STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

Clearbook Center — 003002
Facility Name — I.D. Number

3201 West Campbell Street, Rolling Meadows, Illinois 60008
Address

Date of Survey: 08/30/2004

l

Annual Survey

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE:THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530.DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.620a) 350.1060h) 350.3240a) 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.

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 Qualified Mental Retardation Professional.

WNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

These regulations were not met as evidenced by the following:

STATE OF ILLINOIS

Clearbook Center	0030023
Facility Name	I.D. Number

350.620a)
350.1060h)
350.3240a)

A. Based on observation, interview, record verification, review of incident reports and facilities policies, the facility has failed to prevent resident neglect due to lack of staff supervision three an individuals resulting in the elopement of R12, R19 and R25. The facility also failed to provide Adequate alarm systems and consistent staff supervision to prevent/detect elopements of two individuals (R15 and R21).

Findings include:

1. Review of facility's Client Admission/Face Sheet on 8/18/2004 states R12 is a 28 year old male with a diagnosis of Profound Mental Retardation, Attention Deficit, and Angelman's Syndrome. Review of Behavior Program dated 6/28/2004, progress notes, incident reports and facility's investigation reports on 8/16/2004 and 8/17/2004,states R12 has PICA, physical aggression, and elopement from the facility.

Review of incident reports and progress notes on 8/16/2004 document that on 5/2/2004 R12 was noted to have "large brown colored emesis x3 with projectile, skin warm & pale...(E6), physician, notified (to) send resident to (hospital) for evaluation. (R12) admitted to (hospital)". Physician's progress note dated 5/14/2004, states "s/p (status post) ingested latex glove causing gastric outlet obstruction. Underwent EL (Exploratory Laparotomy) and removal after endoscopic removal failed." Review of Behavior Program dated 6/28/2004 states, "(R12) was recently hospitalized and required surgery after ingesting some type of non-edible item... Due to the severity and danger the pica behavior poses to (R12), a 1:1 Staff will be assigned to (R12) at the (facility). The team agrees that the continued use of psychotropic medication, 1:1 staff, time-out, physical escort and close supervision are necessary to keep him safe..."

On 8/16/2004, an incident report dated 7/17/2004 and Facility Investigation Report were reviewed and states E7, direct care, was assigned 1:1 supervision with R12 on 7/17/2004. At approximately 12:48 p.m., R12 was observed (as recorded by video camera) to leave the building unsupervised, walking across the parking lot at approximately 12:56 p.m. and direct care staff (E8) observed R12 crossing the street toward the park. E8 physically escorted R12 back to the facility.

Clearbook Center	0030023
Facility Name	I.D. Number

350.620a)
350.1060h)
350.3240a)

Investigation Report summary states: "Based on the information above the incident was followed via the video surveillance system. (R12) has been designated a one on one staff to help prevent serious incidents from occurring." "At 12:44 PM (E7) left (R12's) room and left (R12)unobserved for at least 4 minutes. During this four minute time period (R12) left his room, walked towards the front lobby and exited the building." "When (E7) discovered that (R12) was missing he informed the supervisor and the other Red Hall staff (E8)." "(E7) failed to fulfill his 1:1 duties." "E7 has been terminated as of 7/21/04."

Interview with E9, QMRP, on 8/16/2004 states 2 individuals are assigned 1:1 supervision (R12 and R11) on the p.m. shift for 8/16/2004. E9 states, R12's 1:1 direct care staff is E11 and E10, direct care, is assigned 1:1 supervision with R11.

R12 was observed in the Red Hall living room at approximately 4:10 p.m., sitting on a bean bag against the wall E11 who is assigned 1:1 supervision of R12 was observed at an activity table) with 5 other clients, one of whom was R11 who is also on 1:1 supervision. E11 was in the living room alone during most of the observations, since E12 was observed in and out of the living room, assisting clients and obtaining water. R12 was observed unengaged in any activity or programs nor were staff observed attempting to engage R12. E11 was at the activity table with 5 other clients who were involved with building items with plastic blocks and not observed providing 1:1 supervision for R12. E11 was observed alone in Red Hall living room with 2 individuals requiring 1:1 supervision and 4 other additional clients. The minimum number of staff which should have been present in the living room should have been 3 and this was not observed by the surveyor from approximately 4:10 p.m. to 4:41 p.m. At approximately 4:41 p.m., E11 was observed escorting R12 to the dining room when clients were called for dinner.

350.620a)
350.1060h)
350.3240a)

4. Per the clinical record, R15 is a 39 year old male functioning in the Profound level of Mental Retardation. He is also 350.1060h) diagnosed with Autistic Disorder and Seizure Disorder. R15 has a Behavior Management Program (BMP) targeting physical aggression, and PICA. R15's 10/30/03 annual Individual Program Plan (IPP) history section states: "Behaviors unique to (R15):
He has always wandered in and out of the building. (R15) wanders in the parking lot to watch the cars of his favored staff drive away.
His frequency of physically aggressive episodes was more regular then currently.
(R15) has a history of eloping. However, he has not eloped in a long time.
When (R15) is acting out, behaviorally, he will ingest anything: shampoo, toilet bowl cleaner, one Christmas he drank a bottle of (name brand) cologne that he received as a gift, excessive amounts of water, and urine."

Review of incident reports, detailed an occurrence of 8/6/04. R15 eloped from the facility at approximately 6:26 p.m. R15 got up off the couch and walked out the front door. He went to the park across the street and was escorted back to the facility by the police at 7:04 p.m.

Per interview with E1, administrator and E2, quality assurance facilitator on 8/18/04, R15 sat down at a picnic table and interacted with people in the park. The people were concerned and called the police. The police brought R15 back to the facility.

350.620a)
350.1060.h)
350.3240a)

The facility investigation of the 8/6/04 incident included observation of surveillance tapes. The Conclusion/Summary reads as) follows: "Based on the information above (R15) eloped at 6:26 PM. The aide at that time may have started his 6:30 PM roll call a)slightly early. The aide reported that when he completed the 6:30 PM roll call that (R15) was on the couch. The video cameras confirm this statement. According to video surveillance, (R15) simply got up off the couch and walked out the front door. (R15) was escorted back to the facility just after 7:00 PM. The aide was finishing his 7:00 PM roll call when (R15) was brought back in to the building. The alarm system appeared to be working sporadically during the time of the incident. The alarms were functioning over the weekend. There are no signs of abuse or neglect in this case. (R15) was not) gitated that day and was sitting on the couch when he got up and walked out the front door... "

Per E1 (8/18/04) most of the people in the facility are checked every 30 minutes. There is no policy for level of supervision that is individualized, based on client need. A list of individuals, requiring 15 minute roll call due to elopement risk, was presented to surveyors on 8/19/04. R15 was not included on this list.

During interview with E1 he stated there is currently a problem with the front door alarm on the East wing. There are other stand alone door alarms on the east and west wings. E1 said the alarm system is old and can no longer be repaired due to lack of parts. E1 agreed that the alarm system problem was identified in the annual Public Health survey conducted in September, 2003. E1 said he first noted the alarms were working sporadically on October 15, 2003. He began checking the alarms on a monthly basis.

Surveyors were given a copy of a bid to install an alarm system dated 7/26/04. E1 said he left a message with the company on August 16, 2004 stating that he wanted a contract for new door alarms.

350.620a)
350.1060h)
350.3240a)

5. Another example of an individual who eloped is R21, who left the building on 15/17/04, door alarms were not heard by staff at that time.

6. Five people eloped since May 17, 2004. Action was not taken to correct the systemic alarm problem until 8/9/04. On 8/9/04 a staff member was assigned to remain in the front lobby during the P.M. shift (2:30 - 11:00 p.m.) every day and from 6:30 a.m. - 2:30 p.m. on weekend and holidays.

B. Based on interview, incident report review and review of facility policies, the facility has failed to develop and implement policies for all levels of supervision including one to one, and defining standardized body checks. Lack of these policies has the potential to affect 91 of 91 individuals residing at the facility, because abuse, neglect and mistreatment can go undetected.

Findings include:

Review of incident reports, detailed an occurrence of 8/6/04. R15 eloped from the facility at approximately 6:26 p.m. R15 got up off the couch and walked out the front door. He went to the park across the street and was escorted back to the facility by the police at 7:04 p.m.

The facility investigation of the 8/6/04 incident included observation of surveillance tapes. The inusion/Summary reads as Based on the information above (R15) eloped at 6:26 PM. The aide at that time may have started his 6:30 PM roll early. The aide reported that when he completed the 6:30 PM roll call that R15 was on the couch. The video cameras confirm this statement. According to video surveillance, (R15) simply got up off the couch and walked out the front door. (R15) was escorted back to the facility just after 7:00 PM. The aide was finishing his 7:00 PM roll call when (R15) was brought back in to the building."

Per E1 (8/18/04) most of the people in the facility are checked every 30 minutes. There is no policy for level of supervision that is individualized, based on client need. A list of individuals, requiring 15 minute checks was presented to surveyors on 8/19/04. R15 was not included on the list. R15's 10/30/03 annual Individual Program Plan (IPP) history section states: "Behaviors unique to (R15):

350.620a) He has always wandered in and out of the building. (R15) wanders in the parking lot to
350.1060h) watch the cars of his favored staff drive away.
350.3240a) His frequency of physically aggressive episodes was more regular then currently. (R15) has a history of eloping. However, he has not eloped in a long time. When (R15) is acting out, behaviorally, he will ingest anything: shampoo, toilet bowl cleaner, one Christmas he drank a bottle of (name brand) cologne that he received as a gift, excessive amounts of water, and urine."

The incident report of 8/6/04 for R15, states a body check was done. Review of the nurse's notes state "8-6-04 7:30 p (Resident) eloped and went across the street to park. Police escorted back to Commons. Body (check) done. Administration notified."

During interview with E18, Registered Nurse (R.N.) on 8/18/04, she said E19, Licensed Practical Nurse (L.P.N.) performed the body check. Per E18, there is no body check policy, but if there is an elopement a complete body check is done. The body check is head to toe including the rectal and penis area. Findings would dictate if the physician is notified.

2. Per the clinical record R19, is a 67 year old female diagnosed with Moderate Mental Retardation and Obsessive Compulsive Disorder.

Per facility Incident Report R19 was in the bathroom when another individual, (Z2) touched her in an inappropriate manner. R19 is described in the Investigation Report as "a verbal client and is a reliable source of information." R19's statement reads in part "Tall boy put his fingers back here." "(Z2) put his finger up my hole back here, it hurt, I was screaming."

Nurse's notes read "8/13/04 11:45 am Called to (Day training site) by staff. Body (check) done. (No) injuries noted nor hematomas, (no) bleeding or drainage. Denies any pain or discomfort at this time." E18 stated R19's rectal area was checked and nothing was noted. R19 did not complain of pain.

350.620a)
350.1060h)
350.3240a)

E1, Administrator, confirmed there is no policy about what is looked at during the body check. During discussion E1 acknowledged that the lack of a clearly defined body check procedure could result in less than thorough checks being done, which 350.3240a) in turn could result in abuse going undetected.

Surveyors were given information that is part of the disaster drill regarding steps staff are to take when a resident is missing. There are no instructions for staff to follow regarding body checks if the resident is found.

C. Based on review of incident reports and interview, the facility failed to effectively prevent resident-to-resident abuse by R23 toward two peers (R9, R24).

Findings include:

Per the Facility Face Sheet and his Behavior Program, R23 is a 27 year old male whose diagnoses include Moderate Mental Retardation, Obsessive Compulsive Disorder, Behavior Induced Chronic Picking of Scabbed Wounds and Smith Magenis Syndrome. R23 has a Behavior Program dated 7/7/03 which addresses, in part, physical aggression. The program describes using psychoactive medication, verbal prompt to stop, blocking, and physical guidance to a time out area when R23 refuses to voluntarily move away from others as the interventions to address his displaying physical aggression. The Behavior Program does not stipulate the level of supervision that R23 is to receive.

Review of Incident and Injury Reports from June 14, 2004 to date showed that R23 had seriously aggressed against two peers (R9 and R24) during the past two months. Per Unusual Incident Report, on 6/30/04, R9 was noted to be holding a bloody cloth to his face. When asked what happened, R9 stated that his roommate (R23) hit him in the nose, causing his nose to bleed. R9 stated he did not know why R23 hit him. When asked, R23 admitted he had struck R9 but did not give a reason for doing so.

DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

Clearbook Center	0030023
Facility Name	I.D. Number

350.620a)
350.1060h)
350.3240a)

Per Incident Report dated 7/21/04, R23 was observed punching R24 "in the head and then put both of his hands in (R24's) mouth – pulling his lower mouth in 2 different directions as hard as he could (apparently). Client (R24) was shaking with fright - no injury noted....Client (R23) was stretching (R24's) mouth as wide as (R24's) mouth could stretch."

During interview with E1(Administrator) and E2 (Quality Assurance Facilitator) on 8/18/04, E1 and E2 were asked if R23'sBehavior Program had been reviewed for possible needed revisions to prevent further incidents from occurring. E1 and E2 stated "No - he's already on a program for aggression and sometimes things (like these two incidents) happen." During further discussion, E2 stated that he understood that it was probably advisable to take additional corrective or proactive steps when it became apparent that current programs were not effective or leading to the desired results.

During interview with E5 (Assistant Administrator) on 8/30/04, E5 stated it is the policy of the facility to revise Behavior Programs annually and as needed. E5 stated R23's Behavior Program is scheduled for review later in the week.