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	14G103	A. BUILDING _____ B. WING _____	01/11/2006

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PIASA MANOR	110 NORTH ALBY COURT GODFREY, IL 62035

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W 255	Continued From page 42 maladaptive behaviors of aggression and current day training objectives reviewed for ongoing progress. There was no evidence that collected "data collection" is systematically recorded and analyzed to address changes for specific objectives as identified by the IPP. The current reviews have a singular statement that addresses only "continue-progress" and there is no review to current objectives as identified in the current individual program plan 2. Additional examples available for R#1, R#3 & R#4 that determine that the residential facility failed to review and revise current successful objectives identified in the individual program plan.	W 255		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Per file review and staff interview it was determined that the residential facility failed to review and revise as necessary objectives identified in the individual program plan for 4 of 4 clients(R#1-4) in the sample. Findings include: 1. Per file review and staff interview it was	W 257		2/17/06

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W 257	Continued From page 43 determined that R#4 is a 50 year old male with a diagnosis of severe MR & Schizophrenia. Per review it was noted that R#4 had his last IPP on 11/7/05 and has current objectives to address deficits in meal time-utilize a napkin, self-medication, coin identification, leisure activity, counting & maladaptive behaviors-disruptive behaviors. Per file review and staff verification it was noted that R#4 had the following objectives with noted failure to progress from 9/01/05-11/30/05;"coin identification, counting, leisure activity & self-medication". Per review it was noted that the residential facility failed to note revisions made for R#4's unsuccessful current objectives. In addition there was no evidence that addressed maladaptive behaviors of disruptive behaviors and current DT objectives have been reviewed. There was no evidence that collected data collection is systematically recorded and analyzed to address changes for specific objectives as identified by the IPP. The current reviews have a singular statement that addresses only "continue-no change" and there is no review to current objectives as identified in the current individual program plan. 2. Additional examples available for R#1, R#2 & R#3 that determine that the residential facility failed to review and revise current unsuccessful objectives identified in the individual program plan.	W 257		
W9999	FINAL OBSERVATIONS Licensure Violations 350.620a) 350.1060d)e)h)	W9999		

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W9999	Continued From page 44 350.2700d)2) 350.3240a)b)c)d)	W9999		

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 .
d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.
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 350.2700 General Building Requirements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a patient leaves

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W9999	Continued From page 45 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. 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These regulations were not met as evidenced by the following: Based on observation, interview and record verification, the facility failed to implement its policy to prohibit neglect for 1 of 1 (R5) when they failed to prevent R5's elopement/leaving the facility unsupervised and when they failed to: A) put systems into place and provide safeguards to prevent elopement of R5, who had a known	W9999		

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W9999	Continued From page 46 history of elopement and who had unauthorized absences when he left the facility unsupervised (eloped) on multiple occasions; B) follow the facility policy for Missing Persons when they failed to report and investigate incidents when R5 eloped from the facility; C) provide adequate supervision to prevent R5's elopement/unauthorized absence from the facility after R5 was determined to have poor community and personal safety skills and has a history theft from stores; D) ensure that clients could easily re-enter the facility, if outside, when the door bells did not work, door alarms were turned off or malfunctioned and all doors locked automatically from the outside when closed, making independent re-entry to the facility impossible for clients who went outside; and E) ensure training programs were developed for R5 when he had multiple elopements and after the guardian requested such a program be written. This failure has the potential to affect 12 of 12 other individuals at the facility (R1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 13) who could leave the facility leave the facility without staff knowledge/ supervision and without being able to independently re-enter the facility. A) According to the record, R5 is a 50 year old male with a diagnosis that includes (per physician order sheet) R/O [Rule Out] Beginning Organic Mental Disorder, Moderate Mental Retardation,	W9999		

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W9999	Continued From page 47 Hearing Loss and Depression as well as other medical diagnosis. A Behavioral Support Plan also lists additional diagnoses of Schizophrenia, Paranoid Type and Schizoid Personality Disorder. Per the record face sheet, R5 was admitted to the facility 2-10-86 and has a court appointed guardian. Per his record, he has an IQ of 53 and a functioning level of 6 years 4 months. The Annual Social Assessment dated 3-29-05 states R5 has a history of verbal and physical aggression and has "been known to elope and he has been known to engage in illegal behavior, such as stealing, going through people cars and mail boxes." R5 has a behavior plan to address his stealing by teaching him to budget his money. The Social Assessment states R5 should be " Supervised and assisted community activities due to poor self-preservation skills and poor money management skills." Per R5's Individual Support Plan dated 3-15-05, R5 has shown he sometimes does not recognize social boundaries, refuses to communicate with others by walking away or refusing to response to what someone is saying - that this usually occurs when confronted about inappropriate behavior. He is to have service objectives to monitor for inappropriate touching, property destruction and noncompliance with staff directives, however there is no evidence these service objectives were developed. Community safety and awareness assessments show that R5 does not have community or personal safety skills. Per R5's Individual Service Plan, he is on a cigarette restriction for budgetary reasons and will take opportunities to find cigarette butts (to	W9999		

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W9999	Continued From page 48	W9999		

smoke). The Individual Service Plan states, "Per guardian request, (R5) should not walk to the store with a peer. He should only be escorted to the store by staff."

There are 9 documented incidents of R5 eloping/ leaving the facility without staff knowledge or authorization between July and October, 2005. There is no evidence the facility has taken action to prevent R5 from having further incidents of elopement.

Per review of facility incident reports, there is a report written by E2, house manager, on 9-6-05 at 1:51 PM, for an incident of 9-3-05 at 10:00 AM. The incident reflects information written on an " ABC Documentation" sheet dated 9-3-05 at 10: 00 AM written by E7, Direct Support Person (DSP). The note and incident report state that, " Staff noticed [R5] was not in the building. Staff went to look for him outside and he was walking down the highway and 2 cars had to go around him. Staff counseled him about the dangers of walking by the highway. He just walked off into the house." The incident report was signed by E 2 and E7. Per the incident report, the guardian was not notified of the incident until 9-6-05 at 1: 51 PM. The guardian returned the call at 3:28 PM per the incident report and said that "she wanted the QMRP [Qualified Mental Retardation Professional] to write a program offering praise."

Review of behavior documentation notes on ABC Documentation sheets and "Chronologicals" written by the Direct Support Staff shows that R5 had multiple episodes of elopement with no evidence of the guardian being notified, an incident report being written or further action

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W9999	Continued From page 49	W9999		

taken, other than to remind R5 that he should not leave the facility unsupervised. The following incidents of elopement are documented in ABC documentation sheets and chronologicals written by direct care staff:

7-10-05 at 10:45 AM - "After being checked by staff in his room [R5] sneaked out the back door and walked to store. Staff followed up on [R5] and [R5] was walking continuously to store. Upon return he was counseled not to walk to store [without] telling staff. [R5] continued to store and back with a cup of soda hidden on the back of fish tank."

7-10-05 at 1:45 PM - "Redirected by staff away from dumpster salvaging trash. [R5] walked sneaked back to store while (unreadable) out door when left by staff."

7-16-05 at 12:30 PM - "After eating his lunch. Walked to outdoor/gas station without telling staff . Eloped through back door. Female staff followed up [R5] walking back. [R5] bought soda at the gas station."

7-23-05 at 9 AM - "Residents finishing ADL's [Activities of Daily Living] and AM care. Another resident told staff [R5] walked to the gas station. When [R5] came back staff ask him to see his pockets. He had 2 cig butts in his pocked. [R5] counseled about stealing things. Staff threw them away."

7-25-05 at 9 AM - During hygiene programs left out of door and returned with a pocket full of cigarette butts.

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W9999	Continued From page 50 8-6-05 at 5:15 PM - Per the ABC Documentation sheet R5 was redirected after masturbating in the TV room while watching television. At 6:15 PM it was documented that he was looking at TV the day room. "Missed at 6:30 PM. Looked him - saw him coming from store. Left premise without signing up on book. Went to store brought back a soda. Counseled. Could be dangerous not appropriate to go to store without consent." 8-13-05 at 12:30 PM - "After lunch [R5] 'eloped' walked to store after lunch without staff knowledge. Was followed up by staff. [R5] was picked by staff in van." 9-3-05 at 10:00 AM - Previously noted incident when R5 was missing. 10-1-05 at 1:55 PM - [R5] was outside standing with a few resident (front area) socializing. Went to the store without asking staff to buy soda. He had a cig butt in his hand. He was redirected and talk to about this. Said to leave him alone and went to his room." Per interview with E1, Qualified Mental Retardation Professional (QMRP) on 12-23-05 R 5 is not allowed to go into the community without staff and had a past behavior of stealing soda from the [name of] gas station. Per interview with E7 on 12-22-05 at 7:45 AM, R5 would go to the gas station to get sodas. E7 said that R5 chose opportune times to leave the facility such as when there are fewer staff and when staff are busy. This was verified by interview with E5, Direct Support Staff (DSP),	W9999		

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W9999	Continued From page 51 interview on 12-29-05 at 4:00 PM and with E10, DSP, interview on 12-23-05 at 11:40 AM. R7 said that R5 had left the facility before and that staff always found him - "most of the time (he was) standing in front of the strip mall watching traffic - about 1/2 block away and out of eyesight of facility." E7 said that on 9-3-05 when she found that R5 was missing - she saw that R5 was gone and she ran to find him. He was about 1/2 way to the gas station walking in the roadway and 2 cars had to swerve around him, according to documentation. He was upset and was cursing and saying leave me alone. E7 said that she kept talking and walking with R5 coaxing him to return to the facility. Per E7, she was probably doing the laundry when R5 left on 9-3-05 that she was not sure how long he was gone, but that R5 was probably gone about 5 to 10 minutes (when his absence was discovered). Per E7, and verified in R5's Individual Service Plan [ISP] in the area marked "Communication," R5 wears a hearing aid and he cannot hear well without the use of the aid. Per the ISP, his speech is sometimes difficult to understand and does not recognize appropriate social boundaries. E7, who has worked at the facility for 11 years, said that R5 is not to leave the facility without staff and the guardian "said that she wanted staff to go with him (to the store)." E7 said that R5 turns his hearing aid off - "When we talk to him [and he does not] want to listen to us." E7 said that R5 turns the hearing aid off when he leaves the facility. He would not be able to hear a train with his hearing aid turned off.	W9999		

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W9999	Continued From page 52 Per observation of the route from the facility to the gas station/convenience mart to which R5 goes, the gas station is 0.2 mile from the facility. The route includes walking about 1/2 block down a lane by the facility that dead ends into a main street/highway. This is a busy 2 lane street. The route continues turning left onto the busy 2 lane street street for about 1 block. The busy 2 lane street has a narrow shoulder and no sidewalk. The route includes crossing a single railroad track with a crossing gate. Per observation and per interview with Z2 on 12-28-05 at 2:15 PM, the passenger trains that frequent the railroad tracks "flies through and does not slow down at the crossing." The route then continues to a dead end at a 4 lane road with a 3 way stop sign. The busy intersection/street must be crossed to get to the site of the gas station. The route to the gas station then turns right on the 4 lane street without a sidewalk about 1/2 block to the gas mart. The route crosses driveways of several businesses and a carwash. Per Z2, there are about 4 clients who come to the convenience store without staff. Z2 said that some of the people (from the facility) would come in and eat things in the store - they would throw a fit and the police were called." Z2 said that an unknown gentleman from the facility called and said if certain individuals come (to the store) we should call him. Z2 did not know the date the man called or the name of the man. Z2 said that the store policy is to call the police or sheriff (and not the facility) if there is a disturbance or theft. No facility documentation regarding incidents of police being called by the store was noted during the survey.	W9999		

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W9999	Continued From page 53 Following the elopements of R5, there is no evidence the facility put any additional system into place to prevent further elopements. Per interview with E1 on 12-23-05 no additional systems were put into place to prevent R5 from eloping, because she did not consider his leaving the facility as an elopement but as leaving the facility without permission. E1 said that you cannot believe all that the DSP's write - that even though they document R5's " elopement," it is not elopement per E1. Per E1, her definition of an elopement is not seeing clients and not knowing where they (clients) have gone. E1 said that R5 always goes to the store/ gas station. When out of facility eyesight and supervision, there is no way the facility can assure R5's destination or safe arrival. Based on assessments, there is no way to assure R5's health and safety when he is out of eyesight of the facility staff: R5's "Community Safety" assessment states R5 needs physical prompts to "only gets in vehicles with people they know...Walks away from strangers who approach them. Able to identify police when out in the community. Crosses the street at the cross walks. Stops and looks both ways before crossing the street/railroad tracks. Checks for traffic before crossing alleys, driveways and parking lots. Follow safety signs (Danger). Asks for help when in danger. Asks for directions if lost..." Per his ISP, R5 does not hear well without his hearing aid and is difficult to understand (in communication). Per interview with R5 on 12-22-05 at 8:15 AM, he	W9999		

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W9999	Continued From page 54 goes to the store and goes by himself. He said that he leaves without staff. "Can go by myself - go to buy soda." When asked if there is soda at the facility for R5 so that he does not have to go to the store, R5 said that there is none, that he has to go to buy it (at the store.) R5 said that he does not "sign out." "I just go - don't have to tell anyone." Each time R5 has eloped, upon return staff documented that they have talked to R5 about leaving the facility without staff. No additional facility systems are put into place to safeguard R5 to prevent his leaving the facility without staff knowledge or supervision. B) The facility failed to follow its policies for missing persons and neglect when they failed to report and investigate incidents when R5 left the facility on multiple occasions. The facility's policy includes the definition for neglect as being an "omission by an employee or person which denies the standard care and treatment due an individual as required by law, rules, regulations, policies, procedures guidelines, or Individual Support Plan and the act.....where the act has the probable consequence of inflicting significant harm." 1. The facility's policy for "Missing Individual" states that if an individual is missing from the facility, the identified standard procedures are to be followed. Additionally the policy states that if the individual's runaway behavior is habitual and dangerous to the individual's health and safety.... alternative environment shall be considered when	W9999		

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W9999	Continued From page 55 reasonable behavior management techniques have failed to reduce the individual's runaway behavior. The facility failed to implement the policy when R 5 had 9 documented incidents of leaving the facility between 7-10-05 and 10-1-05 when they failed to develop behavior management techniques to reduce the behavior including behavior management techniques. 2. The facility failed to implement it's Missing Person Policy when they failed to notify the Administrator of the incident of a missing person. Per the documented incidents of R5 leaving the facility and the one documented Incident Report of 9-3-05, there is no evidence the facility notified the Administrator of the repeated incidents of R5 leaving the facility. It was verified by E1, Qualified Mental Retardation Professional (QMRP), on 12-23-05 that the Administrator was not notified of any of the incidents of R5 leaving the facility since E1 had not considered the incidents as elopements or missing persons. 3. The facility failed to implement it's Missing Person Policy when they failed to complete the Unusual Incident Report Form when a person has been missing. The only Unusual Incident Report Form completed (when R5 was found to have left the facility) was from the 9-3-05 incident when R5 was walking to the store without staff after it he was found to be missing from the facility. None of the other documented 8 incidents had an Unusual Incident Report Form completed. Per E1, she did not track and did not know the dates or times of the other incidents	W9999		

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	14G103	A. BUILDING _____ B. WING _____	01/11/2006

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W9999	Continued From page 56 documented in behavior and narrative notes. 4. The facility failed to implement its Missing Person Policy when it failed to implement the " follow-up activities" to be undertaken to: "Notify appropriate parties, Determine the condition of the individual, and consider actions necessary to prevent recurrences." There is no evidence that the guardian, administrator, QMRP or the Department were notified of the incidents of elopement at the time of occurrence. There is no evidence the facility considered actions to prevent recurrences of R5 leaving the facility following multiple incidents of elopement. E1 verified this since she considered R5's actions as only leaving the facility without permission and not an elopement or missing person incident. C) Per observation and interview and record verification, the facility failed to ensure there was adequate staff supervision to monitor and prevent R5's behavior from leaving the facility without staff knowledge or supervision. Per observation during the survey, R5 independently walked throughout the facility and sat unsupervised in the recreation room. There was no observed additional staff monitoring all of R5's whereabouts during the survey. Per interview with E5 on 12-29-05 at 4:00 PM, E7 on 12-22-05 at 7:45 AM and with E10 on 12-23-05 at 11:40 AM, R5 chooses times to leave the facility when there were fewer staff working and at times when the staff is busy. This usually is on the week ends, per E10. Per verification of the staff schedule, there are 2	W9999		

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W9999	Continued From page 57 direct care staff scheduled to work the day and evening shift and one direct care staff scheduled to work the night shift on weekends. The 2 direct care staff are responsible for cooking, medication pass, housekeeping/laundry duties and assisting with active treatment for the 14 clients who reside at the facility. All staff interviewed said that try to monitor R5's whereabouts, but when one staff is cooking and one staff is giving medications, there is no staff to visually monitor the clients in the facility including the whereabouts of R5. E5 and E7 both said that R5 usually leaves the facility when staff are busy. E7 said that the "office told us to keep a closer eye on him [R5]," but no extra staff are scheduled to ensure this could happen when the 2 working staff had to pass medications, cook and perform other duties. E7 said that at one time there was a third staff scheduled, but that was a "long time ago." E2, house manager, verified in interview on 12-23-05 at 1:45 PM that there are only 2 direct care staff, including a staff assigned to cook on week ends. E2 completes the staff work schedule. There is no evidence in R5's record that there was a need identified for additional supervision/ monitoring to be provided to prevent him from leaving the facility without staff knowledge or supervision. D) The facility failed to ensue clients can easily gain access to their home if outside the facility when all outside doors are locked, clients have no key to the facility, door alarms are not functioning or are turned off and the door bells did not function. Per observation at the facility during the survey	W9999		

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W9999	Continued From page 58 on 12-21-05, the outside doors of the facility are all locked. The door bells to the facility did not work. Access to the facility can be gained only when staff answer a knock on the door. The doors lock automatically when the outside door is closed. A side door was observed to be partially propped open to allow staff and clients access to the outside by the parking lot on 12-21 and 12-22 -05 during observation hours. A door alarm for the door was not activated. E1 and E2 were not aware that the door bell was not working on 12-21-05 and E2 said on 12-22-05 that sometimes the battery for the door bells did not work in cold weather. E1 verified on 12-23 -05 that the door bells did not work on 12-21-05 and 12-22-05 but the door bells were replaced on 12-22-05. Per observation, E9 was observed to replace all door bells because they did not work. There was nothing documented in staff communication that the door bells did not function. E1 said that to the best of her knowledge, door alarms work. When asked how clients are able to get in the building if they go out to the patio, etc, E1 said normally the door was not shut all the way, but sometimes R4 will shut the door and clients will knock to come in. Per observation of the door alarm system, when the door alarms are on, the alarm stays on [activated] as long as the door is open. If a door is not shut tightly and if the alarm system was turned on, the alarm would have a constant loud buzz as long as the door was open and/or until the alarm was turned off and reset after the door was closed.	W9999		

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W9999	Continued From page 59 Per observation of the door alarm system none of the door alarm switches are identified. There are 8 switches for 5 doors. A communication in the communication book from direct care staff stated on 12-8-05 that #2 and #4 door alarm would not shut off and on 12-10-05 "2 and 4 alarms not working." E2 said that the 2 alarms are not connected to any door. E2 could not say which other switch is not connected to a door, but no other switch had a constant buzz (as did #2 and #4) when it was turned on. #2 and #4 were turned to the "off" position. Per observation on 12-28-05 the #2 and 4 switches sounded as soon as the switches were turned on. E2 did not know which of the 8 switches were connected to which door and said if a door buzzer is activated, staff have to check all doors to determine what door is opened to activate the switch. During the survey observations on 12-22-05, R4 was home from the workshop and independently paced throughout the facility during the day. The surveyors went in and out of the building several times and no door alarm for the front doors sounded. On 12-23-05 all clients were home from the workshop. During the day when the surveyor left the facility, no door alarm sounded. Per interview with E2 on 12-28-05 at 12:30 PM, it was possible that the door alarms did not go off if they were not turned on. E5 said in interview on 12-29-05 at 4:00 PM that as far as she knew, door alarms were turned on, but may be turned off at times and staff forget to turn them back on at times. E7 verified that all outside doors are locked, and there is one key to a side door	W9999		

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W9999	Continued From page 60 available to staff that is on the van key ring. E7 said that the door alarms have not been working right and did not know if the door alarms were on when R5 eloped from the facility on 9-3-05. The QMRP notes for "Monthly Progress Review" for the Month of November - 2005 stated that "[R 5's] guardian called QMRP and stated that [R5] was going outside and taking cigarette buts from the smoking can, and then he would be locked outside and would have to walk around the building to be let back in because the door would lock behind him. DT [Day Training] QMRP stated that [R5] was going outside when it was not break time, and that she was going to move him to an area that would be able to monitor him closer." Although this November entry apparently refers to the DT site, the same situation would be applicable to the facility since R5 has gone outside for cigarette butts without staff knowledge, as indicated by staff documentation and the facility doors lock behind him. There is no evidence the facility has addressed how clients (who can independently leave the facility) can independently gain access to the building when outside. Z2 stated that 4 clients come to the store independently. E4 verified that R2, R8 and R10 go to the gas mart independently and that R7 goes with another client - usually R8. If outside doors are locked, no client has a key for the building and door bells do not work, there is the potential that staff or clients inside the facility would not hear clients knocking from outside if there was no one in the area of the outside doors. E1 verified that no client has a key for the facility.	W9999		

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W9999	Continued From page 61 E) Per interview and record verification, the facility failed to develop a training program for R5 when he exhibited behaviors of elopement and after the guardian requested such a program be developed. Per R5's ISP, he has a history of theft from stores, verbal and physical aggression. The ISP "Recommendations" include [#2] "Supervised and assisted community activities due to poor self-preservation skills and poor money management skills. [#3] Assist [R5] in money management and financial issues due to his inability to handle his money appropriately." A community safety assessment showed that R5 needed "physical prompt" to cross the street at cross walks; stop and look both ways before crossing the street/railroad tracks; check for traffic before crossing alleys, driveways and parking lots; follow safety signs; ask for help when in danger; ask for direction if lost; walk away from strangers who approach [him]; locks/ unlocks doors when necessary; only get in vehicles with people they know. The recommendation is that R5 would benefit from learning his address. His community safety skills were not addressed as a need when R5 had multiple incidents of leaving the facility, crossing busy streets, railroad tracks, driveways of businesses, getting soda from a store and/or coming home with cigarette butts (it was not witnessed how he obtained the soda or cigarette butts). Past and current Social History and independent living skills assessments showed that R5 can be verbally and physically aggressive, he can be overly affectionate at times, does not have the ability to give informed consent for sexual activity,	W9999		