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W 189	Continued From page 18 Another group leader informed E8 that she needed to take care of her (E8's) own group, so she checked on her group. R1 was seated at the table. E8 was sitting with her back to R1 while she fed another resident. E8 did not realize that R1 had left the building until he was brought back to the dining room by the nurse..." The facility's Internal Review report dated 07/06/07 does not identify that the committee reviewed the practice of assigning R1 to a staff member (E8) who had worked less than 30 days at the facility. E1 (Assistant Executive Director) and E2 (Executive Director) were interviewed on 07/11/07 at 12:10 P.M.. During this interview, E2 stated that the facility does provide staff with training needed to supervise the individuals, but that staff do not always demonstrate those competencies that they are trained in.	W 189		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a)d)e)h 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.	W9999		

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W9999	Continued From page 19 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 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. 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. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff implement their own	W9999		

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policy prohibiting neglect when staff failed to provide necessary supervision to prevent elopement behaviors, whereby posing a risk to the health and safety of 2 of 2 individuals in the sample (R1 and R2) who have a known history of elopement behaviors as evidenced by:

1) Facility staff neglected to provide necessary supervision to R2 on 06/28/07 on the 10:00 P.M. to 6:00 P.M. shift. As a result, R2 eloped from the Logan cottage without staff's knowledge on 06/28/07 at approximately 5:00 A.M. and made it 100 yards away from his cottage before he was stopped by staff from Hardin Apartments. A four lane street runs north and south, adjacent to this apartment complex. R2 can not recognize environmental hazards which places him at risk for harm when he is outside of his home unsupervised; and

2) Facility staff neglected to provide necessary supervision to R1 on 06/30/07 during 2:00 P.M. to 10:00 P.M. shift. As a result, R1 eloped from the Hilliard cottage without staff's knowledge on 06/30/07 at approximately 4:50 P.M. R1 left the facility property and crossed a four lane (residential) street with oncoming and ongoing traffic before he was stopped by security personnel. R1 cannot recognize environmental hazards which places him at risk for harm when he is outside of his home unsupervised.

Findings include:

The facility's policy and procedures on "Abuse and Neglect" were reviewed. The facility's policy identifies, "No individual receiving services from "----- ---- ----" (name of facility) will be abused or neglected by anyone, including, but not limited to

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staff, volunteers, contractors, family members, friends or guardians."

Further review of the facility's policy identifies that NEGLECT is defined as, "a failure in a Facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a individual or in the deterioration of a individual's physical or mental condition."

1) R2 eloped from the Logan cottage without staff's knowledge on 06/28/07 at approximately 5:00 A.M.

Review of the Client Information Inventory updated 10/06 identifies that R2 is a 69 year old male who functions at a profound level of mental retardation. The Scales of Independent Behavior (SIB) assessment dated 11/15/06 identifies that R2 functions at an age equivalent to that of a 1 year 10 month old individual. The SIB assessment also identifies that R2 never or rarely, even if asked:

* Stays in an unfenced yard for ten minutes when expected without wandering way;

* Goes alone or with friends to houses on the same block;

* Crosses nearby residential streets, roads and unmarked intersections alone;

* Goes at least four blocks (or one fourth mile) from home, school, or work alone or with friends;

* Goes on foot or bicycle to a familiar place more than one half mile (or eight blocks) from home; and/or

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* Finds planned destination, when confused, by asking directions, telephoning for help, or otherwise regaining direction.

R2 was observed in his residential unit on 07/10/07 at 3:15 P.M. R2 was observed to ambulate without staff assistance. R2 did not verbally communicate with the surveyor. A male staff was present in the group room and informed the surveyor that R2 is basically non verbal, but does say words like "coffee."

R2's Individual Habilitation Plan dated 10/24/06 was reviewed. Documentation within this plan identifies that R2 has history of elopement and is on a program to reduce episodes of agitation (physical aggression, poor sleep, responding to hallucinations, inappropriate laughter and elopement.) Review of the behavior program states,

"Staff should keep R2 in same room supervision when he is awake. When he is sleeping, staff should be sitting outside of his room. Same room supervision means that R2 should be in the same room as his group leader during waking hours and have a staff outside of his room on midnights. Monitor R2 for elopement from the area and building. He can wander off and doesn't appear to have a good sense of direction. As such he is at risk for getting lost..."

Review of the facility's Initial Complaint/Investigation Form dated 06/29/07 identifies that R2 eloped from the facility on 06/28/07. This form states,

"6/28/07 at approximately 5 A.M., R2 left his

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residential cottage unsupervised, walked to another "---- ----- " (name of facility) residential area approximately 100 yards away and was returned unharmed, to his cottage..."

The facility's Internal Review report dated 07/02/07 was reviewed. This report identifies that E3, E4 and E6 (Direct Care Staff) were on duty on 06/28/07 at the time R2 eloped from the facility. This review also identifies that E3 was the staff who was assigned to monitor R2 at the time he eloped from the facility. The Internal Review report states,

" In this instance we have an allegation of neglect. R2 is same room supervision for all waking hours and is to have someone outside of his room when he is in his room. R2 was put to bed and E4 (Direct Care), who was assigned to be with R2, was in the activity room. While E3 was in the activity room, R2 exited the building and walked to another residential area approximately 100 yards away. R2 was returned to his residential area by "----- ----" (name of facility) staff. He was examined by nursing upon his return and was unharmed..."

E3's written statement dated 06/29/07 was reviewed. E3's statement identifies,"R2 sat with me in the activity room until 5 A.M.. I was trying to keep him from going to the kitchen. R3 kept leaving the building and coming back... Around five in the morning I had to go use the restroom and so I asked E4 to watch him (R2). When I got back he (E4) told me he put him (R2) in bed and so I waited in the activity room. About 5:20 ... the phone rang. I answered the phone and E5 (Direct Care Staff) was on the line, he asked me where R2 was and I told him in bed. He asked

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me to go look and I did and he (R2) wasn't in bed. I asked him where he was and he told me Hardin Apts. (apartments) and so I went and picked him up. Then we got back around 5:30 and the Nurse was called and checked him over and no injuries were reported."

E3 (Direct Care Staff) was interviewed by telephone on 07/12/07 at 2:00 P.M. E3 stated, "I had worked at the facility for over a year. I was transferred to Logan cottage about a month ago. I generally worked the first shift. I was mandated to work the midnight shift on 06/30/07. That was the second time I had ever worked midnight shift. The first time I had worked the female end. I had never worked with R2 before. He never went to bed that night and when I went to the bathroom, E4 had put him to bed. E4 did not tell me that I had to sit out in the hall and watch R2's door. I didn't know that I was to sit in the hall when he was in his bedroom. I found that out the next morning after he eloped. I don't remember if they told me he was an elopement risk. I think I would have remembered that... R2 was wearing pajama bottoms, socks and a shirt when I picked him up from the apartments. R2 had no shoes on."

The street directly in front of the Hardin Apartments and the facility known as Humbert Road was observed by the surveyor on 07/10/07 at 4:50 P.M. The road was noted to be a four lane (residential) street with a small median in between to divide the lanes. Two lanes of traffic were observed running north in front of the facility and two lanes of traffic were observed running south in front of the facility. A continual flow of traffic was observed.

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E7 (Behavior Specialist) was interviewed on 07/10/07 at 2:50 P.M.. E7 confirmed that R2 was to have had staff sitting outside his door at the time he eloped from the facility on 06/28/07.

The facility's Internal Review report dated 07/02/07 identifies, "The internal review committee found there was not a preponderance of evidence to substantiate the allegation of neglect."

E1 (Assistant Administrator) was interviewed on 07/10/07 at 1:30 P.M. E1 stated that the internal committee did not substantiate neglect because no injury occurred as a result of the elopement incident.

The facility's Inservice Training record dated 06/28/07 was reviewed. Documentation identifies that staff were trained on R2's modified behavior program as well as facility wide training on same room supervision and responding to door alarms.

Two days after the 06/28/07 Inservice Training, R1, who was to be on same room supervision, eloped from the facility without staff's knowledge.

2) R1 eloped from the Hilliard cottage on 06/30/07 at approximately 5:40 P.M. without staff's knowledge.

Review of the Individual Habilitation Plan (IHP) dated 07/02/07 identifies that R1 is a 71 year old male who functions at a moderate level of mental retardation. R1 also has diagnosis of Autism. The Scales of Independent Behavior (SIB) assessment dated 01/31/07 identifies that R1 functions at an age equivalent to that of 1 year 10 month old individual. The SIB assessment also

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identifies that R1 never or rarely, even if asked:

* Stays in an unfenced yard for ten minutes when expected without wandering way;

* Goes alone or with friends to houses on the same block;

* Crosses nearby residential streets, roads and unmarked intersections alone;

* Goes at least four blocks (or one fourth mile) from home, school, or work alone or with friends;

* Goes on foot or bicycle to a familiar place more than one half mile (or eight blocks) from home; and/or

* Finds planned destination, when confused, by asking directions, telephoning for help, or otherwise regaining direction.

R1 was observed on 07/10/07 at 4:40 P.M. R1 was escorted by staff and was observed to ambulate to the the dining room of his cottage. R1 was not observed to communicate with staff and did not respond to the surveyor when attempts were made to communicate with him.

R1's Individual Habilitation Plan (IHP) dated 02/10/07 was reviewed. Documentation within this plan states,

"The most serious problem R1 has is his attempts at elopement. R1 no longer wears a tracking device bracelet on his wrist. R1 is to be in same room supervision unless he is in a room with alarms armed on the doors and windows. These are currently in his bedroom in the cottage. R1

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has no concept of danger and will run carelessly into the road without looking for traffic. He will enter people's homes without regard to their wishes. R1 has been known to search out trains to aid in his elopement."

Review of the facility's Initial Complaint/Investigation Form dated 07/02/07 identifies that R1 eloped from the facility and made it across the street in front of the facility before being stopped by security personnel. This form identifies,

"6/30/07 at approximately 4:50 P.M., R1, client, exited his residential cottage without his group leader, E8 (staff). He was observed by "---" (initials of the facility) Security leaving his cottage area. "---" Security was able to retrieve him at the fruit market across the street. R1 was not out of security's eye sight and was returned to "---" without injury."

E15 (Security Personnel) was interviewed on 07/10/07 at 3:20 P.M. E15 stated, "I was at the main gate when I saw someone coming from between the trees by Hilliard. I saw him (did not know that it was R1 at the time) starting to cross Humbert Road and I radioed for the second security guard and called the nurse's station. He (R1) walked straight across the road. There was a medium flow of traffic. There were cars coming and going down the road. I pursued on foot and had to stop a few cars to get across the street. I caught up with him near the white house, south of the fruit stand."

The street directly in front of the facility known as Humbert Road was observed by the surveyor on 07/10/07 at 4:50 P.M. The road was noted to be

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a four lane (residential) street with a small median in between to divide the lanes. Two lanes of traffic were observed running north in front of the facility and two lanes of traffic were observed running south in front of the facility. A continual flow of traffic was observed.

The facility's Internal Review report dated 07/06/07 was reviewed. The Internal Review identifies that E8 (Direct Care Staff) was assigned to monitor R1 on 06/30/07 at the time he eloped from the facility. This report states,

" E8 states that she was aware that R1 was an elopement risk, but that she had never put a name with a face. The supervisor for the shift (E9) gave E8 her assignment and the information about her group. When it was time for dinner, R1 was brought to he dining room. E8 stated she was bringing other residents to the dining room. Another group leader informed E8 that she needed to take care of her own group (E8's), so she checked on her group. R1 was seated at the table. E8 was sitting with her back to R1 while she fed another resident. E8 did not realize that R1 had left the building until he was brought back to the dining room by the nurse..."

E8's initial written statement (no date) was reviewed. E8 wrote, "I was helping to pass out trays and I was feeding R4. E15 and E16 came in with R1 in hand saying that he was across the street at the fruit stand. Then I let them know he was in my group. This was my first day with my own group and I have never worked with group 6 and I have been told I think 2 times he is a runner and I never even saw him get up. He was at the table to my back while I was feeding."

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E8 was interviewed by telephone on 07/13/07 at 11:15 A.M. - E8 stated, "Yes, I was hired on 06/04/07. I was in class for two weeks and I had just got off of on the job training (OJT) on 06/30/07. I had never had a group all by myself before that day. I had always worked with someone else or just observed a group. I knew the females on Hilliard cottage, but I had not worked with any of the men. During my training, R1 had been pointed out to me as the "runner." On 06/30/07, I was assigned Group # 6. E9 just gave me the Group Sheet. I was not told what type of monitoring R1 needed. I was not given any actual direction. I had never seen his behavior plan."

E9's (Shift Supervisor on 06/30/07) written statement dated 06/30/07 was reviewed. E9's statement does not identify that she gave E8 her assignment and information about working with R1 and the rest of the group. E9's statement identifies, "At the time R1 got out, I had just walked back into the dining room from checking on other client in her room. When I walked back in the nurse was walking in with R1 who was found at the fruit stand across (from) the hall."

Per review of the written statements and as confirmed per the facility's schedule for 06/30/07, E8, E9, E10, E11, E12, E13 and E14 were present on duty at the time R1 eloped from the facility. The written statements completed by E8, E9, E10, E11, E12, E13 and E14 identify that none of the staff present on duty were aware that R1 had eloped from the facility until he was returned back to the cottage.

E17 (QMRP - Qualified Mental Retardation Professional) was interviewed on 07/10/07 at 4:25

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W9999	Continued From page 30 P.M.. E17 confirmed that R1 had a behavior plan in place to address his elopement behaviors at the time he eloped from the facility on 06/30/07. E17 also confirmed that R1 was to be supervised by staff at all times to prevent incidents of elopement. The facility's Internal Review report dated 07/06/07, "The internal review committee found there was not a preponderance of evidence to substantiate the allegation of neglect." E1 (Assistant Administrator) was interviewed on 07/10/07 at 1:30 P.M. E1 stated that the internal committee did not substantiate neglect because no injury occurred as a result of the elopement incident. (A)	W9999		