STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G324	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORRENCE PLACE	2601 223RD STREET SAUK VILLAGE, IL 60411

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W 340	Continued From page 19 medications. An interview was conducted on 8/14/13 at 6:45am with E6. E6 stated, " When R1 punches out his medications, he usually drops his, so I put my hand under the bubble pack to catch it and then put it in the cup". An interview was conducted with E7 (Registered Nurse) on 8/14/13 at 12:40pm. E7 stated that medication should always be punched directly into a cup and not in your hand. E7 also stated " nurse training is done with all the staff, they do an 8 hour class called Medication Authorization and every 3 months they have a rotation of training. There is also a practical application of training with an In-service of which staff must pass with 100%". E7 stated that she would address this practice and re-in-service all staff.	W 340		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.1060h) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1060 Training and Habilitation	W9999		

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W9999	Continued From page 20 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. h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review and interview, the facility failed to implement their policy on neglect for 1 of 4 in the sample, R2. R2 has a known behavior of elopement from previous placements, has eloped 2 times from this facility and 1 time from the day training. After 2 attempts at elopement the facility failed to conduct a complete investigation and the facility neglected to provide the services including appropriate supervision to ensure the safety of R2. Findings include: Review of the Physician's Orders Sheet dated	W9999		

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7/23/13 notes R2 is a 24 year old female whose diagnoses includes Moderate Intellectual Disability, Schizophrenia, Major Depression and Agitation at times. R2 is currently receiving medications of Lithium, Depakote, Risperdal, Prozac and Geodon to aid in behavioral management.

Review of the facility policy dated 9/2009 for Physical Injury and Illness/Individual Medical Emergencies defines neglect as, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

R2 was admitted to the facility on 5/6/13. The Resident Evaluation Tool dated 5/8/13 completed by E2, House Manager, notes R2 is ambulatory, does not have the ability to go into the community alone and does not know her way around town/neighborhood.

The Pre-Screening Assessment dated 6/9/13 states at her previous placement R2 had difficulties with physical aggression, self-harm, elopement, oppositional behaviors, impulsivity, poor coping skills, affect dysregulation, depression and poor social skills. The Pre-Screening Assessment also documents R2 has had numerous psychiatric hospitalizations.

R2 has a behavior program dated 8/1/13. The behavior program targets the maladaptive behaviors of inappropriate behavior including history of non-compliance, suicidal ideations, rude and discourteous comments, swearing, verbal aggression, yelling, physical aggression, property destruction, refusal of medication, refusal of personal hygiene. The plan documents R2 also has a history of elopement, locking doors

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preventing people from entering the facility or leaving their rooms. The plan states, "R2 has frequent episodes of catatonic states, urinating and/or defecating on herself, experiencing "spirits" around her. R2 exhibits these maladaptive behaviors at least daily."

The behavior program lists under Adaptive Behavior, "When R2 displays the maladaptive behaviors of inappropriate conduct staff will take R2 to her room and talk with her on how to appropriately interact with others. R2 will participate monthly in socialization classes."

Under Methods and Instruction (techniques, reinforcement, delivery, etc.), "If staff notices R2 is being inappropriate, they will intervene and redirect her by showing her another way she could express her feelings. Staff will explain how she could have handled the situation appropriately. They will ask her to apologize to the person that she was being inappropriate towards."

Review of a Progress Note dated 7/11/13 notes R2 was being non-compliant and refusing to take her medications. The report documents R2 closed her door on staff and staff said they would leave her alone for a while. Upon returning at 7:30am, staff noticed the window screen was missing, the window was raised and R2 had left the facility through the window. A ground search was conducted and R2 was not found. Staff left in a van to continue the search and the police were contacted. R2 was found by the police and brought back to the facility unharmed.

Notification to the Illinois Department of Public Health dated 7/18/13 documents on 7/17/13, R2

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was transported to the hospital at about 10:30am. R2 began displaying aggressive maladaptive behaviors. R2 was discharged and diagnosed with aggression. On 7/18/13 at approximately 6:00pm R2 was transported via ambulance (she had refused to ride in facility vehicle) to the hospital for displaying aggressive maladaptive behaviors. R2 continued to engage in aggressive behaviors towards the paramedics. R2 remained in the hospital until 7/23/13.

Record review of a hospital consultation note dated 7/25/13 states R2 had been taken to the emergency room and transferred for a psychiatric evaluation. R2 was, "Agitated, exhibiting physical aggression towards staff and other residents. Destroying property in the facility. Verbally aggressive, threatening the staff, refusing medication, activities of daily living, posing danger requiring hospitalization." R2 remained in the hospital until returning to the facility on 8/2/13.

Review of a Progress Note dated 8/2/13 and a report to Illinois Department of Public Health dated 8/2/13 documents on 8/2/13 at 11:23pm, "R2 was having maladaptive behaviors and eloped from the home. The staff on duty followed R2 outside and encouraged her to come back but R2 continued to walk away. The staff member was unable to follow R2 further due to being an overnight shift and staffed with only one staff person. R2 was found by the police within 10 minutes and brought back to the facility unharmed." Interview with E2, House Manager, on 8/13/13 at 12:53pm stated R2 was found by the police walking 1/4 to 1/2 block away from the facility on a 4 lane highway near the facility.

On 8/13/13 at approximately 12:53pm, Surveyor

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observed R2 coming into the facility. E2, House Manager, stated R2 had eloped from the day training site and was transported back to the facility. E2 stated R2 eloped from the day training site and day training staff followed her out the door. Review of the Incident Report from the elopement states R2 walked out the door stating she wanted to go home. Day Training staff stayed with R2 who after 20 minutes returned to the day training site.

On 8/13/13 at 12:53pm E2, House Manager, stated R2 had her 30 day staffing on 7/24/13 but that it is not completed yet. E2 stated, "R2 came in May and initially her behaviors were clinging, non-compliance and speaking inappropriately to staff. It then progressed to physical aggression mainly to me. The incident of elopement on 7/11/13 the police were called and she was found lying on the ground behind the car wash."

The facility's investigation of R2's elopement on 7/11/13 does not state where R2 had eloped to and where the police found her. Interview with E2, House Manager, on 8/13/13 at 12:53pm states R2 was found lying on the ground behind the car wash. Surveyor drove personal car to the car wash which is approximately 1/2/ half mile from the facility. Additionally, to get to the car wash R2 had to have crossed a 4 lane highway with a posted speed limit of 35 mph.

The facility's investigation of R2's elopement on 8/2/13 does not state where R2 had eloped to and where the police found her.

Interview with E2, House Manager, on 8/13/13 at 12:53pm stated R2 was found by the police walking 1/4 to 1/2 block on a 4 lane highway near

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W9999	Continued From page 25 the facility. Surveyor assessed the 4 lane highway and it has a posted speed limit of 35 mph. On 8/15/13 at 9:35am E1, Facility Representative, was asked why the facility in their investigation of R2's 2 elopements did not include where she was found. E1 stated that is something we need to start doing. E2 was asked what changes if any were implemented as a result of this elopement. E2 said, "More monitoring. The day she eloped I had 1 staff out sick. Normally we can do 3 people including the cook but there is no 1 on 1 for R2. On 7/18/13 R2 was punching her (E2) and was transferred to the hospital and returned on 7/23/13 at 4:00pm. At midnight on 7/24/13 She exhibited property destruction and attempted to elope, spitting and kicking and was hospitalized. She returned on 8/2/13. At her first staffing (May 6,2013) there were no issues on destruction and aggression. On 8/2/13 she eloped on 3rd shift." E2 was asked if any changes were implemented as a result of R2's elopement on 8/2/13. E2 said, "Nothing else was done. The only thing I know to do is talking to her. We can't force her to stay and try and keep an eye on her." E2 was asked if R2's supervision level had changed. E2 said there was no increase in supervision. The facility neglected to provide the services necessary to ensure the safety of R2 who exhibits elopement behavior. (B)	W9999		