

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2007
NAME OF PROVIDER OR SUPPLIER SOUTH HAVEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH REED ST., P.O. BOX 134 ROBINSON, IL 62454	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
W 122	<p>Incident Investigation Survey Incident of 01/28/07 - IL 27059</p> <p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility has neglected to provide necessary supervision to prevent reoccurrence of elopement behaviors for 1 of 1 individual in the sample (R1) who eloped from the facility on 01/28/07, and then eloped from the facility again on 01/31/07.</p> <p>Refer to deficiencies cited at:</p> <p>W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p>	W 122		2/23/07
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility has neglected to provide necessary supervision to prevent reoccurrence of elopement for 1 of 1 individual in the sample (R1) by their failure to:</p>	W 149		2/23/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	<p>Continued From page 1</p> <p>1) Develop a behavior program to address R1's prior history of elopement at the time of her admission to the facility on 05/19/06; and</p> <p>2) Increase R1's level of supervision after she eloped from the facility on 01/28/07. On 01/28/07, R1 eloped from the facility while on fifteen minute checks. After this incident, R1 remained on fifteen minute checks. Three days later, R1 eloped from the facility again while on fifteen minute checks.</p> <p>Findings include:</p> <p>As identified on the Physician's Order sheet dated 02/2007, R1 is a 46 year old female who functions at a mild level of mental retardation and has diagnosis of Intractable Epilepsy, Seizure Disorder and Adjustment Disorder with Depression. Documentation on the Physician's Order sheet also identified that R1 was admitted to the facility on 05/19/06.</p> <p>R1 was observed at the local day training site on 02/07/07 at 1:05 P.M.. E6 (One on One Staff) was present in the work area and was observed to sit directly to the left side of R1. R1 was observed to wear a protective helmet on her head while seated at the table. R1 did not verbalize with the surveyor during this observation.</p> <p>1) The facility neglected to develop a behavior program to address R1's prior history of elopement at the time of her admission to the facility on 05/19/06.</p> <p>The Pre Admission Information (no date) packet</p>	W 149			

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W 149	<p>Continued From page 2</p> <p>for R1 was reviewed by the surveyor. Documentation within this packet identified, "R1's whole life has been disrupted. She stayed in her father and step mother's home for a few nights but she was not happy about this arrangement. Her father also has some major health issues. When he could no longer care for R1, she went to her brother's house where she remained until April 20, 2006. She is now with her mother temporarily until she agrees to consider some other residential arrangement. R1 has visited a CILA (Community Independent Living Arrangement) and an ICF/DD (Intermediate Care Facility/Developmentally Disabled) facility ... but she hates being there and she doesn't belong with those people"... R1 has run away from the CILA home twice while visiting..."</p> <p>During the Entrance Communication on 02/07/07 at 10:55 A.M., E1(QMRP- Qualified Mental Retardation Professional) informed the surveyor that, "R1 was admitted to the facility in June of 2006 as an emergency placement. She is from the Sterling, Rock Falls area and was living at home. R1's mother had a heart attack and they tried to place her (R1) in other homes." E1 also stated that she began her employment at the facility in July of 2006 and was "unsure about R1's prior history of elopement".</p> <p>In review of R1's Behavior Support Plan dated 06/21/06, targeted behaviors were identified as: inappropriate social behaviors (defined as making insulting or rude remarks to others, addressing profanity towards others, making inappropriate comments to others, or others responding in a manner that is rude or insulting); verbal aggression; refusing to complete required activities of daily living; and stealing cigarettes.</p>	W 149			

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W 149	<p>Continued From page 3</p> <p>There were no procedures noted within this plan to address R1's history of elopement behaviors.</p> <p>During record review, E1 (QMRP) provided the surveyor with R1's revised behavior plans. At this time, E1 confirmed that R1's behavior plan was not revised until 02/02/07 after she eloped from the facility on 01/28/07.</p> <p>2) The facility neglected to increase R1's supervision level after she eloped from the facility on 01/28/07.</p> <p>The Incident Report dated 01/28/07 identifies that R1 eloped from the facility without staff's knowledge. Documentation within this report stated, "R1 left the building unsupervised between 10:10 A.M. and 10:15 A.M. and returned at approximately (no time specified) when local police assisted in bringing her home... Transfer resident to ER (Emergency Room) for evaluation..."</p> <p>The Emergency Room Report dated 01/28/07 identifies that R1 was seen in the Emergency Room (no time specified) at the local hospital. This report states, "The patient is a 46 year old white female from South Haven. Today she was out about 35-40 minutes without her coat. She was found behind an apartment building around South Haven. She was brought into the ER to "get checked out". She denied any pain, shortness of breath, nausea, vomiting, diarrhea, GI (gastrointestinal) symptoms, fever, she said she was aggravated about not seeing her mother. The staff member who came with her said she ran away 3 days ago while she was on an outing..."</p>	W 149			

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W 149	<p>Continued From page 4</p> <p>The Underground.com web site identifies that the temperature in Robinson, Illinois on 01/28/07 at 10:00 A.M. was 12.3 degrees Farenheit with wind gust up to 25.3 miles an hour.</p> <p>Per telephone interview with E1 (QMRP) on 02/08/07 at 10:25 A.M., E1 confirmed that R1 did not have a coat on when she eloped from the facility on 01/28/07.</p> <p>During the Entrance Communication on 02/07/07 at 10:55 A.M., E1 and E2 (Shift Supervisor) both confirmed that R1 eloped from the facility on 01/28/07. During this discussion, E2 informed the surveyor, "It started when R1 was on an outing with Day Training in Lawrenceville on Thursday (01/25/07) and left the group. She was always within eyesight of staff during this incident. We met with the Behavior Management Committee on Friday (01/26/07). R1 eloped from the facility on Sunday (01/28/07)." E1 and E2 both confirmed that R1 was placed on fifteen minute checks after she eloped from the facility on 01/28/07.</p> <p>In reviewing R1's Behavior Support Plan dated February 2, 2007, documentation identifies, "Throughout each day (while R1 is awake and while she is in bed), every 15 minutes a staff member will check in on R1 to verify her whereabouts."</p> <p>During review of R1's record on 02/07/07, the surveyor noted that fifteen minute checklist records were being maintained for R1 prior to her elopement incident of 01/28/07. In review of the checklist(s), documentation identified, "01/27(07) Fifteen minute checklist for VNS (Vegas Nerve Stimulator) magnet... Staff will check to see if R1</p>	W 149			

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W 149	<p>Continued From page 5</p> <p>is wearing her magnet on her wrist every 15 minutes all wake hours". The Fifteen Minute Checklist for VNS Magnet dated 01/28 (07) identified that R1 was on fifteen minute checks at the time she eloped from the facility.</p> <p>During the survey dates, no documentation was provided to the surveyor that would identify that R1's supervision level was increased from the fifteen minutes checks that were being completed prior to her elopement from the facility on 01/28/07.</p> <p>Three days after R1 eloped from the facility on 01/28/07, R1 again eloped from the facility while on fifteen minute checks. Per review of the facility's investigation dated 01/31/07, R1 eloped from the facility at 3:15 A.M. on 01/31/07. Documentation within the facility's investigation identifies,</p> <p>"Be advised that R1, a resident of South Haven Home, left the facility unsupervised at approximately 3:15 A.M. on the morning of 01/31/07. The two facility staff members on duty (E4 and 5), noted that the facility door alarm was sounded at 3:15 A.M. Both staff members immediately checked to see if the other had exited the facility. Staff members entered R1's bedroom and did not find her there. They went directly to the exit door nearest R1's bedroom, walked around the facility grounds and called R1's name, but could not locate her... At approximately 3:35 A.M. the facility notified the local police that R1 could not be located. Facility staff and police searched the immediate area and R1 was located unharmed at approximately 6:30 A.M. directly behind the facility. At the time R1 was located, she was wearing pants, a</p>	W 149			

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W 149	<p>Continued From page 6</p> <p>sweatshirt, a coat and shoes. R1 was taken to the ER for assessment... Facility staff members, both second and third shift, completed the 15 minute checks as directed. Facility staff member E4 completed the third shift checks at 12:00 A.M. through 12:45 A.M.. Staff member E5 completed 15 minute checks between 1:00 A.M. and 3:00 A.M. These checks are documented. At approximately 3:15 A.M. R1 left the facility. R1 does have a history of leaving the facility without notifying staff members. R1 left the facility on 01/28/07 between 10:10 A.M. and 10:15 A.M. and was returned to the facility at approximately 10:30 A.M. after facility staff and local police searched for and located her. As a result of this incident, R1 was placed on 15 minute checks. These checks continued from 01/29/07 through the time R1 left the facility at 3:15 A.M. on the morning of 01/31/07..."</p> <p>The Underground.com web site identifies that the temperature in Robinson, Illinois on 01/31/07 at 3:26 A.M. was 8.6 degrees Farenheit when R1 eloped from the facility.</p> <p>Per telephone interview with Z1 on 02/06/07 at 1:45 P.M., Z1 confirmed that the police department had been notified on 01/28 and 01/31/07 regarding R1 unauthorized absence from the facility. Z1 stated, "We returned R1 back to the facility on two occasions. On 01/31/07 it was really cold and the temperature was in the single digits. We had the Rescue Squad and Fire Department out looking for her. She was taken to the Emergency Room after she was found after 6:00 A.M.." During this telephone interview, Z1 confirmed that no Police Report was completed for either the 01/28 or 01/31/07 incident.</p>	W 149			

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W 149	<p>Continued From page 7</p> <p>The hospital report dated 01/31/07 identified that R1 was brought to the ER by paramedics for acute agitation. Documentation identified,</p> <p>"History of Present Illness: This is a 46 yr. (year) old mentally handicapped white female who is a resident at South Haven who has sneaked out and was unaccounted for a since about 0400 hours this morning. She was then found about 0700 hours by police after they were called to help a very agitated woman. They found her cursing and screaming and speech was difficult to comprehend although she was mentioning that her mom was dying. The patient was quite combative in the ER department and was given some intramuscular injections of Haldol 5 mg (milligrams) which was repeated once. she was then given Ativan and her behavior calmed substantially... Apparently she sneaked out of the workshop last Thursday and she also left South Haven on Sunday and today being the third episode..."</p> <p>During record review for R1, interview with E1 (QMRP) on 02/07/08 at 11:00 A.M., E1 (QMRP) confirmed that R1 wears a helmet due to "drop seizures" and was not wearing her helmet when she eloped from the facility on 01/31/07. E1 also informed the surveyor that R1 was being monitored every fifteen minutes by staff to ensure that she was wearing her magnetic bracelet to swipe her VNS during seizure activity.</p> <p>During the interview with E1 at 11:20 A.M., E1 confirmed that R1 eloped from the facility 01/28/07 and that R1 "was placed on fifteen minute checks". E1 also confirmed during this interview that R1 eloped from the facility again on</p>	W 149			

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W 149	Continued From page 8 01/31/07 while on fifteen minute checks with two staff present at the facility at the time she eloped.	W 149			
W9999	During the Daily Status Meeting on 02/07/07 at 1:20 P.M., E5 (Administrator) informed the surveyor that the facility had issued R1 a Twenty-One Day Notice as of 02/02/07. FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060a) 350.1060d) 350.1060e) 350.1060h) 350.3240a) 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. 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	W9999			

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W9999	<p>Continued From page 9</p> <p>services shall be the responsibility of a</p> <p>Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>Based on observation, interview and record review, the facility neglected to provide necessary supervision to prevent reoccurrence of elopement for 1 of 1 individual in the sample (R1) by their failure to:</p> <p>1) Develop a behavior program to address R1's prior history of elopement at the time of her admission to the facility on 05/19/06; and</p> <p>2) Increase R1's level of supervision after she eloped from the facility on 01/28/07. On 01/28/07, R1 eloped from the facility while on fifteen minute checks. After this incident, R1 remained on fifteen minute checks. Three days later, R1 eloped from the facility again while on fifteen minute checks.</p> <p>Findings include:</p> <p>As identified on the Physician's Order sheet dated 02/2007, R1 is a 46 year old female who functions at a mild level of mental retardation and has diagnosis of Intractable Epilepsy, Seizure Disorder and Adjustment Disorder with Depression. Documentation on the Physician's Order sheet also identified that R1 was admitted to the facility on 05/19/06.</p> <p>1) The facility neglected to develop a behavior program to address R1's prior history of elopement at the time of her admission to the</p>	W9999			

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W9999	<p>Continued From page 10 facility on 05/19/06.</p> <p>The Pre Admission Information (no date) packet for R1 was reviewed by the surveyor. Documentation within this packet identified, "R1's whole life has been disrupted. She stayed in her father and step mother's home for a few nights but she was not happy about this arrangement. Her father also has some major health issues. When he could no longer care for R1, she went to her brother's house where she remained until April 20, 2006. She is now with her mother temporarily until she agrees to consider some other residential arrangement. R1 has visited a CILA (Community Independent Living Arrangement) and an ICF/DD (Intermediate Care Facility/Developmentally Disabled) facility ... but she hates being there and she doesn't belong with those people"... R1 has run away from the CILA home twice while visiting..."</p> <p>During the Entrance Communication on 02/07/07 at 10:55 A.M., E1(QMRP- Qualified Mental Retardation Professional) informed the surveyor that, "R1 was admitted to the facility in June of 2006 as an emergency placement. She is from the Sterling, Rock Falls area and was living at home. R1's mother had a heart attack and they tried to place her (R1) in other homes." E1 also stated that she began her employment at the facility in July of 2006 and was "unsure about R1's prior history of elopement."</p> <p>In review of R1's Behavior Support Plan dated 06/21/06, targeted behaviors were identified as: inappropriate social behaviors (defined as making insulting or rude remarks to others, addressing profanity towards others, making inappropriate comments to others, or others</p>	W9999			

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W9999	<p>Continued From page 11</p> <p>responding in a manner that is rude or insulting); verbal aggression; refusing to complete required activities of daily living; and stealing cigarettes. There were no procedures noted within this plan to address R1's history of elopement behaviors.</p> <p>During record review, E1 (QMRP) provided the surveyor with R1's revised behavior plans. At this time, E1 confirmed that R1's behavior plan was not revised until 02/02/07 after she eloped from the facility on 01/28/07.</p> <p>2) The facility neglected to increase R1's supervision level after she eloped from the facility on 01/28/07.</p> <p>The Incident Report dated 01/28/07 identifies that R1 eloped from the facility without staff's knowledge. Documentation within this report stated, "R1 left the building unsupervised between 10:10 A.M. and 10:15 A.M. and returned at approximately (no time specified) when local police assisted in bringing her home... Transfer resident to ER (Emergency Room) for evaluation..."</p> <p>The Emergency Room Report dated 01/28/07 identifies that R1 was seen in the Emergency Room (no time specified) at the local hospital. This report states, "The patient is a 46 year old white female from South Haven. Today she was out about 35-40 minutes without her coat. She was found behind an apartment building around South Haven. She was brought into the ER to "get checked out." She denied any pain, shortness of breath, nausea, vomiting, diarrhea, GI (gastrointestinal) symptoms, fever, she said she was aggravated about not seeing her mother. The staff member who came with her</p>	W9999			

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W9999	<p>Continued From page 12</p> <p>said she ran away 3 days ago while she was on an outing..."</p> <p>The Underground.com web site identifies that the temperature in Robinson, Illinois on 01/28/07 at 10:00 A.M. was 12.3 degrees Farenheit with wind gust up to 25.3 miles an hour.</p> <p>Per telephone interview with E1 (QMRP) on 02/08/07 at 10:25 A.M., E1 confirmed that R1 did not have a coat on when she eloped from the facility on 01/28/07.</p> <p>During the Entrance Communication on 02/07/07 at 10:55 A.M., E1 and E2 (Shift Supervisor) both confirmed that R1 eloped from the facility on 01/28/07. During this discussion, E2 informed the surveyor, "It started when R1 was on an outing with Day Training in Lawrenceville on Thursday (01/25/07) and left the group. She was always within eyesight of staff during this incident. We met with the Behavior Management Committee on Friday (01/26/07). R1 eloped from the facility on Sunday (01/28/07)." E1 and E2 both confirmed that R1 was placed on fifteen minute checks after she eloped from the facility on 01/28/07.</p> <p>In reviewing R1's Behavior Support Plan dated February 2, 2007, documentation identifies, "Throughout each day (while R1 is awake and while she is in bed), every 15 minutes a staff member will check in on R1 to verify her whereabouts."</p> <p>During review of R1's record on 02/07/07, the surveyor noted that fifteen minute checklist records were being maintained for R1 prior to her elopement incident of 01/28/07. In review of the</p>	W9999			

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W9999	<p>Continued From page 13</p> <p>checklist(s), documentation identified, "01/27(07) Fifteen minute checklist for VNS (Vegas Nerve Stimulator) magnet... Staff will check to see if R1 is wearing her magnet on her wrist every 15 minutes all wake hours." The Fifteen Minute Checklist for VNS Magnet dated 01/28 (07) identified that R1 was on fifteen minute checks at the time she eloped from the facility.</p> <p>During the survey dates, no documentation was provided to the surveyor that would identify that R1's supervision level was increased from the fifteen minutes checks that were being completed prior to her elopement from the facility on 01/28/07.</p> <p>Three days after R1 eloped from the facility on 01/28/07, R1 again eloped from the facility while on fifteen minute checks. Per review of the facility's investigation dated 01/31/07, R1 eloped from the facility at 3:15 A.M. on 01/31/07. Documentation within the facility's investigation identifies,</p> <p>"Be advised that R1, a resident of South Haven Home, left the facility unsupervised at approximately 3:15 A.M. on the morning of 01/31/07. The two facility staff members on duty (E4 and 5), noted that the facility door alarm was sounded at 3:15 A.M. Both staff members immediately checked to see if the other had exited the facility. Staff members entered R1's bedroom and did not find her there. They went directly to the exit door nearest R1's bedroom, walked around the facility grounds and called R1's name, but could not locate her... At approximately 3:35 A.M. the facility notified the local police that R1 could not be located. Facility staff and police searched the immediate area and</p>	W9999			

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W9999	<p>Continued From page 14</p> <p>R1 was located unharmed at approximately 6:30 A.M. directly behind the facility. At the time R1 was located, she was wearing pants, a sweatshirt, a coat and shoes. R1 was taken to the ER for assessment... Facility staff members, both second and third shift, completed the 15 minute checks as directed. Facility staff member E4 completed the third shift checks at 12:00 A.M. through 12:45 A.M.. Staff member E5 completed 15 minute checks between 1:00 A.M. and 3:00 A.M. These checks are documented. At approximately 3:15 A.M. R1 left the facility. R1 does have a history of leaving the facility without notifying staff members. R1 left the facility on 01/28/07 between 10:10 A.M. and 10:15 A.M. and was returned to the facility at approximately 10:30 A.M. after facility staff and local police searched for and located her. As a result of this incident, R1 was placed on 15 minute checks. These checks continued from 01/29/07 through the time R1 left the facility at 3:15 A.M. on the morning of 01/31/07..."</p> <p>The Underground.com web site identifies that the temperature in Robinson, Illinois on 01/31/07 at 3:26 A.M. was 8.6 degrees Fahrenheit when R1 eloped from the facility.</p> <p>Per telephone interview with Z1 on 02/06/07 at 1:45 P.M., Z1 confirmed that the police department had been notified on 01/28 and 01/31/07 regarding R1 unauthorized absence from the facility. Z1 stated, "We returned R1 back to the facility on two occasions. On 01/31/07 it was really cold and the temperature was in the single digits. We had the Rescue Squad and Fire Department out looking for her. She was taken to the Emergency Room after she was found after 6:00 A.M." During this</p>	W9999			

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W9999	<p>Continued From page 15</p> <p>telephone interview, Z1 confirmed that no Police Report was completed for either the 01/28 or 01/31/07 incident.</p> <p>The hospital report dated 01/31/07 identified that R1 was brought to the ER by paramedics for acute agitation. Documentation identified,</p> <p>"History of Present Illness: This is a 46 yr. (year) old mentally handicapped white female who is a resident at South Haven who has sneaked out and was unaccounted for a since about 0400 hours this morning. She was then found about 0700 hours by police after they were called to help a very agitated woman. They found her cursing and screaming and speech was difficult to comprehend although she was mentioning that her mom was dying. The patient was quite combative in the ER department and was given some intramuscular injections of Haldol 5 mg (milligrams) which was repeated once. She was then given Ativan and her behavior calmed substantially... Apparently she sneaked out of the workshop last Thursday and she also left South Haven on Sunday and today being the third episode..."</p> <p>During record review for R1, interview with E1 (QMRP) on 02/07/08 at 11:00 A.M., E1 (QMRP) confirmed that R1 wears a helmet due to "drop seizures" and was not wearing her helmet when she eloped from the facility on 01/31/07. E1 also informed the surveyor that R1 was being monitored every fifteen minutes by staff to ensure that she was wearing her magnetic bracelet to swipe her VNS during seizure activity.</p> <p>During the interview with E1 at 11:20 A.M., E1 confirmed that R1 eloped from the facility</p>	W9999			

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W9999	Continued From page 16 01/28/07 and that R1 "was placed on fifteen minute checks." E1 also confirmed during this interview that R1 eloped from the facility again on 01/31/07 while on fifteen minute checks with two staff present at the facility at the time she eloped. During the Daily Status Meeting on 02/07/07 at 1:20 P.M., E5 (Administrator) informed the surveyor that the facility had issued R1 a Twenty-One Day Involuntary Discharge Notice as of 02/02/07. <p style="text-align: center;">(A)</p>	W9999			