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W 186	Continued From page 29 taking R1 on rounds and /or into client room with them. E1 said if assistance was needed for caring for R 1, the staff should either approach the night nurse or another staff to ask for assistance if needed.	W 186		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION Section 350.1230 Nursing Services 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 350.3000 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These REGULATIONS are not met as evidenced by: Based on observation, interview and record review, the facility failed to implement their policies, to properly alarm or supervise exit	W9999		

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W9999	Continued From page 30 doors, and to provide adequate supervision to prevent one resident (R1), with a diagnosis of Profound Mental Retardation and a history of Self -Injurious Behaviors, from leaving the facility unsupervised. Specifically, the facility failed to: a. Have systems in place, including training programs, to provide safeguards to prevent R1's elopement; b. Report R1's elopement to the administrator, and immediately and thoroughly investigate the incident of R1's elopement from the facility; c. Evaluate and distribute staff effectively to provide supervision for R1 to prevent elopement; d. Fully develop and implement their policy for door alarms to be turned on and functioning. Findings include: 1) R1's personal record face sheet, Individual Service Plan (ISP), and Physician Order Sheet state she is a 21 year old female with a diagnosis that includes Profound Mental Retardation (IQ of 10 and Broad Level of Independence age of 1 year, 2 months), Attention Deficit Disorder with Hyperactivity and Autistic Disorder. R1's Admission Record states that she was admitted to the facility on 4-17-02 and has a court appointed guardian. R1 's record includes a document titled "Process to Enhance Community Inclusion by Elimination of PICA and SIB (Self Injurious Behaviors)" program dated 3-5-05. The "Description of	W9999		

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Behavior" states she "engages in SIB of biting her wrist or arm, banging her head with her hands" and banging her head on the wall from 0 to 30 times per day. The PICA behavior includes eating foam cups, clumps of dirt, paper and small bits of plastic. The program states [R1] " may physically move staff as she attempts to reach food or drink, and staff often have to block access to these items...Behaviors such as restlessness, wandering, agitation and mood swings" have been observed. Increased sleeplessness is also observed.

The program states that R1 is to be "closely monitored when agitated. Staff will remain alert to [R1's] attempts to engage in activities including SIB, PICA, running through the building, and biting others." Additionally, the program states " staff are to redirect her to a stimulating environment when she begins rapid walking and will be closely monitored by staff to ensure her safety."

R1's Individual Service Plan [ISP] dated 4-13-05 states R1 does not know poison precautions, does not orient to locations, does not know what to do when lost, displays physically inappropriate behaviors toward herself and the environment and "must be watched continually to insure that she does not ingest items that are non-edible." The ISP says that R1 is non-verbal and will follow simple directions, although they often require repetition. The area of "Mobility" states R1 walks at a fast pace with her head leaning forward, is in constant motion and does not sit long. The " Summary of Team Response" in the ISP states R 1 is unable to understand or needs assistance with "... Visits/Visitors, Potentially Hazardous

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W9999	Continued From page 32 Materials...Sexuality...Process to Enhance Community Inclusion and Alcohol...and requires pervasive intensity of supports. These supports are characterized by their constancy, high intensity, provided across environments; potential life-sustaining nature. Pervasive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports." R1's "Review of Rights Limitations" states "[R1] must be accompanied by staff...when in the community" staff must "Monitor for elopement during walks or outside activities." Upon review of an initial report, sent to the Department on 1-28-06, R1 eloped from the facility about 10:30 PM on 1-27-06 without staff knowledge, walked to a bowling alley/local fraternal organization building [open to the public] and drank from a soda can at the bowling alley. R1 was returned to the facility, according to the initial report. A "Summary of Investigation" dated 2-3-06 was sent to the Department. The report was completed by E2, Residential Services Director [RSD]. The summary report states that the midnight nurse, E5, from the Skilled Nursing Facility portion of the building, reported that "3 teenage boys came into the building...They told her there was a girl at the bowling alley next door in her pajamas drinking soda's off the table that might live here. The nurse grabbed her coat and before she got off the porch a gentleman was walking [R1] down the sidewalk. The nurse took [R1] back to the family 2 group room where the person in charge of F2 [family 2] residents [E6] stated that she thought another staff person was watching [R1]."	W9999		

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The report states E6 had asked E14, Direct Support Person [DSP] to watch R1 while E6 cleaned up another client. The report said that R 1 was left sleeping on a couch in the family 2 room. E6 assumed R1 was with E14 until she saw R1 walking down the hall with E5 and was told what had happened [regarding the elopement]. The report does not state how R1 left the facility without staff knowledge, if door alarms were turned off at the time of R1's elopement, exactly what she was wearing at the time of the elopement, how long she was gone from the facility, if the staff from the bowling alley/ fraternal organization building could give further information, and measures to be taken to prevent further incidents of elopement.

Z1 was interviewed on 2-8-06 at 10 AM and said he was tending bar at the public building next door to the facility. Z1 said that boys working at the bowling alley told him that they thought someone from "the home" was upstairs at the bowling alley. They went to alert the facility that " one of their people was there." Z1 said that when he went upstairs [to the bowling alley] that R1 was standing there playing around with soda cans. He said that she had a night gown on and bare feet. Z1 said that this occurred sometime between 10 and 11:30 PM and was after bingo at the building (usually over about 10 PM), Z1 said he took R1's hand and walked her back to the facility and "handed her" to a nurse who was just coming out of the building (on the skilled side of the building). Z1 said R1 was not afraid when he took her hand to walk her home and as he took R1 home, she tried to pull him toward the back of the building. Z1 said that R1 may have

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W9999	Continued From page 34 left the facility from a rear door since she tried to go that direction when he returned her to the facility. E5, the nurse who took R1 from Z1, said on 2-6-06 at 10:30 AM, that R1 was wearing a summer night gown with pajama pants and was barefoot. She said when she returned R1 to the DD side of the building, E6 did not seem aware that R1 had been missing. E5 said this was sometime between 10:15 and 10:45 PM. on 1-27-06. 2) The facility failed to put training programs, systems and safeguards in place to ensure R1 was provided with the consistent and "high intensity" support identified in her ISP to ensure R1's safety. R1 was observed in her group room and the front dining area on 2-7-06 and 2-8-06 in the afternoon after 3 PM at intervals. She had a staff member at her side at all times. When she walked, she walked rapidly. She was working with manipulative items when in the family group room 2. R1 has recurrent documentation of R1 running off . "Daily Notes" written by direct care staff in January 2006 state: R1 trying to run off on 1-1-06; 1-5-06 ran off a few times and set off her "room alarm several times"; 1-6-06 attempting to run off as well as physical	W9999		

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W9999	Continued From page 35 aggression [repeatedly pushing a wheelchair with a peer in it into a staff]; 1-7-06 [R1] "was very hyper today couldn't stay still. Nothing new."; 1-12-06 "[R1] has been very active tonight. A lot of SIB, and trying to run off."; 1-13-06 tried "so many times to run off."; 1-20-06 threw items at staff and to the other side of the room; 1-21-06 threw chairs over repeatedly, threw dishes on the floor, drank peers' drink and continually tried to run from the group room; 1-27-06 trying to run from the group room, " snatching drinks," shoving staff more, pushed staff's face. Per interview with E4, Qualified Mental Retardation Professional [QMRP] on 2-7-06 at 11 AM, R1 is to be in visual sight at all times and when she leaves an area, she will keep going until she finds something to drink. E4 said on 2-8-06 at 2:05 PM that R1 has tried to go out the front door by the dining room and staff constantly monitor her to bring her back. E4 said that he witnessed R1 leaving the facility when he was outside and staff "went after her." E7, DSP, said in interview on 2-8-06 at 2:40 PM that R1 has tried to leave the facility numerous times, but staff always catch her. E7 said that R1 is to be one on one supervision unless she is in	W9999		

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her room that has an alarm on the door.

E8, DSP and Assistant Family Program Director (AFPD) said in interview on 2-8-06 at 3 PM that R 1 has tried to elope in the day and evening and that she will usually try to leave through the doors by the dining room or by the hall doors by family 3 group room.

E10, DSP, said in interview 2-8-06 at 3:40 PM that R1 tries to get out doors, but he has not seen this so much in the last 2 months. E10 said there is an alarm to the door to her room if she tries to leave her room at night, but staff would have no way to know if she left the building if she is not in her room and no staff are with her. He said that staff have to be with her at all times - no more than 2 feet away - because she runs fast when trying to leave.

E11 said on 2-8-06 at 4:10 PM that R1 runs but E 11 said she doesn't know if R1 knows where she is going. E11 said that R1 has to be one to one supervision.

E2 stated in interview on 2-8-06 at 6 PM, that the documentation in the "Daily Notes" are kept in a desk drawer and are not incorporated in the active client Program Chart . The notes are not part of the monthly review from the QMRP in her chart since the elopement or aggression are not targeted behaviors that are tracked. Review of R 1's current chart shows no mention of R1's recurrent running from areas of supervision and/ or attempts (successful or unsuccessful) to leave the building.

There is no reproducible evidence that the

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W9999	Continued From page 37 Interdisciplinary Team [IDT] has reviewed the direct cares staff "Daily Notes" or evaluated the behaviors identified in the notes. E4, Qualified Mental Retardation Professional [QMRP] stated and revealed on 2-8-06 at 2:05 PM the following about R1: Has no training program objective for elopement from the facility or level of supervision needed; Has no information in the behavior training objective to tell the level of supervision needed at all times to prevent the PICA or Self Injurious behavior. Has no training program for the alarm to her bedroom and no information in her ISP to identify the reason for the alarm, or to identify when the alarm is to be used. E4 said the alarm was used for her roommate, R 19, and R1 was moved into R19's room a few months ago to be closer to her family group room . In addition, they wanted to put her in a bedroom with a door alarm to alert staff if R1 tries to leave her room at night. Per observation, R1's bedroom is across from the family group room. 3) The facility failed to follow their policy for missing persons and thoroughly investigate R1's elopement of 1-27-06. According to the facility policy, when a person is missing and returned, they are to be examined by the nurse upon return for signs of injury.	W9999		

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W9999	Continued From page 38 The nursing notes dated 1-27-06 4 PM to 12 AM (no specific time given) state R1 was brought back from bowling alley and was checked immediately after the reported incident and had no apparent injuries. The written statement from the nurse, E18, stated, "I looked her over standing next to [E6] and there were no injuries noted." E6 said in interview on 2-8-06 at 11 AM that she did not see the nurse examine R1 and the nurse just talked to them (R1 and E6) in the group room . This corresponded with the nurses written statement. There is no evidence the nurse did a full body check of R1 for injuries or examined the bottom of her feet after 2 witnesses reported that R1 was barefoot. The route to the bowling alley covers a large unpaved parking lot and grass. Per review of the investigation report of the incident, the facility failed to perform a thorough investigation of the incident when they only interviewed staff who were present at the facility at the time of the incident and the shift previous to the incident. E2 verified in interview on 2/8/06 at 9:40 AM that she conducted the investigation of R1's elopement and did not interview the employees of the bowling alley or the community member (was previously identified as the person tending bar at the adjoining building) who returned R1 to the facility. E2 did not verify what or how much R 1 was drinking (the teen boys from the bowling alley reported R1 went randomly from table to table drinking sodas), how long R1 was at the bowling alley, what specifically R1 was wearing, if she was upset, or how she left the facility without	W9999		

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staff knowledge. The investigation did not include the fact that the front doors alarms had been malfunctioning (according to the maintenance person and direct care staff) or the back (South) door alarm was not functioning and had not been turned on in years. E2 did not know that the back door alarm was not functioning until 2-8-06 when she checked to ensure the door alarms functioned (during the survey). E2 said the back door alarm worked sometime around Feb 3 when they she checked the door with the maintenance person after learning the front door alarm was not working. There is no documentation of the door alarm check, according to E2. E2 verified that these issues were not investigated by her.

The investigation did not include how R1 was left alone in the group room on the night of 1-27-06 and why she was not in her bedroom which had a door alarm.

There is no evidence the investigation included evaluation of staff distribution for the staff on duty at 10 PM on 1-27-06. The staff time schedule sheet showed that there was one direct care staff person for each family group room (3 staff) and one nurse working. This was verified in R2's interview.

When E6 was interviewed on 2-8-06 at 11 AM, she stated that she thought R1 was sleeping on the couch in the group room and she had to change another person who was incontinent of stool. E6 explained that to get help to watch R1, E6 had to go to the other side of the DD side of the building on different hall to get another staff. E6 stated there is no means to communicate

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between staff or throughout other parts of the building if staff assistance is needed. E6 stated she would have to leave the client unattended, yell for assistance, take R1 with her to get help or wait for another staff to come in the vicinity.

E1, administrator, verified on 2-8-06 at 12:10 PM that there was not a means for staff to readily get assistance if needed. E4, QMRP, verified on 2-7-06 at 11 AM that this had been a concern that he has raised in the past, that staff could not call for assistance if staff were alone with a client(s) and needed help.

4) The facility failed to ensure there was adequate supervision for R1 who is known to have a history of eloping and makes frequent attempts to run from staff supervised areas.

Based on written statements from the staff, on 1-27-06, when R1 eloped from the facility without staff knowledge, E6 said that she had told the nurse, E16, and DSP for family 1, E14, to "keep an eye" on R1 while she tended to another client (who was in bed and incontinent of stool) whose room was at the far end of the back hallway. Neither E14 or E16 monitored R1. During the time E6 was changing the other client for incontinence, E16 gave E14 permission to go to the store and E14 said that the nurse could watch his family 1 while gone.

E14's written statement [as part of the investigation] wrote that he was told that R1 was sleeping. E14 said that he did not know why he was told that R1 was sleeping and that R1 was not his responsibility. E14 stated his responsibility was to the family (1) where he was

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working and "responsible for those residents." R 1 was assumed to have eloped during the time E 14 was gone from the facility and E6 was cleaning up a person who was incontinent.

On the night shift, according to the work schedule and interview with E9, DSP, on 2-8-06 at 3:30 PM, there is one staff person on the night shift per each group and one nurse (for the ICF/DD side) from 9 PM to 5:45 AM for a total of 4 staff. This was verified by the staff schedule sheet.

E3, nurse, stated on 2-8-06 at 9:40 AM, that there is one individual in family 1 group, R8, who requires one to one staff supervision due to elopement behaviors. This was verified in R8's record. R1, per the staff and ISP, requires constant supervision. Per the QMRP, on 2-7-06 at 11 AM, this means within eye sight. E7, 8, 9, 10, 11 and 17 (DSP's) all said on 2-8-06 in interviews between 3 PM to 5 PM, that they take R1 to client rooms with them when doing rounds for client care. E9 said that if R1 is sleeping in the group room, she will wake her up and take her with her for rounds or to find staff to watch her while she is doing client care.

There are no written guidelines for the staff as to how to monitor and care for clients on 3 different halls in 3 different family groups and with 2 clients (R1 and R8) on 2 different halls who require constant staff monitoring when rounds are to be made, client care is needed and for lunch and breaks from 9 PM to 5:45 AM or at other times when there are few staff working.

5) The facility failed to put systems into place to provide safeguards for R1 when they had no

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 42 alarms that were turned on or functioning for the DD part of the building that has 47 clients on 3 different wings. During the survey, it was observed that there were no door alarms that sounded when the outside doors opened. The facility had no policy as to when door alarms were to be turned on or turned off. The only policy given to the surveyor was identified as " Locking Entry Doors/Security at [name of facility] Policy & Procedure." The policy states that entry doors to the DD side of the building will be locked at 10:30 PM and unlocked at 5 AM. The main door will be locked when the receptionist leaves during the week and unlocked at 8:30 AM. On weekends and holidays, the main door will be locked at 9:30 PM and unlocked at 5 AM. There is a door bell for the main entrance of the DD side of the building. The locked door policy does not indicate how clients are to enter the building if they leave when no exit door alarms are activated (and the exit doors are locked to prevent entry from the outside) if the client does not know where the door bell is located or how to use the door bell. The "Policy for Elopement" states residents will receive adequate supervision to prevent accidents. "Of special concern are cases in which a resident is deemed to be 'at risk for wandering or elopement'." The policy said due to wandering outside the building and or elopement situations, the exit doors are equipped with special keyed exits and door alarms. The policy states staff are	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G111	A. BUILDING _____ B. WING _____	C 02/22/2006

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W9999	Continued From page 43 to monitor the exit doors and how to respond to a sounded door alarm. This policy does not state when the alarms are to be turned on. The following staff verified that door alarms are not normally turned on: E2, RSD in 2-8-06 interview at 6 PM. E2 verified that the DD door on the South end of the building was not working at this time and that door alarms are not normally turned on due to client rights. E3, LPN and Assistant Director of Nursing (ADON) said in interview on 2-8-06 at 5:30 PM that the staff were told about 2 years ago that the alarms on doors (outside) were not to be turned on because it is "written under rights." E4, QMRP, did not know what time the front door alarm is to be armed in interview on 2-7-06 at 11 AM. E6, DSP, said in interview on 2-8-06 at 11 AM that door alarms are not turned on. E7, DSP,said in interview on 2-8-06 at 2:40 PM, that door alarms are not turned on, but said that in last two weeks, the front door alarm is on at 9 PM. E8, DSP,on 2-8-06 at 3 PM in interview said the door alarm to the outside door by the dining room was recently turned on at 6 PM. E10, DSP on 2-8-06 at 3:30 PM said there are no outside door alarms and there was no way staff would know if R1 got out of the building if not with staff.	W9999		

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W9999	Continued From page 44 E11, DSP, on 2-8-06 at 4:10 PM said the two glass doors (front doors) are on now, but were not on before recently. She said there is no information she is aware of as to how to activate or deactivate the alarm. E17, DSP, said in interview on 2-8-06 at 4:50 that the alarms are not on during the day time and are usually on at 8 PM. She said that about 2 weeks ago, she punched the code on the front door alarm to set the door alarm and the alarm did not go on. E17 said she reported the malfunction but did not fill out a maintenance request. She said it was fixed 2 days later. E13, Maintenance person said on 2-8-06 at 6:45 PM that the South/back door by the time clock has not been "on as long as I've been here - 3 years." Staff go out of that door to smoke. E13 came to the facility on the evening of 2-8-06 when E2 identified that the alarm would not activate when it was turned on with the key switch. He said the battery was dead. E13 said he was not aware of the battery ever being checked because the alarm was never activated. E12, Maintenance Supervisor on 2-10-06 at 3 PM, said that he became aware that the front door alarm did not work on 2-1-06 when the QMRP for family 1 told him that she saw visitors in the building who came in the front door and the alarm did not go off. He said that it was fixed the same day that it was reported to him and reported to the repair company. The work order from the repair company said "Problem reported - East Double door (front door) keypad frozen with all leds on, will not operate, or clear. Service as	W9999		

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W9999	Continued From page 45 soon as possible." E12 said they [repair company] came out the same day. There is no written record that E17 or the family or QMRP reported or requested repair for the malfunctioning front door or what measures were taken to monitor the door while the door alarm malfunctioned. E12 said that a maintenance request form is to be completed when any repairs are needed and verified there is no record as to when the door was first noted to malfunction. There is no written record as to how long the rear exit door had not functioned or how the exit was to be monitored when the alarm had been turned off for 3 years. There is no written record as to how staff are instructed to monitor exit doors when staff have no visual access to the doors when alarms are turned off. Following R1's elopement on 1-27-06, there is no evidence the facility took measures to ensure systems were in place prevent elopement and ensure staff monitoring for R1.	W9999		