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	IL6013809	A. BUILDING: _____ B. WING _____	08/16/2018

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Z 000	COMMENTS Annual Licensure survey - Focused Fundamental Survey extended into Client Protections Inspection Of Care.	Z 000		
Z9999	FINDINGS Statement of Licensure Violation 350.620a) 350.700a) 350.810a) 350.810c)1)2)3) 350.1230b)3)6)7) 350.1230e) 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 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 Section 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. At a minimum, there shall be at least one staff member awake dressed and on duty at all times. c) The number and categories of personnel to be provided shall be based on the following: 1) Number of residents. 2) Amount and kind of program content, supervision, and personal care needed to meet the particular needs of the residents at all times. 3) Size, physical condition, and the layout of the building including proximity of service areas to the resident's rooms. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.	Z9999		

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Z9999	Continued From page 2 e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. 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 evidence by: Based on observation, interview and record review, the facility failed to ensure: 1. Policy and procedure to prevent neglect was implemented for 1 of 1 client in the sample (R1) with identified elopement attempts, running away from staff and non-compliance behavior when R1 eloped from facility on 6/4/18 for approximately 30 minutes and was not followed by the staff. 2. Policy and procedure on conducting thorough investigation was implemented for R1 who eloped from facility for approximately 30 minutes on 6/4/18. 3. Safety measures were identified and put in place to ensure R1's supervision level is provided according to identified elopement needs. Findings include: Per Facility Policy on Investigative Committee (revised 8/17), "Neglect: failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Purpose: The investigative committee shall be responsible for	Z9999		

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A.To identify, review and determine if alleged violations of any individual's rights, including abuse and neglect have occurred. C. To protect individuals from further harm. Procedure: G. The administrator shall make the final decision as to the appropriate action required, taking into consideration the findings and recommendations of the committee."

Per Facility Policy on Missing Individuals (revised 12/15), "Procedure: In the event that staff becomes aware that an individual in their care is not where staff believed him/her to be and cannot be located quickly. A. The staff member first aware of the missing individual shall contact all other staff on duty to inquire about the individual's whereabouts. H. Medical attention shall be obtained if required by an injury."

On 6/4/18 at 3:25 PM, R1 ran out of the facility. R1 was redirected by DSP (Direct Service Professional) E3 but R1 ran away from facility and towards the direction of the area park. E3 contacted Administrator E1 and was directed to contact local emergency number 911. There was only one staff working at the facility on 6/4/18 afternoon/evening shift. Per facility report, R1 was returned to facility safely within thirty minutes with the aid of a neighbor and police.

R1's ISP (Individual Service Plan) dated 1/26/18 validates R1 is ambulatory and non-verbal, with diagnoses including Autism, ADHD and Profound Intellectual Disability. R1 was admitted to the facility on 12/28/16. R1 requires daily redirection and verbal cues throughout the day. R1 does exhibit maladaptive behaviors (including) non-compliance, and eats non-edible objects/items. R1 is on a behavior program to track all behaviors. R1 do (sic) not access the

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commmunity independently and relies on staff to help when crossing the street. R1 is unable to go in the community alone, R1 does not cross the street without assistance of staff, and is not aware of the community safety/safety signs (sic).

R1's BPF (Behavior Program Form) and ISP do not identify the supervision level required for R1 to address the behaviors of running away from staff and attempts to elope.

R1 's Behavior Support Plan (BSP) dated 6/23/17 reports a history of engaging in elopement and noncompliance and identified behaviors include noncompliance defined as "any instance in which R1 does not follow a direct instruction presented by staff after 15 seconds." (elopement is reported as a history and not an identified behavior). R1 's BSP listed behavior support and intervention strategies of "during unstructured times, offer choices throughout the day of a variety of activities for R1 to participate. When R1 is more engaged in sensory activities as well as other preferred activities, the frequency in which R1 engages in maladaptive behaviors is often decreased."

R1's 2/1/18 Behavior Program Form (BPF) reports R1 "displays behaviors of running throughout the house and away from staff, attempts elopement." Per the BPF, R1 's program and reinforcement materials include "verbal praise, one to one, staff redirection, allow relaxation, activity of choice, program book/pen.

R1's BPF and ISP do not identify the supervision level required for R1 to address the behaviors of running away from staff and attempts to elope.

R1's 4/18/18 Behavior ManagemenVIndividual

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Z9999	Continued From page 5 Rights Committee reports the following behaviors for the month of March 2018: 3 non-cooperative (non-compliance), 1 attempt elopement, 7 running and 3 not following directions. Nursing note by Nurse E1 O dated 6/6/18 reports "R1 presents in no acute distress. Report received (date and time not stated in the note) that R1 eloped outside in the community. Upon head to toe assessment, no visible injuries. Elopement precautions implemented." Administrator E1 confirmed on 6/27/18 at 1 :05 PM that Nurse E10's note on 6/6/18 confirm an assessment of R1 on 6/6/18. There is no documentation by E3 that a body check was done on R1 upon return to facility by the neighbor and police on 6/4/18. On 6/27/18 at 2:00 PM, E1 was asked which park R1 went on 6/4/18, what the weather was and how many staff were working at the facility on 6/4/18. E1 validated 6/4/18 was a nice day, E1 was informed by DSP E3 that R1 went to the park/grassy area of the day care center east of the facility. E1 confirmed there was only one staff working on 6/4/18 and it was E3. On 6/28/18 at 1:00 PM, E1 and E2 were asked about which park R1 ran towards on 6/4/18. E2 confirmed that R1 ran to the walking trail for a local park west of the facility. Surveyor and E2 walked towards the end of the sidewalk west of the facility. This was approximately 100 feet away from the end of the driveway of the facility. The walking trail for the local park can be accessed by crossing a two-way street approximately 30 feet wide. The walking trail is approximately 120 feet in length and apP.roximate!Y eight feet wide. At the end of the trail is a grass area that dips from	Z9999		

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Z9999	Continued From page 6 the end of the paved path into a grassy area with one exposed concrete pipe (for excess rainwater drainage). The diameter of the pipe is approximately one foot wide and approximately ten feet from the end of the paved trail. This grassy area is approximately 200 feet long and 100 feet wide. This grassy area contains a play area consisting of slides, swing and a climbing apparatus and is surrounded by backyards of several residential buildings. Administrator E1 was asked on 6/27/18 at 1:05 PM regarding R1 's supervision level. E1 referred surveyor to QIDP E2. QIDP E2 was asked about R1 's supervision level on 6/28/18 at 12:25 PM. E2 stated "R1 is not on one to one supervision." Review of the June 2018 monthly facility schedule and electronic time clock report from June 1 to June 16 validates that there was only one staff working for the afternoon/evening (2:00PM to 11 :30 PM) shift on6/4/18, 6/5/18, 6/6/18, 6/8/18, 6/9/18, 6/10/18, 6/11 /18, 6/14/18, 6/15/18, 6/16/18, 6/27/18 and 6/28/18. The monthly June Schedule reports that only one staff was scheduled to work evening shift on 6/17/18, 6/20/18, 6/22/18, 6/23/18, 6/24/18, 6/25/18 and 6/26/18. Interview with E1 on 6/28/18 at 1 :00 PM confirm that the home manager E7 and direct support person E9 are no longer employed in the facility for the last few weeks. E1 confirmed they are short on staff and have staffed evening shift with one staff at times even before E7 and E9 ended employment with the facility. E1 validated that E10's 6/6/18 note was an observation of R1 on 6/6/18 post the 6/4/18 event.	Z9999		

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Z9999	Continued From page 7 Facility investigation did not include relevant information such as: - distance R1 travelled from home, number of streets crossed by R1. - description of area R1 travelled to. - weather at time of R1's elopement. - was R1 wearing clothes and shoes appropriate for the weather at time of leaving facility. - what was R1 wearing and the condition of clothes and shoes upon return to the facility. - what was the status of the grassy area, was it filled with water or dry. - whether body check on 6/4/18 was conducted on R1 upon return to facility. - review of R1's need of a supervision level to address elopement events in the recent past and plan of action to respond accordingly when R1 elopes at the facility. (B)	Z9999		