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|---|---|---|---|
| | 14G200 | A. BUILDING _____ B. WING _____ | C 06/29/2006 |

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| W 149 | Continued From page 7<br><br>He said one staff (E13) had been approved to take two individuals (R2 and R13) on an outing to a local store, but another staff (E6) had also went on this outing for a personal reason. He said she was not approved nor needed to go on this outing . He said another staff (E9) also left the facility during this time to do a personal errand, and she was not approved to do so either. This left two staff at the facility with 9 clients. He said E6/DSP was the staff responsible for monitoring R1 whereabouts at the time R1 had eloped. He said, "the staff dropped the ball with (R1)." He said the staff should have checked on R1's whereabouts when the door alarm sounded, but they did not do so."<br><br>E1/QMRP on 6/20/06 at 11:00 A.M. said, R1's level of supervision had been changed after she had eloped from the facility the first time on 05/07 /06. The staff were to keep R1 in their vision at all times when she was not sleeping. She said only two staff were at the facility at the time R1 eloped on 6/10/06, and 5 were scheduled to be on duty.<br><br>The facility failed to ensure R1's safety when they failed to provide necessary supervision and monitoring to prevent R1's elopement from the facility on 05/05/06 and 06/10/06. | W 149 | | |
| W9999 | FINAL OBSERVATIONS<br>LICENSURE VIOLATIONS<br><br>350.1060a)<br>350.1060d)<br>350.1060e)<br>350.1060h)<br>350.1070 | W9999 | | |

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| W9999 | Continued From page 8<br><br>350.2700d)2)<br>350.3240a)<br><br>Section 350.1060 Training and Habilitation Services<br>a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.<br>d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.<br>e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.<br>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.<br><br>Section 350.1070 Training and Habilitation Staff<br>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.<br><br>Section 350.2700 General Building Requirements<br>d) Doors and Windows | W9999 | | |

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| W9999 | Continued From page 9<br><br>2) All exterior doors shall be equipped with a signal that will alert the staff if a patient 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 twenty-four (24) hour a day supervision of the door, a signal is not required.<br><br>Section 350.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to implement their system to ensure client protections when they failed to implement their policy to prevent neglect for R1, who had an incident of elopement on 05/07/06 and again on 06/10/06. The facility failed to:<br><br>1) Ensure staff maintained visual contact with R1 at all times during waking hours,<br><br>2) Ensure staffing was increased to prevent elopement,<br><br>3) Ensure staff monitored all exits and responded appropriately to exit alarms, and<br><br>4.) Ensure staff implemented R1's Behavior Plan to prevent elopement.<br><br>Findings include:<br><br>Per review of R1's Psychological Evaluation | W9999 | | |

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dated 3/31/02, R1 is functioning in a Profound level of Mental Retardation, and has a diagnosis of Intermittent Explosive Disorder. This evaluation states R1 was administered the Slosson Intelligence Test on this date, and R1's Intelligence Quotient was assessed at less than 15. This report states R1 is nonverbal and communicates her basic needs by gesturing, pointing, or physically leading staff. R1's birth date is listed as being 09/24/72, and she was admitted to this facility on 07/25/02.

R1's physician orders dated 06/20/06 include orders for Paxil 20 MG.(Milligram) one tablet 2 times a day by mouth, Guanfacine 1 MG. one tablet by mouth 2 times a day, Depakote 500 MG . one tablet 3 times a day by mouth, Depakote 250 MG .one tablet every night at bedtime by mouth, and Risperdal 3 MG. one tablet 2 times a day by mouth. The physician orders state these medications are given due to R1's diagnosis of Intermittent Explosive Disorder.

The QMRP/PSYCHIATRIC NOTES dated 2/15/ 06 state the facility had received technical assistance in January 2006 for R1 due to "(R1) has had an increase in behavior for the past few months. Workshop stated that grabbing and aggression is getting worse. She has been pushing and knocking people down." The targeted behaviors listed are: 1) Inappropriate Social Behavior, 2) Stealing food, and 3) Grabbing and Compulsive Behavior. Data for R1 's incidents of grabbing others is documented as having occurred 266 times in 01/06, 258 times in 2/06, 233 times in 3/06, and 158 times in 4/06.

As an example of R1's maladaptive behavior of

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grabbing others, R1 entered the facility's dining room on 6/20/06 at 4:00 P.M. She walked quickly to the surveyor grabbing the surveyor's left wrist tightly. A staff standing beside R1 intervened by verbally prompting R1 to let go. When R1 did not do so, the staff put her hand over R1's hand and took her hand while prompting her again to let go, and R1 then released the surveyor's wrist. When R1 attempted to grab the surveyor again, the surveyor moved her arm away, and the staff was able to redirect R1 to another activity.

The facility's investigation report dated 05/08/06 regarding R1's elopement from the facility on 05/07/06 states,"On May 7,2006 at approximately 3:15 P.M., (R1) left the facility's property...(R1) walked two doors to another residence and entered the home. The local police department was contacted immediately by the owners of the home that (R1) entered." The report states that E 15/DSP (Direct Support Person) then went to the home that R1 had entered and brought R1 back to the facility.

Interview with E1/QMRP (Qualified Mental Retardation Professional) on 06/20/06, she said R1 has eloped to the same neighbor's home twice. She said R1 has to crossed the railroad tracks located north of the facility to get to this home. On 06/28/06 E1 said the railroad tracks are approximately 9 feet north of the facility's driveway, and the neighbor's home is approximately 32 feet north of the railroad tracks.

E1/QMRP completed a Safety Skills Assessment of R1 on 05/08/06. This assessment states, "(R1) does not know how to use the telephone and would not be able to tell anyone that she is lost/

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missing. On 5-7-06, (R1) left the premises and went to a neighbor's house. As a result of this incident, (R1) will be on a 15 minute check, tag team method, and she will be within eyesight of staff at all times. There has been an increase in staff support at this time... Staff will continue to ensure that (R1) is constantly supervised while at home or in the community."

An Incident Report dated 6/10/06 states, "At approximately 1:45 P.M. Sat. the home received a call from the police dispatcher inquiring about a S.H. (abbreviation for the facility) resident. (R1) left the home and went inside the neighbors home across the Rail Road tracks." The report continued to say, "Staff checked on (R1) at approximately 1:40 P.M. She was lying on her bed. A couple of minutes later a door buzzer sounded. Staff checked this and witnessed a different resident outside. A couple of minutes later the police dispatcher called. Staff immediately went and retrieved (R1)." E2/ Administrator documented on this Incident Report, "staff hours were increased to help avoid issues. Staff must be retrained on the importance of programming execution."

Review of R1's Behavior Plan Consultation dated 05/08/06, states recommendations to increase staff supervision of R1 due to R1's elopement on 05/07/06. R1's behavior plan was revised to include the recommendations of:
1.) Staff are to check on and document R1's whereabouts every 15 minutes.
2.) Staff to use a tag team method to keep R1 within their eyesight during all waking hours.

Based on an interview with E2 on 06/20/06, he

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| W9999 | Continued From page 13<br><br>said the staff did not implement R1's behavior plan for elopement. He said per the behavior program the staff should have kept R1 within their vision at all times during her waking hours. He said this should have been done by a tag team method. He said the facility had increased their staffing, but two staff had left the facility on 06/10/06 without their supervisor's approval, and R1 did not receive the level of supervision she needed to prevent her elopement.<br><br>When E3/DSP was interviewed on 6/20/06 at 2: 00 P.M., E3 stated R1 was checked at 1:40 P.M. on 6/10/06, and was in bed with a cover over her head. She was not sure if R1 was actually asleep. "When I left (R1's) room another client (R 7) from the other wing came to me, and asked if I could go to his room."<br><br>E3 stated one other staff was at the facility at this time. This staff (E10) was in the dining room with R3 and R15 because they were eating. Per E3, the facility has a policy that a staff must stay with clients if they are eating. E3 stated she had started to go with R7 to the men's wing, when she heard a door alarm. E3 checked outside the front door and saw R8 on the front porch. She said, "I thought that was why the alarm went off... I know now I should have checked on (R1), but I didn't. I thought I had just checked on her and she was still in bed."<br><br>E3's written statement dated 6/12/06 was reviewed. In response to the question on the statement of "what happened with (R1)?", she had written "checked on her - in bed- not sleeping. Other staff in DR w/ res eating - Another res came and got me. I helped him. | W9999 | | |

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| W9999 | Continued From page 14<br><br>Came into DR - got call from dispatcher."<br><br>E10/DSP said during an interview on 6/20/06 at 2 :50 P.M.,that E3 had checked on R1 at approximately 1:40 P.M., and then she went to the men's end with R7. She said the door alarm then went off, and E3 went to check outside the front door. R8 was outside on the front porch, and we thought this was why the alarm went off. E10 said, "We should have checked to see if (R1 ) was still in bed. We've had retraining since then and know to do this now." E10 then said, "Just about that time the phone rang and it was the police dispatcher asking about a resident at a neighbor's house. (E3) immediately left to go to the house to get (R1)." E10 said she and E3 were the only staff at the facility at the time of R1 's elopement from the facility.<br><br>Per interview with E10 on 6/21/06 at 4:30 P.M., E 10 stated nine clients were home at the time R1 left the facility on 6/10/06, (R1, R3, R4, R6, R7, R8, R9, R12, and R15). E1 said,"(R3) is in a wheelchair and is incontinent of B/B (Bowel and Bladder) at times and when he has a stool in his pants he fights you, and we have to coax him, and it takes two staff to change him." E10 stated R15 is also in a wheelchair, and he requires one staff to transfer him, and to assist him and monitor him when he is eating. R15 was eating at the time R1 eloped on 6/10/06. "(R4) has drop seizures, and had one two days ago in the kitchen when she was helping clean up, had her helmet on, but hit her head hard, lasted a couple of minutes." E10 said R6 is also incontinent if he is not toileted at least every two hours. R6 is Blind and Deaf, and requires at least one staff with all activities of daily living. | W9999 | | |

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| W9999 | Continued From page 15<br><br>An interview was conducted with E2/ Administrator on 6/20/06 at 4:10 P.M. He said five staff were scheduled on duty at the time R1 left the facility without staff's knowledge. He said three staff had left the facility at the same time, leaving only two staff (E3 and E10) at the facility. He said one staff (E13) had been approved to take two individuals (R2 and R13) on an outing to a local store, but another staff (E6) also went on this outing for a personal reason. He said she was not approved nor needed to go on this outing . He said another staff (E9) also left the facility during this time to do a personal errand, and she was not approved to do so either. This left two staff at the facility with nine clients. He said E6/ DSP was the staff responsible for monitoring R1 's whereabouts at the time R1 eloped. He said, " the staff dropped the ball with (R1)." He said the staff should have checked on R1's whereabouts when the door alarm sounded, but they did not do so."<br><br>E1/QMRP on 6/20/06 at 11:00 A.M. said R1's level of supervision had been changed after she had eloped from the facility the first time on 05/07 /06. The staff were to keep R1 in their vision at all times when she was not sleeping. She said only two staff were at the facility at the time R1 eloped on 6/10/06, and five were scheduled to be on duty.<br><br>The facility failed to ensure R1's safety when they failed to provide necessary supervision and monitoring to prevent R1's elopement from the facility on 05/05/06 and 06/10/06.<br><br>(A) | W9999 | | |

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