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	14G296	A. BUILDING ______ B. WING ______	C 05/26/2006

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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
W 227	Continued From page 21 and brought (R1) back to the facility." E4 (program supervisor workshop) was interviewed on 5/23/06 at 12:00pm. E4 was asked if R1 currently has a behavior program for elopement. E4 stated, "Right now, no." E1 (QMRP) was interviewed on 5/18/06 at 1:00pm. E 1 was asked if any changes have been made to R1's BSP to include elopement, E1 stated that there was to be a meeting on Tuesday (5/23/06).	W 227		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.810a) 350.3240a) Section 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on interview and record review, the facility failed to, through implementation of its policies, set up a structure which protected R1 from neglect, in that: 1) After the initial incident of elopement on 3/13/	W9999		

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06 at approximately 4:30pm., the facility failed to take corrective action to prevent further incidents of R1 leaving assigned areas, both residential and day training, resulting in R1 being found outside of both buildings unsupervised on further occasions (4/24/06 and 5/13/06).

2) The facility failed to provide sufficient staff to meet the needs of R1 resulting in R1 being able to leave the facility unsupervised on 5/13/06.

Findings Include:

R1, per facility roster, is a 39 year old female who functions in the Profound range of Mental Retardation. According to the facility roster provided at the start of the survey, R1's IQ on the Stanford-Binet intelligence test is 15.

R1's "Individual Profile" from her Individual Program Plan (IPP) of 2/27/06 states, "I need close supervision when I am out." Under the section titled "Relating," the "Individual Profile" states, "I talk to staff by gesturing, pointing, touching. I know three signs, especially toilet. Staff need to watch my face for expressions. I use a lot of non-verbal communication."

R1's current Behavior Support Plan (BSP) of 2/27/06 states, "I like to do the things I enjoy by myself and being alone. I have a very large personal space. I really like to walk and wander in big spaces. I don't like to be touched unless I initiate it." R1's BSP lists the following targeted behaviors: screaming, being aggressive toward self by pulling hair, hitting, grabbing clothing and the skin underneath, and scratching, hitting her head, pulling her hair, and stripping.

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The facility's "Investigative Report" of an incident which occurred on 3/13/06 states, "At approximately 4:30 PM on March 13, 2006" R1 " was seen by" workshop "staff in the middle of 9 th St. The individual was returned to the facility. Staff was not aware that she was missing." In the section titled "Summary of Evidence" it states, "At the time the staff took the individual inside, she was on the boulevard." According to the workshop staff "the whole incident took less then (sic) 10 minutes."

1) After the initial incident of elopement on 3/13/06 at approximately 4:30pm., the facility failed to take corrective action to prevent further incidents of R1 leaving assigned areas, both residential and day training, resulting in R1 being found outside of both buildings unsupervised on further occasions.

The facility's Investigative Report states that after the initial incident at approximately 4:30pm., "The supervisor of the home placed her (R1) on 100% visual coverage until further notice." However, the Investigative Report also states that "At approximately 4:55 PM, the same individual was spotted outside again, a couple of steps off the curb into 9th St." Ninth Street is observed to be a two lane street in a mixed residential and business area with steady traffic. The Investigative Report states that at around 4:55pm., from another resident's bedroom window, staff saw R1 in the parking lot. At that time, staff ran to get R1. The Report indicates that R1 was "a couple of steps off the curb into 9th St."

E3 (direct care staff) was interviewed on 5/18/06

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at 3:05pm. E3 stated that R1 had gotten out two times on 3/13/06. E3 stated that she saw R1 through the bedroom window and ran out.

An "Unusual Incident Report" from 4/24/06 states that facility staff arrived at the workshop "at approximately 10:50 am and found (R1) walking across the parking lot at" the workshop. Workshop staff did not see her leave her assigned area.

E4 (workshop program supervisor) was interviewed on 5/23/06 at 12:00pm. When asked when E4 was notified of R1's incidents of leaving the facility unsupervised on 3/13/06, E4 stated, " The next day." When asked what changes were made after the incidents of 3/13/06, E4 stated, " We didn't change anything here at the time we weren't seeing the behavior here."

E5 (workshop program lead) was interviewed on 5/23/06 at 10:25am. E5 was asked when she heard of R1's incidents of leaving the facility unsupervised on 3/13/06. E5 stated, "Within a day or so." E5 was asked if prior to the incident at workshop any changes had been made. E5 stated, "No, I don't believe so." E5 stated that now they have six staff that rotate a one-on-one for R1 at workshop. If R1 wants to go out of the room and seems calm, we follow; if she is pulling her hair or undressing, we try to keep her in the room.

A facility "Investigation Summary" states that on May 13, 2006, at 2:15pm., R2 "jogged toward the door and went outside." E6 ran after R2 out the front door to get her back inside. "Leaving 9 others inside. It took (E6) about 2 to 3 minutes to

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get her (R2) back inside." Once inside E6 noticed that R1 was not around. E6 initiated a search. R1 "was found by another (workshop) employee from another site standing in front of the facility on the sidewalk. The staff stopped and brought (R1) back to the facility."

An Interdisciplinary Team (IDT) Meeting was held 5/9/06 listed as a "Quarterly Behavior Review." Notes from that meeting state, "Team 6 (workshop) has been providing 1:1 staff to assist with her behavior. R1 has been trying to leave both (workshop) and (facility)."

The facility started tracking "Elopement Attempts" after the incidents of 3/13/06. R1's monthly progress review from March 06 listed 15 elopement attempts. E4 was asked if R1 currently has a behavior program for elopement. E4 stated, "Right now, no." E1 (QMRP) was interviewed on 5/18/06 at 1:00pm. E1 was asked if any changes have been made to R1's BSP to include elopement, E1 stated that there was to be a meeting on Tuesday (5/23/06).

The facility policy titled "Handling, Investigating, and Reporting Unusual Incidents" under section 3.0 "Response Procedures and Reports" number 3.2 states "Upon conclusion of the investigation, the lead investigators will share with the program director their findings. The program director will take any necessary follow-up action to prevent similar incidents from occurring."

2) The facility failed to provide sufficient staff to meet the needs of R1 resulting in R1 being able to leave the facility unsupervised on 5/13/06.

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The facility investigative report from the incidents of 3/13/06 states, "Four staff on second shift (which was the only shift that we looked closely at) does not always appear to have sufficient staff coverage given the amount of work that needs to be done (medication pass, cooking, cleaning up, showers, programs, 4 wander risks, etc.)." Under "Recommendations" it states, "8. Residential management needs to review staffing patterns at (facility) to analyze if current staffing patterns are safely meeting individual's needs."

E1 was interviewed on 5/23/06 at 11:35am. When asked who were the individuals that were currently considered wander risks, E1 stated R1, R3, and R2. R4 is not currently a concern.

The facility investigative report from 5/13/06 states that there were three staff on duty with 12 residents. At the time of the incident, the other two staff on duty were engaged in giving baths to two different individuals leaving E6 to supervise 10 individuals. The "Resident Check Sheet" for 5 /13/06 was reviewed. At 2:00pm and 3:00pm., R 1, R2, and R3 are all listed as in the facility at those times. According to the Investigative Report of 5/13/06, R1, R2, and R3 were not any of the individuals being bathed by the other two staff, leaving all three of them as part of the ten individuals E6 was left to supervise alone.

E6 (direct care staff) was interviewed on 5/18/06 at 3:15pm. E6 stated that they have 7 showers to do on second shift, that they "have to get things done".

Facility staffing schedules were reviewed. Review of direct care schedules for second shift

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on Saturday and Sunday indicates that in April 06 , three direct care staff were scheduled 8 times. In May 06 through 5/19/06, three direct care staff were scheduled 3 of 4 times.

The facility investigative report from 3/13/06, under "Recommendations" it states, "6. Caseloads need to be revised to split up people who are at a high risk of eloping." E6 stated that both R1 and R2 are on the same case load. " Daily Caseload Responsibilities" form provided by the facility on 5/23/06 had printed on it R1 and R2 on the same caseload with R2 crossed out and a different resident added. E2 indicated that the switch of R2 and the other individual went into effect 5/22/06.

The facility policy titled "Handling, Investigating, and Reporting Unusual Incidents" under section 3.0 "Response Procedures and Reports" number 3.2 states "Upon conclusion of the investigation, the lead investigators will share with the program director their findings. The program director will take any necessary follow-up action to prevent similar incidents from occurring."

(A)

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W 149	Continued From page 14 leaving the building unsupervised on 5/29/06, to develop a written procedure to implement the recommendation from the Investigation Summary from R1's incident of leaving the facility unsupervised on 5/13/06. This recommendation was for two staff to be covering "upfront" at all times. This procedure was necessary to provide adequate supervision for all the individuals identified by the facility as "Wander Risks". The facility failed to develop a written training/ inservice record to ensure that all staff were aware of the need to have two staff up front at all times to provide adequate supervision for all the individuals identified by the facility as "Wander Risks". On 6/9/06 at 1:15pm., E6 was notified that the Immediate Jeopardy was removed due to the surveyor confirming the plan submitted by the facility which includes; development of a front coverage protocol, a plan to train staff on the protocol, and supervisory monitoring of staff implementation of the protocol. Also included was that R1 would remain on 24 hour one on one supervision for a minimum of 60 days, and then R1's status would be reviewed by the IDT. Although the Immediate Jeopardy was removed, the non-compliance continues at the time of the exit because the facility has not had the opportunity to fully implement their plan.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a)	W9999		

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350.1060c)1)
350.1060c)2)
350.1060d)
350.1060e)
350.1060h)
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.

c) There shall be written training and habilitation objectives for each resident that are:
1) Based upon complete and relevant diagnostic and prognostic data.
2) Stated in specific behavioral terms that permit the progress of the individual to be assessed.

d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.

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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.

h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.

Section 350.3240 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 interview and record review, the facility failed to set up a structure which protected R1 from neglect by failing to develop and implement written procedures that prohibit neglect, in that:

a) Facility staff neglected to implement facility procedure "Caseload system for monitoring individuals" section 2.3 and 3.1. resulting in R1 being able to leave the facility and facility grounds unsupervised on 5/29/06.

b) The facility neglected, prior to the incident of R1 leaving the building unsupervised on 5/29/06, to develop a written procedure to implement the recommendation from the Investigation Summary

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from R1's incident of leaving the facility and facility grounds unsupervised on 5/13/06. This recommendation was for two staff to be covering "upfront" at all times. The facility failed to develop a written training/inservice record to ensure that all staff were aware of the need to have two staff up front at all times.

Findings include:

a) R1, per facility consumer profile, is a 39 year old female who functions in the Profound range of Mental Retardation. R1's current Individual Program Plan (IPP) of 2/27/06 states that R1 has an estimated IQ level of 15. R1's IPP under the section titled "Community Involvement, Recreation and Leisure" states, "I need close supervision when I am out."

R1's IPP, under the section titled "Relating" states, "I talk to staff by gesturing, pointing, touching. I know three signs, especially toilet. Staff need to watch my face for expressions. I use a lot of non-verbal communication." R1's " Behavior Support Plan" of 2/27/06 describes R1's behavior challenges as screaming, being aggressive toward herself by pulling hair, hitting, grabbing clothing and the skin underneath, and scratching.

Notes from a "Work Meeting" dated 5/23/06 regarding R1 were reviewed. They state, "The IDT (Interdisciplinary Team) met on this date to discuss approaches regarding (R1's) elopement. The first occurrence was on Monday, March 13 at (the facility). The second incident occurred Monday, April 24 at (day training)." It continues, " The third occurred Saturday, May 13."

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A facility "Investigative Report" states that " Between 9:15 AM and 9:30 AM on May 29, 2006, (R1) left (the facility) presumably through the door to the garage and out another door in the garage leading to the parking lot." The report states that R1 was located "walking south down the west sidewalk on 9th Street." The report states that "The time that elapsed from initiating the search to apprehending (R1) was somewhere between 7 - 10 minutes." Ninth Street is observed to be a two lane street in a mixed residential and business area with steady traffic. Notes from a "Work Meeting" of 5/30/06 state R1 was found "about a half a block away."

The facility's "Daily Caseload Responsibilities" form for first shift after 9:00am. lists E1 (direct care) as having R1 on her caseload at that time. E2 (Administrator) was interviewed on 6/7/06 at 2 :50pm. E2 verified that R1 was assigned to E1 at that time.

The facility has a procedure titled "Caseload system for monitoring individuals." It is listed as under the subject of "Safety." Under section 2.0 " CASELOAD RESPONSIBILITY" number 2.3 states, "The staff person is responsible for knowing the whereabouts of the persons on their caseload during their entire shift and ensuring the safety of those persons." Under section 3.0 " TRANSFER OF CASELOAD RESPONSIBILITY" 3.1 states, "Any time the staff person is engaged in an activity that will prevent them from providing the monitoring of their caseload (med pass, showers, cooking, outings, breaks), they will physically transfer the persons on their caseload to another staff at the house if one is available."

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The facility investigative report states that there were four staff on duty at the time. Under the section titled "Analysis of Evidence" it states, " Staff was using the caseload method of assignment to supervise individuals, although there did not appear to be much supervision when (R1) was missing. At the time (R1) disappeared, 3 staff was in the kitchen and 1 staff was in the laundry room doing laundry. No staff was present with individuals."

The facility investigative report states that at the time of R1's leaving, E5 (direct care) was in the laundry room, E1 "was cleaning out the refrigerator," E4 (direct care) "was finishing the dishes from breakfast," and E3 (direct care) "was preparing potatoes for potato salad." E2 was interviewed on 6/7/06 at 3:15pm. E2 stated that " No one had transferred caseloads." E2 stated that if someone needed to be cooking they should have transferred their caseload. E2 also stated that it was a problem that all three staff were in the kitchen.

E2 was asked who the facility had identified as " Wander Risks". E2 identified, R2, R3, R1, and R 4 but stated that R4 is currently inactive as a wander risk. Review of "Resident Check Sheet' from 5/29/06 lists that R1, R2, R3, and R4 were all present on that day at the time of the incident. Investigation Summary from the incident of 5/13/ 06 states that "At about 2:15pm (R3) Jogged toward the door and went outside." Staff ran after R3 and this left R1 unsupervised and that is when she left the facility by another door during the incident of 5/13/06.

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Facility "Team Meeting" notes from 4/28/06 were reviewed. Number 3. lists "Official Caseload Procedure." Under that it includes, emphasized importance of transferring responsibility, read procedure to staff, and all staff received a copy of the procedure. E2 was interviewed on 6/7/06 at 2:50pm. E2 stated that, "They should not have had three in the kitchen. Staff did not follow what they were told to do."

Facility staff neglected to implement the procedure "Caseload system for monitoring individuals" sections 2.3 and 3.1 resulting in a lapse of supervision which allowed R1 to leave the facility and facility grounds unsupervised.

b) The facility neglected, prior to the incident of R1 leaving the building unsupervised on 5/29/06, to develop a written procedure to implement the recommendation from the Investigation Summary from R1's incident of leaving the facility unsupervised on 5/13/06. This recommendation was for two staff to be covering "upfront" at all times. The facility failed to develop a written training/inservice record to ensure that all staff were aware of the need to have two staff up front at all times.

Facility procedure titled "Handling, Investigating, and Reporting Unusual Incidents" under section 3.0 "Response Procedures and Reports" number 3.2 states, "Upon conclusion of the investigation, the lead investigators will share with the program director their findings. The program director will take any necessary follow-up action to prevent similar incidents from occurring. These actions may include but are not limited to: 3.21 Convening meetings of Individuals

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	14G296	A. BUILDING ____ B. WING ____	C 06/13/2006

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Interdisciplinary team to review incident and address concerns. If perpetrator is an (facility/ agency) Individual, the director will convene the perpetrator's interdisciplinary team to review incident and implement procedures to protect safety of self and others."

Investigation Summary from the incident of 5/13/06 states that "At about 2:15pm (R3) Jogged toward the door and went outside." Staff ran after R3 and this left R1 unsupervised and that is when R1 left the facility by another door. R1 was found on the sidewalk in front of the facility. Under recommendations it states, "2. Two staff to do front area coverage at all times due to the set up of the house." In another area it recommends, "When there is 3 staff on duty 2 staff should be covering upfront at all times."

A written statement was taken from E7 (program supervisor) on 6/7/06. E7 wrote, "I did verbally tell my staff post the 5/13/06 incident that 2 staff should remain in common areas (when only three are scheduled) but I do not believe that there is any specific policy stating this, as since this incident no less than four staff have been scheduled at any give time especially on the weekends."

A written statement was taken from E2 (Administrator) on 6/7/06. E2 wrote, "Following the exit review of 5/26/06 it was my understanding that the facility would ensure that two staff were to monitor the front living area. This information was conveyed verbally to staff by (E7), program supervisor." E2 was interviewed on 6/7/06 at 2:16 pm. When asked which staff had been trained on this, E2 stated, "I

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do not know which staff. I can look and see who was working. That's probably something that should have been in the com. (communication) log."

E7 was interviewed on 6/7/06 at 2:08pm. When asked regarding the 2 person supervision of the front area how the training was done, E7 stated, " Verbally, I just told my staff." When asked when this occurred, E7 stated, "Sporadically after the 13th. The following weekend I started scheduling four. I didn't stress keeping two up front. We wouldn't be running short." When asked if keeping two staff up front was still in effect E7 stated, "With her (R1) being one on one, watched 100% of the time, we try to maintain the ratio in caseloads." E7 was asked if there was an inservice record for the training for keeping two staff up front, E7 stated, "No."

E2 was interviewed on 6/7/06 at 2:16pm. When asked if there was a formal procedure for the two person supervision up front, E2 stated that there was a team meeting following the incident of the 29th. When asked what the result of that meeting was, E2 stated that all staff were informed to continue to leave 2 people up front.

E2 was asked on 6/7/06 at 3:15pm., who the facility had identified as "Wander Risks." E2 identified, R2, R3, R1, and R4 but stated that R4 is currently inactive as a wander risk. Investigation Summary from the incident of 5/13/06 states that "At about 2:15pm (R3) Jogged toward the door and went outside." Staff ran after R3 and this left R1 unsupervised and that is when she left the facility by another door.

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W9999	Continued From page 23 On 6/7/06 E2 put out a memo. It states, " Effective IMMEDIATELY, there are to be a minimum of two staff in the front living area providing coverage at times when the individuals are home and awake. This means specifically that only one staff at a time can be in rooms other than the common living area. This includes the kitchen, bedrooms, laundry room and study." (A)	W9999		