting program throughout the day and, "is prompted through the night to use the restroom to avoid bed-wetting." In an interview with E8 on 6/23/06, at the facility at 8:30 a.m., E8 stated that she has worked here for 8-81/2 years. E8 confirmed that R1 is	W9999		

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W9999	Continued From page 62 incontinent of urine and also stated that R1 utilizes disposable briefs. E8 stated that staff wake her up, (at night), "when we get time...approximately every two hours...is always wet...when she tells us (that she is wet), is too late most of the time...". E8 stated that staff puts on her helmet, walker and gait belt when assisting her to the bathroom at night. E8 stated that when staff assist individuals to get up to go to the bathroom at night, it is documented on the nightly bed checks. In review of the nightly bed checks for R1 from 5/1/06-6/22/06 there is no documentation that staff attempted to assist R1 to the bathroom on the following dates: 5/25, 5/30, 5/31, 6/1, 6/2, 6/2, 6/4, 6/12, 6/13, 6/15, 6/16, 6/19 and 6/22. On 5/5/06, it documents that staff found R1 wet at her bedroom door at 12:00 p.m. (The nightly bed check form is set up to start at 11:00 p.m.). There is no documentation that staff had prompted R1 to the bathroom prior to this time. On 6/6/06 the nightly bed checks document that at 2:15 a.m., R1 was up and starting to the bathroom by herself and was already wet. There is no reproducible documentation that R1 was offered or prompted to go to the bathroom prior to this. Facility progress notes (P-15's) document that on 7/4/06 in the a.m. R1 was found in her room after a fall. R1 received a knee abrasion and a 1/4 inch scratch on her nose, and neurological checks were initiated as R1's head was resting on the lower shelf of the night stand when found. Per a progress note of the same day, when E1 was notified, E1, "recommended 15 minute bed checks tonite." In review of the bed check documentation, the documentation begins on	W9999		

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W9999	Continued From page 63 July 5th at 11:30 p.m. (none presented for July 4th) and ends on July 6th at 7:15 a.m. The next 15 minute bed checks are dated July 10th and begin at 11:30 p.m., ending in the a.m.of July 11th at 6:30 a.m. No other reproducible documentation was presented regarding the 15 minute bed checks. In an interview with E1 on 7/12/06, E1 stated that she had told E5 to "eyeball" R1 every 15 minutes. Surveyor asked if E1 meant for the 15 minute checks to be only at night or 24/7. E1 stated, "yes" that she meant 24/7. E1 then asked E4 if she had any documentation on R1's 15 minute checks. E4 asked if E1 meant the 15 minute bed checks. Surveyor again confirmed with E1 that her instructions to staff were for 15 minute checks 24/7 and again E1 confirmed that that was her intention. (As documented above, per this latest diagnosed fracture of 7/11/06 involving two toes), R1 will be required to wear a surgical boot for three weeks, in addition to her usual adaptive equipment of a helmet, gait belt and walker. When R1 returned to the facility on 7/12/06 in the p.m., R1 was utilizing a wheelchair, as R1 had to be non-weight bearing until seeing her podiatrist the next a.m. Additionally, physician's orders on this date prescribed Motrin 600 mg. po every 8 hours for 3 days and ice every 2-4 hours as needed). R1 has a documented history of falls, injuries, sprains and fractures; a documented history of maladaptive behaviors, including wanting to fall, refusing to call for assistance when ambulating, verbal and physical aggression; a documented history of incontinence (with a recent ankle fracture after falling in own urine); two current medications documented as having the possibility	W9999		

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W9999	Continued From page 64 of causing drowsiness; documented inconsistency in implementing R1's informal toileting schedule at night; and documented inconsistency in implementing every 15 minute checks as per Facility Representative's (E1's) instructions; and the facility has failed to take corrective action to reduce the probability of future falls/fractures/ injuries. 2a) The facility failed to adequately monitor and intervene in a timely manner regarding R2's physical safety and level of supervision given his documented behaviors of leaving the day training building and/or property. In review of R2's current Individual Service Plan (ISP) of 5/18/06, R2 functions in the severe range of mental retardation (Intelligence Quotient of 22 on the Leiter International Performance Scale), with an overall adaptive behavior comparable to that of an individual age 3 years/3 months. Additional diagnoses include Down Syndrome, Impulse Control Disorder, Primary Insomnia, Obsessive Compulsive Disorder, Psychosis, Seizure Disorder and Alzheimer's Disease. R2 receives medication to assist in his behavior control and R2's sister serves as his legal guardian. R2's ISP also documents that R2 utilizes sign, gestures and items from his environment as prompts to supplement and augment his limited verbal skills of typical one word phrases. In observations made at the facility in the a.m. and p.m. on 8/2/06, R2 is ambulatory and relies essentially on gestures to communicate to staff. His current ISP further states that, "His judgment is poor...Further, (R2's) diagnoses of Alzheimer disease, Compulsive disorder and Psychosis NOS also interferes with comprehension and awareness of surroundings."	W9999		

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W9999	Continued From page 65 Under the DISCHARGE PROGNOSIS in R2's ISP, it states that R2 is unable to use public transportation or go into the community independently. Under SELF DIRECTION, it states that when R2 does not understand what is expected of him or if expectations are too high for him, he usually responds by wandering, or walking away from situations that are too difficult for him. Under INITIATIVE it states that due to poor response to safety issues and poor judgment, R2 is unable to work in an unsupervised arrangement. A 5/24/06 Individual Performance Evaluation Form completed by R2's case manager at his day training site documents the following: "(R2) will leave the assigned work site. Needs constant supervision..Needs a lot of one on one assistance. Needs a lot of redirection. Needs supervision (safety issues)...leaves assigned worksite frequently...." This evaluation also documents that R2's obsessive behaviors often lead to wandering behaviors. R2's summary of his 1/5/06 Scales of Independent Behavior Revised is as follows: "Overall, (R2) demonstrates moderately serious problem behaviors. He demonstrates moderately serious internalized maladaptive behaviors, including withdrawal or inattentive behavior, unusual or repetitive behaviors, including socially offensive and uncooperative behavior. He demonstrates marginally serious externalized maladaptive behaviors, including disruptive behavior and hurting other. The problem that causes the most concern is wander behaviors and overeating."	W9999		

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W9999	Continued From page 66 In review of R2's current facility behavior program within his personal chart and in his program book that residential staff utilize when implementing programs, R2's program addresses his verbal aggression (defined as yelling loudly while shaking his fist or hitting his head; and addresses his physical aggression (defined as hitting, kicking, or striking objects. Review of a facility form (Maladaptive/Adaptive Behavior Recording Form) documents that data is collected on: taking food from others, taking food from trash, hitting and screaming. Per the program, direct service personnel will follow this program across all environments. While at the day training site on 8/3/06, Z3 presented surveyor with a Behavior Management Plan for R2 that is specific for R2's day training site. This behavior plan is dated 1/16/06. Under the rational for this program, it states that R2 has been wandering from his assigned work site to other parts of the building, including the laundry and the reception area. The adaptive behavior to be supported is that of staying in his assigned area. It further states that R2 may leave the classroom to put away his papers, use the restroom or brush his teeth. Per the program, R2 is allowed to remain unsupervised for 5-10 minute periods. Redirection is utilized with CPI (Crisis Prevention Intervention) as a last resort. In an interview with Z3 at the day training site on 8/3/06 (Z4 also present) at 11:30 a.m., Z3 stated that R2's leaving the day training building behaviors was not an issue prior to R2's fracturing his finger, and it was after the fracture that his leaving the day training building behaviors began. (Per facility nursing notes dated 6/7/06 R2 fell and the subsequent	W9999		

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W9999	Continued From page 67 diagnosis was a fracture of R2's small finger of his right hand). R2 has had subsequent visits to the hospital (which is located within visual and walking distance of the day training site). Z3 also stated that there are staff from the day training site who walk up and down the entry road when going over to the hospital to bring food back for their lunch. Z3 stated that R2 has seen staff coming back with food and believes that he is further motivated by the food and is possibly trying to go to the hospital to obtain food. A review of day training incident reports (presented by the facility on 8/2/06 per surveyor request), document R2's wandering behaviors and other maladaptive behaviors occurring WITHIN the day training building: 2/9/06 - 11:25 a.m. - approached another consumer and took this consumer's lunch meat - staff threw lunch meat in trash - (R2) hit staff. 2/13/06 - 10:15 a.m. - left classroom - found with staff's telephone handset talking into handset - prompted to leave room- went into another staff's office and began taking things off of her shelf. 2/13/06 -- 1:20 p.m. - had taken completed craft to the coatroom and returned with a pair of black leather gloves belonging to a staff person. 3/1/06 - 10:30 a.m. - (R2) stood up and patted front of pants indicating need to go to restroom - went to check on him and found (R2) in hallway with pants and undershorts below his knees - got him back into the restroom and told him to wait for clean clothes - when staff returned was again in hallway with no pants or underwear on.	W9999		

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W9999	Continued From page 68 3/1/06 - 2:15 p.m. - had not returned to classroom after break - went looking for him - trying go get into reception area through the door. 5/25/06 - 11:40 a.m. - stole from another consumer's lunch - then attempted to retrieve it from the trash after it was thrown away - three additional attempts to take food from this consumer's lunch. 7/21/06 - 9:45 a.m. - refused to dress himself and followed staff outside (semi nude) into the reception area. (R2) was holding his underwear and shorts in his hand, refusing prompts to put them on. 7/21/06 - 1:35 p.m. - taking bag of chips out of trash can and tried to eat them - staff removed chips from him. 7/25/06 - 11:00 a.m. - came from the bathroom to client breakroom, with no clothing on from waist down. 7/24/06 - 9:00 a.m. - had taken another consumers food and also tried to get into the trash can. 7/24/06 - 9:15 a.m. - sitting in the breakroom, eating an old "TV" dinner left over from Saturday's staff laundry lunch. 7/26/06 - 1:30 p.m. - attempted to steal another consumer's potato chips -shook fist at staff and yelled. Per observations made at the day training site on 8/3/06 and 8/8/06 the following is a description of the day training physical site in relation to the	W9999		

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W9999	Continued From page 69 hospital: From Court Street (a two way street which runs east and west), the city hospital has two access entrys from this street. The second access (turning north from Court Street) is an asphalted two-way drive which accesses not only the hospital, but also the day training site. In an interview with Z3 on 8/8/06 at the day training site at 12:00 p.m., Z3 stated that she estimated the distance of this asphalt drive (from Court Street to the front of the day training site), as one-quarter of a mile. On the west side of the drive is the hospital building, the current ambulance entrance and the old ambulance bay. (The hospital is closest to Court street, the ambulance entrance next and the old ambulance bay is closest to the front of the day training entrance). In an interview with Z3 on 8/8/06 at 12:00 p.m., at the day training site, Z3 stated that this entrance is the entrance that the ambulance service utilizes. On the east side of the drive is a public parking lot. In an interview with Z3 on 8/8/06 at 12:00 noon at the day training site, Z3 estimated that from the front of the day training building entrance, this portion of the parking lot closest to the day training site was approximately 200 feet away. When turning into the asphalt drive from Court Street the drive also curves around to the west side of the hospital, where another parking lot is located. From this same drive there is a curved asphalt drive that curves around both sides of the day training site. The east side of this drive is utilized for staff and visitor parking. The west	W9999		

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W9999	Continued From page 70 side of the drive is utilized as an access to the back of the building. In an interview with Z3 on 8/8/06 at the day training site at 12:00 p.m., Z3 stated that the day training program has a laundry contract with three city hospitals and a veteran's hospital. Z3 further stated that the west drive is utilized by a full size semi truck and a day training box truck to transport laundry back and forth. Z3 stated that the full size semi truck makes runs twice a day (coming and going) and was not sure how often the day training box truck came and went. Directly in front of the day training entrance, there is a parking area with 3 parking spaces to the east of the front entrance and 2 parking spaces to the west of the front entrance, with a small sidewalk directly in front of the parking area. Z3 stated that these parking spaces are utilized when individuals are transported to and from the day training site at the beginning and ending of the day and throughout the day when consumers have appointments. On 8/3/06 and 8/8/06, during observations at the day training site, cars were observed coming and going from both hospital parking lots and from the day training (east) staff/visitor parking lot. The east parking lot was observed to be approximately 3/4 full. On 8/8/06 at approximately 12:00 p.m., a full size semi was observed parked on the asphalt entry road adjacent to the east parking lot and another delivery truck parked on the opposite side of the asphalt drive, just across from the semi truck. A riding mower was also observed mowing the grassy areas between the hospital and the day training site.	W9999		

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	14G205	A. BUILDING _____ B. WING _____	C 08/15/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANNER PLACE	321 CHESTNUT STREET PARIS, IL 61944

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W9999	Continued From page 71 In review of day training incident reports (presented to surveyor on 8/2/06 per surveyor request), the following is documented relative to R2's LEAVING the day training building: 6/14/06 - 2:30 p.m. - "Went to front hall...(staff) yelling to me from workshop that (R2) was outside. Went out and got him from sidewalk area." (This report is signed by his trainer - as confirmed in an interview with Z3 at the day training site on 8/3/06). The incident report documents that the residential facility was notified on 6/19/06. 6/15/06 - 2:30 p.m. - "Jumped up and got his bag and went outside to wait on van. Got tired and came back in by self." The incident report documents that the facility was notified on 6/19/06. 6/16/06 - 1:00 p.m. - "(R2) walked out the front doors and started walking towards the hospital". The incident report documents that the facility was notified on 6/20/06. 6/20/06 - 10:30 a.m. - "(R2) was outside by himself trying to get in the (facility) van. Was standing behind the van also." The incident report documents that the facility was notified on 6/21/06. 6/20/06 -- 1:40 p.m. - "Writer observed (day training staff) trying to coax (R2) away from a van...told (R2) it was not safe by himself outside - he just smiles." The incident report documents that the facility was notified on 6/21/06. 6/28/06 - 8:45 a.m. - "(R2) was standing in	W9999		

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W9999	Continued From page 72 between the 2 doors and then ran outside. He went to a van parked out in front." The incident report documents that the residential site was notified on 6/30/06. 6/28/06 - 10:40 a.m. - "(R2) was wondering around outside by (staff's) car and then ran to (facility) van. I came walking up the sidewalk and seen him...walked him back inside...." The incident report documents that the facility was notified on 6/30/06. 6/28/06 - 1:50 p.m. - A day training staff was leaving the building to go to her car. R2 followed this staff out. Two other day training staff saw R2 go out the door. Staff found R2 standing in the middle of the parking lot. Staff assisted R2 back in the building. On the way in R2 tried to get in a staff car. The incident report documents that the facility was notified, but there is no date for the notification. There is a note at the bottom of this report stating that the day training site has asked for an IDT (Interdisciplinary Team Meeting) to address this with the group home. 6/28/06 - 2:30 p.m. - "(day training staff) was helping (another day training staff in her classroom). (Consumer) stated that he saw R2 in the parking lot. (Day training staff) ran to the front door...Before (staff) got to him, (day training staff) was pulling up in his van and had to stop because (R2) stopped in front of it. (Day training staff) reached (R2) at the hospital's ambulance maintenance area...(R2) had at least four incidents of leaving the building during the day." The incident report documents that the residential facility was notified, but there is no date as to	W9999		

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W9999	Continued From page 73 when the facility was notified. In an interview with Z3 at the day training site on 8/3/06 in the a.m. (Z4 also present), Z3 confirmed that the day training grounds end at the front parking lot, and confirmed that per the above incident, R2 was off of the day training property and on hospital property. In an interview with Z3 on 8/8/06 at the day training site at 12:00 p.m., Z3 estimated that that the hospital ambulance maintenance area is approximately 130 feet from the day training property. 7/12/06 - 10:00 a.m. - "(Consumer) and (Consumer) reported to writer (day training staff) that (R2) had gone out front door...(R2) was in drive way for hospital when caught up with him. He would not listen to direction to stop. He finally stopped in middle of hospital parking lot...appeared lost." The incident report documents that the residential facility was notified, but there is no date for the notification. In a phone interview with Z3 on 8/4/06 at 10:30 a.m., Z3 confirmed that it was day training consumers who had alerted staff to R2's being off day training property for this incident. In an 8/8/06 interview with Z3 at the day training site at 12:00 p.m., Z3 estimated that the hospital parking lot (the row of cars parked closest to the day training site) was approximately 200 feet from the day training property. (R2 was "in the middle of hospital parking lot" - which would be beyond the 200 feet estimate). 7/12/06 - 10:15 a.m. - "(R2) jumped up from his	W9999		

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W9999	Continued From page 74 chair and darted to front of building leaving out front door with me behind him. Then (staff) from laundry came to help me get him back into the building." The incident report documents that the residential facility was notified, but there is no date for the notification. 7/12/06 - 1:40 p.m. - "(R2) saw (facility staff) from (residential site) and thought she'd let him go home. (Day training staff) followed as did I. (R2) spoke to (residential staff). (Day training staff) helped him back into building. (R2) was in the parking lot getting ready to load the van when stopped." The incident report documents that the residential facility was notified, but there is no date for the notification. 7/14/06 - 8:50 a.m. - "....out front door. Writer followed (R2) started to 'run' when he got to the sidewalk toward driveway to hospital...." The incident report documents that the residential facility was notified, but there is no date for the notification. 7/14/06 - 10:20 a.m. - "...ran to the parking lot...persuaded to return to the building and to class...." The incident report documents that the residential facility was notified, but there is no date for the notification. 7/14/06 - 10:30 a.m. - "Left group room ...saw him coming toward front lobby...(R2) had 2 previous incidents of leaving the building...left reception to follow (R2) to insure safety. (R2) exited building and began to walk then jog across the front lot toward the hospital. (Staff) then intercepted (R2) and (staff) redirected him inside." The incident report documents that the residential facility was notified, but there is no	W9999		

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W9999	Continued From page 75 date for the notification. 7/17/06 - 9:00 a.m. - "(R2) walked outside and was heading towards the hospital. I went after him and walked him back to his classroom. I told his trainer that he had been outside. I explained to (R2) that it is dangerous to leave like that." The incident report documents that the residential facility was notified on 7/17/06. In an interview with Z3 on 8/3/06 at the day training at 11:30 a.m., Z3 stated that R2 was off of the day training property during this incident. 7/26/06 - 9:35 a.m. - "(Day training staff yelled down the hallway for (day training staff)...reported (R2) was in the drive in front of the building. Writer caught up with (R2) between the old ambulance bay and hospital. (R2) was in the middle of the road. (R2) continued walking. Writer discussed taking a walk on the sidewalk, pointing out the hazards of traffic." In an interview with Z3 at the day training site on 8/3/06 at 11:30 a.m. (Z4 also present), Z3 stated that R2 was off of the day training property and on hospital property during this incident. In an interview with Z3 on 8/8/06 at the day training site at 12:00 p.m., Z3 stated that the old ambulance bay is 100-130 feet from the day training property and confirmed that R2 was farther off grounds than 100-130 feet, as R2 was beyond the old ambulance bay and headed toward the hospital. The incident report documents that the residential facility was notified on 7/28/06. Under the comments section of this report, it states that R2's trainer was unaware that R2 had arrived at the day training site. Residential staff had just signed in R2 (after an appointment). R2 had gone down the hallway with residential staff	W9999		

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W9999	Continued From page 76 and headed for his room. R2 then followed the residential staff out the door instead. There is a recommendation in this report for R2 to be walked to his room upon late arrivals or when returning from appointments in order for day training staff to know of his location. It further documents that day training staff also followed up with the residential RSD/QMRP (Residential Services Director/Qualified Mental Retardation Professional) concerning this incident. 7/26/06 - 10:00 a.m. - "Ran outside toward a van that was coming to our building. I (writer/day training staff) stepped in front of him and the van stopped." The incident report documents that the residential facility was notified on 7/28/06. 7/27/07 - 12:00 a.m. - "(R2) went outside and (day training staff) got him back in the building." The incident report documents that the residential facility was notified on 7/28/06. In an interview with Z3 at the day training site on 8/8/06 at 12:00 noon, Z3 stated that the day training site had applied for a one-on-one aid for R2 (through their funding sources), but that the application was denied. Z3 confirmed that R2's physical safety was of concern regarding his new behaviors of leaving the day training building and/or property. In an interview with E1 on 8/2/06 in the p.m. at the facility E1 stated that she was aware of and had read the incident reports cited above. When asked, E1 could not remember when she had reviewed the incident reports, but stated, "not lately." When asked if the facility was tracking R2's leaving the day training building behaviors, E1 stated, "They (day training) are tracking it."	W9999		

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W9999	Continued From page 77 In review of a facility progress note (P-15), dated 7/3/06, it documents that the facility RSD/QMRP (E4), E11 (RSD/QMRP at sister facility in same town), Z3 and Z5 (day training staff), met at the day training site (after the day training's 6/28/06 request for an IDT), to discuss R2's recent behaviors of walking out of the day training site. Per this note, it was decided to try a new program for R2, "such as a puzzle that he would get a piece for staying on task and when completed he would be rewarded, bringing head phones to work, having trainer take short walks outside periodically thru out the day & (and) allowing (R2) to choose activities frequently." This note is signed by E4. In an interview with E4 on 8/3/06 in the a.m., surveyor asked if the new program/s from the IDT on 7/3/06 had been written. E4 stated that they would have been written by day training staff. Surveyor asked for copies of the program/s and if the facility had copies of the program/s. E4 said, "no". E1 (in the p.m. of the same day), told E4 to, "look in bulk...might have been written." No programs were presented. On 8/3/06, at the day training site at 11:30 a.m. surveyor met with Z3 in her office. Z3 stated that E1 had talked to Z5 (Rehabilitation Services Supervisor), "last night" (8/2/06). Z3 stated that they are revising the 1/16/06 behavior program for R2. Per the 7/3/06 recommendations, Z3 stated that they had been in the process of trying different motivators for R2 and that regarding the 7/3/06 meeting no specific program had yet been written. Effective today, however, (8/3/06), the day training receptionist will have a walkie talkie, as will (R2's) trainer, in order to communicate to	W9999		

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W9999	Continued From page 78 each other when R2 leaves his training area. Z3 stated that there is also an aid in R2's training room that is actually there for another consumer, further stating that if the trainer needed to leave the room to go after R2, the other consumers would not be unsupervised. Additionally, the trainer will set up the room so that the trainer is seated closest to the door. R2 will not be restricted from leaving the training area, but having the trainer closest to the exit door, will allow the trainer increased opportunities to redirect R2. The day training's Human Rights Committee will also review this new plan. Z3 stated (as she pointed to her computer), that she was inputing R2's new program into the computer this a.m. The facility failed to intervene in a prompt and timely manner regarding R2's physical safety and supervision level at the day training site, when R2 exhibited his new leaving the day training building and/or property behavior. 2b) The facility failed to notify and/or promptly notify R2's guardian of R2's leaving the day training building and/or property (as documented in example (a). In an interview with E1 (Facility Representative) at the residential site on 8/2/06 in the p.m., when asked, E1 was not sure if the guardian had been notified on the above incidents and stated that she would check. On 8/3/06 E4 (RSD/QMRP) presented a facility progress note (P-15) documented on 7/11/06 at 5:10 p.m. Per this note, it states that R2's guardian was notified per phone, "about (R2's) leaving DT (day training) unsupervised...."	W9999		

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W9999	Continued From page 79 There is no reproducible evidence that R2's incidents occurring after 7/11/06 were reported to the guardian. (7/12/06 - off day training proerty at 10:00 a.m.; 7/12/06 at 1:40 p.m. - in front of moving van; 7/26/06 at 9:35 a.m. - off of day training proerty; 7/26/06 at 10:0 a.m. - ran torward moving van - staff stepped i front of {R2} and the van). When discussed with E1, E4 and E10 (Administrator) at the daily status meeting of 8/3/06 at 3:00 p.m., no further documentation was provided. 2c) The facility failed to report R2's elopements from the day training property to the Department. As per the incidents and interviews with day training staff cited in example (a), R2 left the day training property and eloped to hospital property on 6/28/06 at 2:30 p.m.; 7/12/06 at 10:00 a.m.; and 7/26/06 at 9:35 a.m. In an interview with E1 on 8/2/06 in the p.m. at the facility surveyor, asked E1 if R2's off day training property elopements had been reported to the Department. E1 replied that she would check. No reproducible documentation was provided to the surveyor as of the exit date of this survey. 2d) The facility staff failed to provide sufficient monitoring regarding R2's physical safety. On 8/2/06 at 8:30 a.m. surveyor arrived at the residential facility and drove into the facility parking lot. As surveyor came down the alley parallel to the parking lot, turned left into another alley and then left into the facility parking lot, R's 2, 1, 4, 5, 6 and 7 were observed either sitting or	W9999		

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W9999	Continued From page 80 standing on the concrete patio at the back of the building. R8 was observed to exit the back of the building also and come to the patio. E8 (direct service person) and E14 (maintenance) were also observed sitting on the concrete patio. There are 7 parking spaces in this parking lot and surveyor pulled into the 4th space from the storage shed, car facing away from the building. Surveyor proceeded to gather materials necessary - materials were on the passenger side of the vehicle. When surveyor turned to open the driver side door, R2 (see diagnoses in example (3a) was standing at the front door of surveyors vehicle, (driver side), his whole body pressed up against the car, peering into the window. Surveyor tried motioning to R2 to back up so that surveyor could open the car door. R2 did not respond, but continued to smile. When these attempts failed, surveyor gradually began opening the vehicle door very slowly, and very slowly R2 began to back up until surveyor could exit the car. R2 continued to smile, took his ball cap off and pointed to his head. From where surveyor and R2 were standing, only the east corner of the patio closet to the parking area (where a barrel of flowers sets) could be seen. Surveyor could not see the staff or individuals on the patio from where R2 and surveyor stood, adjacent to surveyor's front passenger side door. E8 and E14 did not come to the parking lot to look for or retrieve R2. Approximately 4 minutes later, E5 (direct service person) came to the parking lot and assisted R2 back to the patio. When asked later in the morning, E5 stated that she had been inside of the facility, and as she came outside to the patio to assist R1, she noticed that R2 was not on the patio and proceeded to try to find him.	W9999		

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W9999	Continued From page 81 This incident was shared with E1on 8/2/06. E1 agreed that there are individuals and businesses who have need to utilize the facility parking lot (other than staff who are familiar with the residents of this facility). On this same morning surveyor observed two separate individuals park in this parking lot, and were observed completing job applications. In a phone interview with E1 on 8/10/06 in the a.m., E1 stated that E14 (maintenance staff) received a written warning regarding visiting with E8 (direct service person), who was to be supervising individuals on the patio. E8 also received a written warning regarding the lack of supervision for R2. R2 has documented diagnoses of severe retardation, Alzheimer's Disease, Impulse Control Disorder, Obsessive Compulsive Disorder, Psychosis and verbal skills of typical one word phrases. It is further documented that his diagnoses interferes with his comprehension and awareness of his surroundings. R2 has documented history of wandering inside the day training building, with documented behaviors of leaving the day training building and the day training property (first documented on 6/14/06); has documented instances of walking in front of moving vehicles; has documented instance of lack of staff supervision at the residential facilitiy; and, his day training site is located by a community hospital, where hospital traffic, the hospital's ambulance and other vehicles utilize the same entry drive as his day training site. The facility did not intervene in a timely manner, regarding R2's level of supervision and physical safety regarding his wandering behaviors.	W9999		

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W9999	Continued From page 82 (A)	W9999		