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W 441	Continued From page 47 7:52a.m., 6:30a.m., 6:45a.m., 6:40a.m., 7:00a.m. and 4:10a.m. In an interview on 02-24-09 at 11:46a.m., E8 Maintenance Operations was asked about most of the third shift drills being conducted in the morning when first shift staff was present to help. E8 replied that the shifts overlap, so that was a good time to do the drills. It was explained that the purpose of the third shift drill was to train the third shift staff, who usually works alone, to be able to evacuate up to 16 residents without assistance, and to train residents to respond appropriately to the emergency when being awakened during the sleeping hours. The facility conducted only one first shift and one second shift drill to train on the proper responses to disasters other than fires (tornado, power outage, gas leak, severe storms, bomb threats, intruders, bus/van accidents etc.) There were no third shift drills conducted during the past twelve months.	W 441		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.670e) 350.670f)1) 350.670f)3) 350.1060e) 350.1610b) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and	W9999		

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W9999	Continued From page 48 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 350.670 Personnel Policies e) All personnel shall have either training or experience, or both, in the job assigned to them. f) Orientation and In-Service Training 1) All new employees, including student interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; the importance of nutrition in general healthcare; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including student interns, shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents. The employee's training and competency shall be documented. 3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. Section 350.1060 Training and Habilitation	W9999		

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W9999	Continued From page 49 Services 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. Section 350.1610 Resident Record Requirements b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as follows: Based on interview and record review, the facility failed to set up a structure which protected 1 of 5 individuals (R4) reviewed for behavioral issues from neglect and abuse when they failed to: 1) Provide adequate supervision to prevent R4 from eloping from the facility on 2/05/09. 2) Ensure staff, who have been trained in the facility's emergency behavior intervention techniques, are on duty at all times.	W9999		

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W9999	Continued From page 50 3) Thoroughly investigate the elopement of R4 on 2/05/09 as potential neglect. 4) Implement the facility's policy on elopement regarding the lack of documentation in R4's record or incident report. Findings Include: 1) The facility staff failed to provide adequate supervision to prevent R4 from eloping from the facility on 2/05/09. R4, per Psychological Evaluation of 9/20/07, is a 29 year old male who functions cognitively in the "low moderately retarded range," with an IQ of 36. R4's Individual Service Plan (ISP) of 3/20/08 states that on an assessment of adaptive behavior, R4 has a broad independence score of 6 years and 4 months. The ISP, in the section titled "Safety," states that R4 "does not navigate the community independently and has no real sense of danger." R4's assessment of adaptive behavior done 3/17/08 in the section titled "Community Living Skills" states that R4 "Crosses nearby residential streets, roads, and unmarked intersections alone" "Does, but not well--or 1/4 of the time--may need to be asked." R4's Psychological Evaluation of 9/20/07 states that a "speech impediment caused by his cerebral palsy makes his speech difficult to understand, especially by those who do not know him well." R4's ISP of 3/20/08 states that R4's "gait is noticeably unsteady due to wearing a leg brace on his right leg." R4's "Behavior Management Program" of 1/01/09 lists maladaptive behaviors	W9999		

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W9999	Continued From page 51 of Physical Aggression, Inappropriate Verbalization, and Compulsive Behavior. The facility investigation report completed on 2/07/09 by E1 (Administrator/Qualified Mental Retardation Professional) into R4's elopement incident of 2/05/09 states, "Staff confirmed that (R4) saw another resident leave the facility and decided that he wanted to go as well. According to staff he went and got his coat and left the facility even though staff attempted to stop him." The report continues, R4 "was returned to the facility by the police who stated that (R4) had been knocking on neighbor's doors attempting to get into the their homes." The facility policy titled "Abuse and Neglect Program" defines Neglect as "failure to provide goods and /or services necessary to avoid physical harm, mental anguish or mental illness." E1 was interviewed on 3/04/09 at 9:57am. E1 was asked what staff were on duty at the facility around the time of R4's elopement. E1 stated that E3 (facility direct care staff), E12 (facility direct care staff), and E11 (direct care staff from another facility) "had come over from (another facility)". E3 provided a written statement to surveyor on 2/27/09. In the written statement E3 states, "After administering meds at (the facility), I, (E3) called over to (the other facility) for a staff member to switch with me so I could administer meds at (the other facility). Before departing, (R3) came out with his bags walking out the door. Shortly (R4) followed after him repeating exactly what (R3) was saying and doing exactly what he sees (R3) doing. (R4) walks out behind (R3). I	W9999		

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W9999	Continued From page 52	W9999		

follow them, trying to talk (R4) in coming back telling him that his mom would be highly upset." E3's written statement continues, "By that time (E11) from (the other facility) has showed up. Shift leader (E6) had been contacted. Forgetting to notify (E11) of the fiasco, I hurriedly go to (the other facility) to pass meds." E3's statement states that by the time E3 returned to the facility, R4 was back at the facility, with the police.

E12 was interviewed on 2/27/09 at 1:45pm. E12 verified that it was her and E11 who were in the facility when R4 left. E12 provided a written statement to surveyor on 2/27/09. It states that R4 "went into his room got a coat on and cursed at staff exactly the way his roommate (R3) did. After a couple of minutes, about 10 - 15 mins, he returned telling me that they were on the street outside. That was after I asked him where they were. He also told me (R3) was still out there and he refused to come. He (R4) later left again saying he was going to look for (R3). About 5 minutes later (R4) came back with cops and they (the police) said that (R4) burst into one of the neighbors house."

E12's written statement provided to the facility on 2/05/09 states the following; "(R3) came out of his room dressed up, he called staff b------ on his way out saying 'see you later you b------' (twice) and left. (R4) was right behind him when (R3) was coming out of his room. (R4) said exactly what (R3) said on his way out." The written statement continues, "A few minutes later, (R4) came back and I (E12) asked him (R4) where (R3) was and he told me he was standing on the street. (E11) was here so I followed (R4) out to show me where (R3) was but there was no sign of (R3)." E12 was interviewed on 2/27/09 at

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W9999	Continued From page 53 1:25pm. E12 was asked if R4 was observed going out of the facility. E12 stated yes. E12 was asked if R4 was going to look for R3 and E12 said yes. E12 stated, "I tried to stop him but he wouldn't listen." E11 provided a written statement to surveyor on 2/27/09. It states that "I came to the facility without knowing that one of the resident (sic) was gone. I heard (R4) screaming and said (E11) (R3) is gone. So, I asked the staff who is (R3) because I don't know him. Staff told me his (sic) is new resident and he is gone. I said what do you mean gone? She said he left." The statement continues, "15 minutes later (R4) came to me again, and said (R3) is here." E11 was interviewed on 2/27/09 at 2:33pm. E11 stated that when she left to go back to the other facility, R4 was still at the facility. When asked about R4 eloping from the facility E11 stated, "I didn't hear about it." A police dispatch record from 2/05/09 at 7:45 under the section titled "Nature Desc." states, "Residential Burglary In Progress, Someone Trying To Break Into Res. Front Door, Someone Pounding On Door." Under the section titled "Additional Comments" it states, "A male had come to the residence and pounded on the door and then tried going into the residence." It continues, "All dark clothing, thin build and was younger. He appeared to struggle when walking. OFCR (officer) was able to locate the subject near (the street the facility is on)." The report concludes, "Several residents had gotten into an argument and one had walked away from the property and ended up at this address." E1 was interviewed on 3/04/09 at 9:57am. When	W9999		

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W9999	Continued From page 54 asked how did R4 get out, E1 stated that he pushed his way out the door. When asked if he was observed leaving the grounds, E1 stated that E3 saw him walking in the driveway. E1 stated that she didn't think E3 saw him leave. E1 was asked, after E3 tried to stop R4 and R3 from leaving the building but they left anyway, did anyone observe them to see what they were doing. E1 stated, "The only thing I got from (E3) was that (R4) was in the driveway and she made phone calls to get help." After reviewing with E1, E12's written statement given to the facility on 2/05/09 where it states "I followed (R4) out to show me where (R3) was and there was no sign of (R3)," which was out by the street, E1 was asked, did E12 leave R4 outside and where. E1 stated, "(E3) stated (R4) was in the driveway." When asked how did R4 get away, E1 stated, "I thought that he left from the driveway." During the interview on 3/04/09 at 9:15am., E1 stated, "They said (R4) tried to burglarize a house. I don't believe it. She answered the door and he tried to push his way in. I can see why she was scared." The facility staff neglected to provide adequate supervision to prevent R4 from eloping from the facility on 2/05/09. 2) The facility failed to ensure that staff, who have been trained in the facility's emergency behavior intervention techniques, are on duty at all times. R4's behavior management program of 1/01/09 authorizes the use of response blocking and response interruption, as necessary, to stop	W9999		

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W9999	Continued From page 55 inappropriate behaviors. Information (undated) typed by E1 which Z2 (Behavior Specialist) provided to E1 per phone conversation, describes "Response Interruption" as "used when the resident escalates and response blocking is no longer effective. Response interruption can also be used for elopement and when the resident becomes a threat to himself. Staff should use holds for short intermittent periods to prevent the resident from harming himself or others." E1 was interviewed on 2/18/09 at 2:25pm. E1 was asked what response blocking was in regard to R4's behavior management plan of 1/01/09. E1 stated that it was part of the facility's emergency behavior intervention techniques that it was a blocking technique. E12 was interviewed on 2/27/09 at 1:25pm. When E12 was asked if she observed R4 going out she stated, "Yes". When asked if it was dark outside at the time, E12 stated, "Yes." When asked if R4 went out looking for R3, E12 stated, "Yes." When asked if R4 can go out around the neighborhood by himself, E12 stated, "I don't know about that." E12 was interviewed on 2/27/09 at 1:45pm. E12 verified that it was she and E11 who were in the facility when R4 left. E11 provided a written statement to surveyor on 2/27/09. It states that "I came to the facility without knowing that one of the resident (sic) was gone. I heard (R4) screaming and said (E11) (R3) is gone. So, I asked the staff who is (R3) because I don't know him. Staff told me his (sic) is new resident and he is gone. I said what do you mean gone? She said he left." E11's written statement states that	W9999		

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W9999	Continued From page 56 E11 came over to the facility from another facility because E3 had to go to the other facility for medication pass. If E3 would have gone over to the other facility, E12 would have been by herself, if E11 had not come to the facility. E1 was interviewed on 3/04/09 at 9:57am. E1 was asked when E12 was hired. E1 verified that E12's hire date was 1/22/09. R4's elopement was on 2/05/09, two weeks later. E1 was asked if E12 had been through the facility's emergency behavior intervention techniques training. E1 stated no. E1 verified that E12 had not completed the habilitation tech training course or been certified as a direct support person. The facility's schedules were reviewed. Payroll records were requested for 2/19/09, 2/20/09, and 2/27/09. Payroll records for 2/19/09 indicate that E12 was the only staff in the facility from 9:53pm until 12:00am. Payroll records for 2/20/09 indicate that E12 was the only staff in the facility from 11:11pm until 12:00am. Payroll records for 2/27/09 indicate that E12 was the only staff in the facility from 10:28pm until 12:00am. E1 was interviewed on 3/04/09 at 2:17pm. E1 verified that E12 was the only staff working on 2/20/09 from 11:11pm until 12:00am. E1 also verified that E12 was the only staff working on 2/27/09 from 10:30pm until 12:00am. The March 09 schedule was reviewed. It showed E12 as being the only staff scheduled to work from 10:00pm. until 12:00am. on 3/06/09. E1 was asked if E12 was the only staff scheduled to work from 10:00pm until 12:00am on 3/06/09 and E1 stated, yes. The facility failed to ensure that staff, who have	W9999		

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W9999	Continued From page 57 been trained in the facility's emergency behavior intervention techniques, are on duty at all times. 3) The facility failed to thoroughly investigate the elopement of R4 on 2/05/09 as potential neglect. E1 was interviewed on 2/17/09 at 11:30am. E1 was asked if there had been any allegations of Abuse or Neglect at the facility over the last year. E1 stated that there had been "no allegations of abuse or neglect" at the facility. E1 was asked for all the incident and accident reports since 11/01/09. R4's elopement was not included in the incident reports. An investigation report titled "(R4) Investigation completed 2/7/09" was reviewed. It states, "Staff confirmed that (R4) saw another resident leave the facility and decided that he wanted to go as well. According to staff he went and got his coat and left the facility even though staff attempted to stop him." The report continues, R4 "was returned to the facility by the police who stated that (R4) had been knocking on neighbor's doors attempting to get into their homes." The report concludes, "The conclusion of this investigation is that (R4) eloped into the community." E1 was interviewed on 3/04/09 at 9:57am. E1 was asked if the final report regarding R4's elopement of 2/05/09, was submitted to the department. E1 stated, "No, because I did an informal investigation." E1 stated that she did not know to inform the department of the final report. When asked how did R4 get out, E1 stated that he pushed his way out the door. When asked if he was observed leaving the grounds, E1 stated that E3 saw him walking in the driveway. E1	W9999		

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W9999	Continued From page 58	W9999		

stated that she did not think E3 saw him leave. E1 was asked, after E3 tried to stop R4 and R3 from leaving the building but they left anyway, did anyone observe them to see what they were doing. E1 stated, "The only thing I got from (E3) was that (R4) was in the driveway and she made phone calls to get help."

E1 was asked about R4 coming back in to the facility per E12's written statement to the facility on 2/05/09, and E1 stated, "I think she has (R4) and (R3) mixed up. That's the way it reads to me."

E12's written statement given to the facility on 2/05/09 was reviewed with E1, where it stated, "A few minutes later, (R4) came back and I (E12) asked him where (R3) was and he told me he was standing on the street." Also reviewed with E1 was the section of E12's written statement given to the facility on 2/05/09 which states, "I followed (R4) out to show me where (R3) was and there was no sign of (R3)." E1 was asked, did E12 leave R4 outside and where. E1 stated, "I didn't get that. When I talked to them, they said (R3) came back. They didn't say (R4) came back. (E3) stated (R4) was in the driveway." When asked how did R4 get away, E1 stated, "I thought that he left from the driveway."

While looking at E12's written statement, E1 stated "I didn't have this thing in front of me when I was asking questions." E1 stated that she based her investigation on staff interviews. During the interview on 3/04/09 at 9:15am., E1 stated, "I interviewed staff over the phone."

E1 was asked if she reviewed the written statements prior to issuing the final report. E1

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W9999	Continued From page 59	W9999		

stated, "Yes I did." E1 stated that she didn't pay attention to E12 saying that R4 came back into the facility. The facility investigation states that staff interviews were conducted with E3, E6 who was called in and arrived after the elopement, E9 who was called in and arrived after the elopement, and E12. E11, the staff from the other facility who was at the facility at the time of the elopement, is not listed as having been interviewed. E1 was asked if she interviewed E11. E1 stated, "Yes I did. I called over to (the other facility)."

E12, in an interview on 2/27/09 at 1:45pm., verified that E11 was at the facility at the time R4 eloped. E11, in an interview on 2/27/09 at 2:33pm., stated that she was aware that R3 was missing but was unaware that R4 had eloped.

E11 provided a written statement to surveyor on 2/27/09. It states that "I came to the facility without knowing that one of the resident (sic) was gone. I heard (R4) screaming and said (E11) (R3) is gone. So, I asked the staff who is (R3) because I don't know him. Staff told me his (sic) is new resident and he is gone. I said what do you mean gone? She said he left." E11's written statement states that E11 came over to the facility from another facility because E3 had to go to the other facility for medication pass and E12 would have been by herself.

The facility investigation states, "The staff involved will be referred to the disciplinary committee." E1 was asked the results of the review by the disciplinary committee. E1 stated that they went over the policies and procedures. E1 stated, "We didn't look at this as neglect. Staff were trying to get help." E1 continued that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G293	A. BUILDING _____ B. WING _____	C 03/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARBROOK PLACE	**228 BRIARBROOK DRIVE EAST PEORIA, IL 61611**

(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
W9999	Continued From page 60 they discussed keeping individuals in eye sight especially R4 at all times. When asked for any written recommendations from the disciplinary committee, E1 produced a hand written document dated 2/07/09 which states that it was from a phone conference with E14 (Director of Operations). It states, "Staff contacted management in regards to the incident. Staff will be retrained on elopement policy. Staff will be refreshed on proper (facility approved emergency behavioral) techniques." The facility policy titled "Abuse and Neglect Program" defines Neglect as "failure to provide goods and /or services necessary to avoid physical harm, mental anguish or mental illness." The facility's investigation failed to address issues such as staff responsibility for providing supervision when R4 was threatening to leave the facility, discrepancies between interviews and written statements of different staff (ie. did R4 leave just once or twice, was he at the street with staff, and were they aware he left), and based on the facility definition of neglect did the facility fail to set up a structure which could protect R4 from harm when he was able to elope from the facility. The facility failed to thoroughly investigate the elopement of R4 on 2/05/09 as potential neglect. 4) The facility failed to implement the facility's policy on elopement regarding the lack of documentation in R4's record or incident report. . The facility's policy titled "Elopement of a resident" dated "March 2007" states the following:	W9999		

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W9999	Continued From page 61 3. Once the resident is found, notify the RSD/QMRP, police and the family/guardian. Documentation of the incident will be noted in the resident chart. 4. Documentation will include the condition of the resident, any marks noted, vitals and any other information pertinent to the incident. Facility "Guidelines For Documentation" (undated) under the section titled "Incidents" states, "I. Know what to document. A. All incidents should be documented on the following forms. 1. Baseline Sheet - how the incident occurred. 2. Observation Form - for all unknown injuries/write the name of the Nurse notified. 3. Incident Reporting Form." A facility staff training document (undated) provided by the facility, discusses documentation. Under section 6 titled "GER-General Event Reports" it lists incident reports, every incident needs to be documented on an incident report, injury or other. It states simply writing a "T-log" for an incident is not sufficient. E1 was interviewed on 2/17/09 at 11:30am. E1 was asked if there had been any allegations of Abuse or Neglect at the facility over the last year. E1 stated that there had been "no allegations of abuse or neglect" at the facility. E1 was asked for all the incident and accident reports since 11/01/09. R4's elopement was not included in the incident reports. E10 (nurse) was interviewed on 2/27/09 at 9:23am. E10 was asked about R4's elopement. E10 stated that she could not locate a General Event Report (GER) or any behavior	W9999		

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W9999	Continued From page 62 documentation about it. E10 stated, "Staff didn't do any documentation." E1 was interviewed on 3/04/09 at 9:15am. E1 stated the staff were told to do a GER and put it on a "T-log". E1 provided a "T-log" dated 2/06/09 at 8:29pm., entered by E1 which states, "I don't see behavior reports from yesterdays behaviors." The facility failed to implement the facility's policy on elopement regarding the lack of documentation in R4's record or incident report. (A)	W9999		