STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 000	COMMENTS COMPLAINT INVESTIGATION 1943709/IL112411 COMPLAINT INVESTIGATION 1944010/IL112733 Statement of licensure violations	Z 000		
Z9999	FINDINGS Licensure 1 of 2 350.620a) 350.1210 350.2700d)2) 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: 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 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	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 door, a signal is not required. These requirements were not met as evidenced by: Based on record review and interview, the facility failed to: 1. ensure safe guards are in place to prevent elopement, affecting 1 of 1 individual who resides in House 5 and is documented as a high risk for elopement. (R4) 2. ensure adequate supervision of individuals affecting 14 of 14 individuals who reside in House 5. (R4-R17) 3. thoroughly investigate peer to peer, affecting 1 of 1 individual involved in peer to peer. (R4) 4. failed to report elopements to Illinois Department of Public Health, affecting 1 of 1 individual who resides in House 5 and is high risk for elopement. (R4) 5. failed to thoroughly investigate all allegations of abuse/neglect/mistreatment, affecting 1 of 1 individual claiming abuse/neglect/mistreatment who resides in House 5. (R4) 6. failed to provide continuous training to staff on R4's leaving the building without permission. findings include: 1. R4's IPP of 1/10/19, R4 functions in the Profound Range of Intellectual Disabilities with psychogenic non-epileptic seizures, seizure disorder, behavioral, anxiety and anger problems. R4's IPP (Individual Program Plan) indicated "R4 requires a staff to be with her when she is out of	Z9999		

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the house, sitting on the patio or going to the gym."

Supervision Assessment for R4 dated 1-2-19: Does consumer have a history of elopement? No; Is consumer capable of sitting on patio without supervision? No; Is consumer capable of sitting on swings without supervision? No; Is consumer capable of walking around SLC (Specialized Living Center) property without supervision? No; Is consumer capable of taking trash cans to dumpster alone? No; Is consumer capable of visiting another SLC house without supervision? No; Is consumer capable of walking to the Core Building without supervision? No; Is consumer capable of walking to the gym without supervision? No; Is consumer capable of being unsupervised in the House without staff in the immediate area: Yes, Time frame: 30 minutes; Is consumer capable of using public transportation without supervision? No; Is consumer capable of going to restroom in public places alone? Yes; Is consumer capable of going anywhere in the community alone? No

Nurses Note for R4 dated 4-3-19 at 6:45 AM: "Writer was told by noc (night) nurse that resident had eloped at approx (approximately) 0540 (5:40 AM) et (and) staff was looking for client call received from DSP (Direct Support Professional) stated client had been located but refused to get in vehicle. Writer and nurse left community, located DSP with client et retrieved client. Upon arrival to community client brought to health office. Alert. Crying. Skin assessment completed."

Nurses Note for R4 dated 5-8-19 at 4:16 AM: "At approximately 3:40 AM it was called over intercom that resident had eloped from House 5.

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This nurse responded. DSP stated she had went out the back door but didn't know what direction she had went. AOD (Administrator on Duty) and Nurse also responded. We proceeded to search the grounds AOD called 911. This nurse drove her personal vehicle around to find police had her in sight on street near grocery store (Approximately 1 mile from facility per MapQuest). Resident would not make eye contact with this nurse or speak she acted afraid by any advances toward her. She stood for a minute then cried. She then agreed to ride in police vehicle back to the facility. Once arrived and into House 5 she pointed and yelled at DSP "You stay away from me!" She proceeded to her room where she began striking her cheeks with clinched fists repeatedly and striking her upper thighs. She proceeded to yell loudly multiple times. This nurse attempted to talk with her for ten minutes. Resident calmed a bit and sat down on her bed with clinched fists and crying. Continues to refuse to talk to staff. Currently sitting on her bed crying with staff sitting outside her closed door."

Nurses Note for R4 dated 5-25-19 at 2057 (08:57 PM): "At approximately 1940 (7:40 PM) resident ran from house upset. DSP staff attempted to find her in van. Grounds cleared. AOD and 911 dispatch notified. EMS (Emergency Medical Service) and police attempting to retrieve resident at this time. Reported she is running in and out of traffic. Medical Director made aware by phone by this nurse. Primary Care Physician on call doctor paged. Awaiting response."

Nurses Note for R4 dated 6-2-19 at 8:04 PM: "Reported by AOD that client had ran out of building. Went to house to find out which way she ran. DSP's were not certain. Went to my car

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and drove around looking for client. Couldn't find her. At 8:24 PM saw client walking on street. Notified AOD who had called the police. Informed her of where client was."

In-Service dated 2-6-19 given by E1 and E3: R4 left the house today without supervision. I have placed a new ABC documentation in her chart on leaving the area unsupervised. She has to have staff with her when she leaves the house, even if it is to walk to PT (physical therapy), staff must escort her. 4-10-19 1:37 AM: Office disregarded prior to arrival due to other officer handling and major delay from road construction. 4-10-19 9:43 AM: R4 got upset and walked away from the facility. R4 located and returned. 4-11-19 2:27 AM: R4 returned to facility prior to my arrival, staff advised they no longer needed assistance.

Per review of police reports provided by police department on 5-28-19 at 10:10 am: On 5-7-19 4:29 PM: "Female resident R4 ran off from the facility. Female was located and escorted back once she calmed down." On 5-8-19 at 5:06 AM: "R4 left the building. Officer located her near major route (Approximately 1 mile from facility per MapQuest). I provided a transport back to facility." On 5-8-19 at 12:22 PM: "R4 walked off, R4 was located and agreed to return." On 5-9-19 5:12 PM: "R4 walked away from facility. Officer located her and staff at park. R4 is her own guardian and wanted to move out of facility. R4 requested ride to police department to call mental health facility. Officer provided R4 with ride to police department and spoke with her at length. Eventually, R4 agreed to go to hospital for medical evaluation. Ambulance responded and transported her to hospital."

Per review of police report provided by police

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departement on 5-29-19 at 11:00 AM: On 5-26-19 6:12 AM: "R4 was found on near by street and was given a courtesy ride back to facility."

Interview on 5-23-19 at 10:00 AM: E1 (Interm Administrator/QIDP) stated, "R4's elopements started eight weeks ago. Yesterday she eloped because E5 (DSP) said to the shift lead to tell R4 not to start that load, they have more stuff to put in it. R4 became angry and was in their faces shaking her fist. E1 attempted to calm her down which didn't work and she took off. Two workers followed her along with one van and one car. R4 was walking in the street. Called police and six police came. They took her to a hospital, but R4 refused to sign herself in." E1 was asked if facility reported yesterday's elopement to IDPH. E1 stated, "no."

Facility and Day Training Behavior Program Summary dated 4-3-19: Behavior Problem at: R4 engages in leaving assigned area without permission. This is in the form of leaving the house or specified area without permission from staff when she is angry and/or upset. R4 does not want anyone to enter her room or that of her suite mates rooms. R4 has walked out of the house and gone to the core building when in a angry mood and has left facility property and walked away from the facility. Operational Definition: Leaving assigned area without permission is defined as when R4 leaves an area without permission or notification. An antecedent that may trigger leaving the assigned area without permission for R4 is in the form of anger and/or being upset about staff, peers, or when she has refused her medication.

Policy/Procedure for Unauthorized Client

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Absence (dated 4/11/19):
If a client leaves out of the house or any other building on facility grounds and should not,based on their supervision assessment, and staff are aware the client left then staff should ensure the client remains within view at all times, page for back up and remain with the client until redirection to a safe location is made, unless otherwise noted in the Individual Program Plan. The client is always to remain within view of staff.

2. There are 14 individuals who reside in House 5:

R4's IPP of 1/10/19, R4 functions in the Profound Range of Intellectual Disabilities with psychogenic non-epileptic seizures, seizure disorder, behavioral, anxiety and anger problems. In the past few months, R4 has eloped from the facility and the facility has needed assisted from the local authorities. R4 requires a staff to be with her when she is out of the house, sitting on the patio or going to the gym.

R5's IPP (Individual Program Plan) of 7/5/18 indicates R5 functions in the Mild Range of Intellectual Disabilities with cerebral palsy, spastic quadriplegia, depression and bipolar disorder.. R5 is a high fall risk due to his noncompliance during toileting, bed transfer and must have staff with him when he transfers to and from the toilet.

R6's IPP of 11/29/18, R6 functions in the Mild Range of Intellectual Disabilities with cerebral palsy. R6 has poor oral movements, and swallowing deficits and poor breath control due to his cerebral palsy. R6 has a history of leaving the area without supervision.

R7's IPP of 3/28/19, R7 functions in the Moderate

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Range of Intellectual Disabilities with seizure disorder, major depressive and anxiety disorder. R7 has a history of leaving the area unsupervised when she has been told she has to wait to do something or when she is angry. Staff must keep door alarms on at all times and check on R7 at least every 30 minutes during waking hours and every 30 minutes when she is asleep.

R8's IPP of 3/21/19, R8 functions in the Mild Range of Intellectual Disabilities with psychotic disorder, depressive disorder and behavior disorder.

R9's IPP of 9/6/18, R9 functions in the Moderate Range of Intellectual Disabilities with seizure disorder. R9 has displayed 12 seizures in the past year. R9 is to be supervised at all times, except during sleeping hours and then 30 minute bed checks.

R10's IPP of 12/6/18, R10 functions in the Profound Range of Intellectual Disabilities with total blindness, history of seizure disorder and hearing loss. R10 requires total care from staff to complete all activities.

R11's IPP of 10/25/18, R11 functions in the Profound Range of Intellectual Disabilities with convulsive disorder, bipolar disorder and anxiety. R11 has a history of seizure disorder and must always have staff with her when in the shower or in the restroom.

R12's IPP of 1/24/19, R12 functions in the Profound Range of Intellectual Disabilities with history of seizure disorder. R12 requires total staff assistance with most daily living skills.

R13's IPP of 4/25/19, R13 functions in the

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Z9999	Continued From page 8 Profound Range of Intellectual Disabilities with epilepsy and severe gait disorder. R13 requires staff supervision for all activities. R14's IPP of 5/23/19, R14 functions in the Profound Range of Intellectual Disabilities with psychotic disorder, non specific depressive disorder and anxiety disorder. R14 has a history of leaving the assigned area without permission but has not done this within the last 2 years. R15's IPP of 12/6/18, R15 functions in the Profound Range of Intellectual Disabilities with seizure disorder. R15 requires total assistance for all daily activities. R16's IPP of 12/13/18, R16 functions in the Profound Range of Intellectual Disabilities. R16 is blind and has anxiety disorder. Due to R16's blindness requires total assistance to walk to his room and complete daily activities. R17's IPP of 9/20/18, R17 functions in the Profound Range of Intellectual Disabilities with cerebral palsy. R17 requires total assistance from one staff and a shower chair for all bathing. The Facility Policy/Procedure for Staffing (dated 3/30/10): Each House has sufficient, appropriately qualified, and adequately trained personnel assigned to conduct the client living program in accord with all applicable Federal, State, and Local laws, regulations and codes as well as Facility policies and procedures. The minimum staff-client ratio of Direct staff Person serving severly and profoundly retarded clients , clients with severe physical disabilities, or clients who are aggressive, psychotic-like behavior, is 1 to 3.2. The minimum staff-client ratio of Direct Staff	Z9999		

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person serving moderately retarded clients is 1 to 4, and 1 to 6.4 for Direct Staff Person serving clients who function within the range of mild retardation. Direct Staff Person are, present, awake, dressed and on duty every day of the year.

Mistreatment of Residents Policy/ Procedures (dated 8/13/18):
The Facility has organized itself to proactively assured that its clients are free from serious and immediate threat to their physical and psyhological health and safety. In keeping with the stated philosophy, goals, and objectives of the facility abuse, mistreatment, and /or neglect of a resident is thoroughly and vigorously investigated and, when indicated, reported to the appropraite law enforcement agency having juridication as well as IDPH.

Mistreatment includes behavior or facility practices that result in any type of inedividual exploitation such as financial, sexual, or criminal. mistreatment means abuse or neglect.

Neglect means failure in a facility to provide adequate medical or personal care or maintenance and in which such failure results in physical or mental injury to a resident, the deterioration of a resident's or mental condition, or the potential for phyical or mental injury.

Investigation Report dated 5-20-19: "On 5-14-19 at approximately 3:00 PM E1 (QIDP/Interm Administrator) was notified that residents in House 5 were left unsupervised by the AOD and three DSP from approximately 8:50 PM-9:20 PM on the evening of 5-13-19. On 5-13-19 at 8:20 PM-8:30 PM E17 (DSP) called E10 (AOD) to ask if he had someone to relieve all employees in

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House 5 at 9:00 PM. E10 told E17 that he did not have anyone to relieve them and asked if one of the three that were working in House 5 could stay until someone took over for them, as to which, E17 did not respond. E10 told E17 to let him know which employee was going to stay until he got another staff member to relieve them. E17 never called E10 back. E10 then called into House 3, where two workers were in that house who worked until 10:45 PM. E10 spoke with E15 (DSP) telling her that someone had to go to House 5 at 9:00 PM to relieve the staff there. E10 heard E15 tell E14 (DSP) that he needed to leave House 3 and go to House 5 at 9:00 PM. E10 did not know if E14 got the message to go to House 5 at 9:00 PM. E6 (DSP) stated that E1, E17 and E18 (DSP) knew he was leaving and at approximately 8:38 PM he went to warm up his car. E6 said before he left he noticed E17 working on his books and E18 was watching television. E6 then left House 5 and R8 turned off the door alarm. Approximately 8:45 PM E17 left House 5, walked over to House 4, then walked to the core building to where he clocked out and left. Approximately 8:45 PM E18 left out the kitchen door, unaware who disarmed the alarm and left to go home because E6 was her ride. At some point E10 observed E6 (DSP) and E18 at the time clock before their scheduled off time at 9:00 PM. E10 did not go to House 5 at 9:00 PM to see if anyone went to the House to relieve the staff. E10 assumed if there was no relief that someone would notify him. Approximately 9:20 PM E11 (DSP), whose shift started at 10:30 PM, came into the house and realized there was no staff present. She checked all bedrooms to where she still did not find any staff. E11 did not notice any door alarms sounding and thought that the clients who were awake may have turned the door alarm off. Per staff, residents that may or may not have

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been up during the time that no staff were in the building: R4,R7, R8, R9, R10 and R14."

Interview on 6-3-19 at 1:58 PM: E19 (Administrative Assistant) was asked what are the shift hours for the DSP's for afternoon and midnight shifts? E19 stated, "For DSP's for afternoon shift is 2:15 PM-10:45 PM and midnight shift is 10:30 PM-7:00 AM."

Schedule for DSP's dated 5-13-19: House 5 afternoon shift on 5-13-19 is to be E6, E17 and E18.

Employee time sheets dated 5-23-19: For the day of 5-13-19: E6 clocked in at 6:05 AM and clocked out at 4:21 PM, clocked back in at 5:02 PM then clocked back out at 8:50 PM. E17 clocked in at 2:07 PM and clocked out at 8:59 PM. E18 clocked in at 2:46 PM and clocked out at 8:49 PM. E11 clocked in at 9:47 PM.

Interview on 5-23-19 at 10:20 AM: E1 was asked to tell writer about the evening of 5-13-19, when there was no staff in House 5: E1 stated, "There were three DSP's in House 5 that evening. I gave E6 permission to leave because he worked a double that day, he did not notify the AOD when he left and clocked out at 8:50 PM. E17 did not have permission to leave and he left shortly after E6, but did not clock out right away. E17 left House 5, walked over to another house then went to the administrative building, clocked out and never notified the AOD. E18 left at 8:45 PM because she said E6 was her ride. She knew E17 had left. She did not notify the AOD or have permission to leave. E10 was the AOD that evening and he called House 3 at 8:30-9:00 PM for a DSP to go to House 5 by 9:00 PM." E1 was asked how many DSP's are to be in House 5 with

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the census that day? E1 stated, "3 DSP's during morning shift, 3 DSP's during evening shift and 2 DSP's during midnight shift."

Interview on 5-23-19 at 10:35 AM: E2 (Quality Assurance) was asked how long was House 5 unattended? E2 stated, "There was no staff there from 8:50 PM until 9:15 or 9:20 PM when the midnight girl, E11 (DSP), just happened to come in early. E11 walked into House 5 and asked where the staff was and the residents said no one is here. E11 called E10 (AOD) and E10 was pulled from House 3."

Interview on 5-28-19 at 2:25 PM: E2 was asked what was the time that E17 left house 5 and went over to House 4? E2 stated, "E17 left House 5 at 8:45 PM and went over to House 4."

Interview on 5-28-19 at 3:56 PM: E10 was asked to tell writer about the evening of 5-13-19, when there was no staff in House 5. E10 stated, "I did a round between 6:00 PM-7:00 PM. I then went back to the office and E17 called me saying we are all leaving at 9:00 PM. I told E17 either someone needs to stay or call me back and I'll start calling people. I started calling other Houses to see who stays until 10:45 PM. I talked to E15 to tell E14 to go to House 5 at 9:00 PM. E14 said he would after his showers were done. E17 never called me back so I assumed someone was staying. No one reported to me that they were leaving except E6. I saw E6 and E18 clock out. It wasn't until I got a phone call from E11 when she came in that I knew no one was in House 5. We were short staffed that day."

Interview on 5-28-19 at 1:10 PM: E6 was asked to describe to writer what happened the night of 5-13-19 when E6, E17 and E18 left House 5 with

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no staff in the house. E6 stated, "I left at 8:43 PM, I had permission from E1. I accidentally left my charger so I came back and grabbed it. The other two DSP's knew I was leaving. I went to clock out and E10 saw me clock out." E6 was asked if he told E10 he was leaving? E6 stated, "No, because I had permission from E1 to leave." E6 was asked if anyone in the house has seizures? E6 stated, "yes." E6 was asked if anyone is on 15 minute/30 minute/1 hour checks? E6 stated, "yes the whole house is on 30 minute checks."

Interview on 5-28-19 at 4:20 PM: E11 was asked to tell writer about the evening of 5-13-19, when House 5 was left for a period of time with no staff? E11 stated, "I got there around 9:20 PM and went to House 5, walked through all the rooms and saw there was no staff in the building. I called E10 and he said he told someone from House 3 was to come over. As soon as I got off the phone I went out the door and E14, from House 3, was heading in House 5."

Interview on 5-29-19 at 3:42 PM: E15 was asked, on 5-13-19, what time did E10 call House 3 to ask for someone to go to House 5? E15 stated, "At 8:45 PM E10 called me to tell E14 to go to House 5." E15 was asked when did E14 leave House 3? E15 stated, "E14 stated that it was after 9:00 PM."

Interview on 5-29-19 at 3:34 PM: E14 was asked who spoke to E10 on the evening of 5-13-19? E14 stated, "E15 got the phone call from E10. I was giving care to R19, E15 came in and told me to go to House 5. I called E10 and told him I was giving care, can you send someone else, E10 said to just hurry. I got over there about 9:20 PM." E14 was asked who was awake in House 5

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when he arrived at 9:20 PM? E14 stated R7, R8, R9, R14. R18 was over at House 5 at that time also. R18 and R7 are boyfriend and girlfriend. They were all in the TV room watching wrestling." E14 was asked if there was a certain time that R18 is suppose to stay in his house? E14 stated, "R18 is suppose to stay in his house after 9:00 PM."
(B)
Licensure 2 of 2
350.620a)
350.1060e)
350.1210
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
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 350.1210 Health Services
The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:

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Z9999	Continued From page 15 These requirements were not met as evidenced by: Based on record review and interview, the facility failed to: 1) Ensure individuals are adequately assessment prior to admission of the facility affecting 1 of 1 individuals (R4) 2) Ensure individuals receive continuous active treatment across all environment affecting 1 of 1 individuals (R4) 3) Ensure interventions for maladaptive behaviors are identified in 1 of 1 individuals (R4) behavior program. findings include: Review of R4's Pre-Admission Packet (dated 11/7/18) , R4 functions in the Mild to Moderate Range of Intellectual Disabilities with History of Seizure Disorder, pseudo seizures, headaches, migraines, behavioral, anxiety, and anger problems. R4 needs regular close supervision and care in daily living activities. R4 exhibits the following deficits: communication deficits, learning/academic deficits, some impairment for independent living, self -care, self-direction and decision making deficits, and being at risk for being taken advantage of by others. R4 would greatly benefit from an appropriate residential placement and work/day program placement and any other appropriate supportive services to assist with her special needs. R4"s Pre-Admission Packet also included a Physical Examination (dated 10/16/18), ICAP Evaluation and Psychological, Evaluation.	Z9999		

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Interview with E16 (Facility's Social Worker) on 5/30/19, R4 had a dinner visit on 12/4/18 and a weekend visit on 12/8/18.
Nursing note indicates:
9:45am refused breakfast
11:30am refused to get up for lunch
12:00pm refused medication

R4 was admitted to the facility on 12/11/18.

E16 stated, the facility did not complete any assessments prior to admission and after her non-compliance during visits to the facility to ensure the facility could meet her needs and R4 would benefit from placement at this facility.

Review of R4"s IPP (Individual Program Plan) of 1/10/19, R4 is an ambulatory verbal female who functions in the Mild Range of Intellectual Disabilities with additional diagnosis of Psychogenic non-epileptic, Seizure Disorder, Behavioral, Anxiety and Anger Problems.

R4 was admitted to the facility on 12/11/18, Interview with E1 (Qualified Intellectual Disabilities Professional), E1 stated during her preadmission visits R4 did not display any inappropriate behaviors.

R4's IPP indicates R4 enjoys coloring pictures for others and making bracelets for staff and peers. R4 loves to watch her videos and listen to her CD's in her room with her head phones.

Interview with E11 (Direct Support Staff) on 5/28/19, E11 states that R4 enjoys taking walks and loves animals, (There a dog park down the street from the facility).

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Z9999	Continued From page 17 On 4/3/19, A formal behavior program was initiated due to R4 leaving the area without supervision/approval of staff due to several incidents beginning documented in the nursing notes. Operational Definition: Leaving assigned area without permission is defined as when R4 leaves an area without permission or notification. An antecedent that may trigger leaving the assigned area without permission for R4 is in the form of anger and/or being upset about staff, peers, or when she has refused her medication. The program identifies how staff are to react after R4 becomes upset. Example: attempt to find why R4 is upset, redirect away from other individuals. R4's Positive Reinforcement: Staff will encourage R4 to come out of her room and be engaged with staff or peers. R4 will receive verbal praise for channeling her anger in a positive direction. The plan does not identify appropriate activities which will eliminate or decrease to R4's need to leave the facility. Interview with E13 (Qualified Intellectual Disabilities Professional) on 5/30/19 at 1:34pm, E13 stated, every house has a book identifying all the individuals who reside in that house. The book contains information on each individuals (example adaptive equipment/appliances and individual activities preference). On 5/30/19, Surveyors reviewed the House Book with E13 to identify R4's interests. The individuals activities preference had not been updated since 12/17, R4 was not admitted to facility until 12/18.	Z9999		

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