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

MARIGOLD ESTATES	**0039370**
Facility Name	**I.D. Number**

3240 BARNEY AVENUE, PEKIN, IL 61554
Address

Date of Survey: 7/8/04

Incident Report Investigation of 6/3/04

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):

350.1060a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.

350.1230d)1) Direct care personnel shall be trained in, but are not limited to the following: Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

350.3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These REGULATIONS are not met as evidenced by:

Based on interview and file verification, the facility failed to prevent neglect when:

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350.1060a) **1. It failed to ensure that facility policies and procedures were implemented which specify that**
350.1230d)1) **individuals are to be counted before returning to the facility. Therefore one individual (R1) was**
350.3240a) **left behind at a movie theater in a neighboring town at 9 p.m. on 06/03/04.**
(Cont'd.)

2. It did not train staff to provide special supervision when taking R1 into the community when R1 is exhibiting symptoms (including lethargy and unresponsiveness) of a Bipolar cycle.

3. It did not develop programming to teach R1 to be willing and able to provide identifying information when lost in the community.

Findings include:

R1 is a 27 year old verbal and ambulatory man who is listed on his Individual Program Plan [IPP] dated 12/29/03 as functioning in the Moderate Range. According to the IPP, R1 was admitted to this facility on 12/01/03. According to his "Community Resources" assessment, R1 requires "assist" in all aspects of accessing community resources.

According to the Physicians' Order Sheet [POS], R1's diagnoses include Bipolar Disorder, Obsessive-Compulsive Disorder, Depression, and Psychosis. The POS for June 2004 shows that R1 receives Anafranil 100mg at HS; Depakote *ER* 100mg at 6PM, Risperdal 2mg at 6PM, and Zonegran 300mg at HS for control of behaviors. R1's IPP describes behaviors of R1's exposing himself, being physically and verbally aggressive, and showing symptoms of depression which include being withdrawn and lethargic. These behaviors are described as occurring in monthly cycles.

1. On the night of 06/03/04, 2 [two] facility staff did not follow facility policy and procedures and did not count the individuals before leaving the movie theater which resulted in R1 being left behind at 9 p.m. in a parking lot in a neighboring town (Washington), being sent to the Emergency Room [ER] in another town (Peoria) via ambulance, and finally being retrieved at the ER by the Residential Services Director [RSD] at 11:26 p.m.--2 hours and 26 minutes after first being left alone.

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350.1060a) **Staff who were on the outing on 06/03/04, E3 and E4, agreed when interviewed separately on**
350.1230d)1) **07/02/04 that after the movie, when the group collected in the lobby area, E4 counted heads and**
350.3240a) **all 9 individuals were present. When interviewed on 07/02/04 at 10:10 a.m., E3 stated that E4**
(Cont'd.) **proceeded to the van with some of the individuals, and that E3 remained in the lobby with R3, R4, and R5 who indicated that they wanted to go to the bathroom and with R1 who was "standing by himself" in the lobby. E3 stated that R5 created a small disturbance by approaching strangers and trying to touch them. E3 stated that she was focused on redirecting R5's behavior when E3 ushered the group back to the van. E3 and E4 confirmed that neither completed a head count in the van before leaving the parking lot.**

When interviewed on 07/02/04 at 3:30 p.m., E4 stated that the group arrived back at the facility at 9:30 p.m.. Since her shift was over, E4 left after completing the necessary paperwork regarding the van. E4 stated that she did not know that R1 was missing when she left the facility.

As E5 explained when interviewed on 07/02/04 at 10:30 a.m., it was his job to pass medication that evening, and that he could not find R1 anywhere either inside or outside the house. E5 stated that he asked E3 where R1 was, and she did not know. E3 stated during her interview on 07/02/04 at 10:10a.m. that it was at that point that she realized that R1 had been left at the theater. E3 explained that she and E5 tried to call the theater, but kept getting their automated menu selection program. After several attempts, E3 said that she was able to speak with someone at the theater who told her that a "large, heavy-set man was walking back and forth outside of the theater, and that they called the police and then an ambulance had come and taken him away."

According to ER records, the ambulance responded to the emergency call at 9:56 p.m. The ER records describe R1 as being "disoriented", with possible neurological problems, and transported R1 to the ER in Peoria arriving at 10:10 p.m. The records show that R1 was not providing identifying information, and he was initially assessed as being "Disoriented".

When interviewed on 07/02/04 at 10:10 a.m., E3 stated that it was "right after 10 p.m." that she called the RSD. According to the incident investigation report completed by the

facility on 06/04/04, the RSD (E1) then called the police who informed her that an ambulance was called and was in route to a Peoria hospital. The investigation report states that the RSD confirmed R1's presence in the ER and immediately drove to Peoria to retrieve R1. The hospital report shows that R1 was discharged at 11:26 p.m. on 06/03/04. E4 stated during her interview that R1 and the RSD (E1) arrived back at the facility after midnight.

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A review of facility policy shows that the RSD is to be notified immediately whenever an incident such as leaving a resident behind occurs. When interviewed on 07/02/04 at 10:10 a.m., E3 confirmed that there had been a delay in her reporting the incident to the RSD. E3 did not follow facility policy regarding reporting incidents which could have resulted in a further delay in locating and retrieving R1.

Facility "Transportation Policies" state that "Residents will be counted before leaving the facility on any outing. They will be counted again after the outing is finished before leaving to come back to the facility." E3 and E4 did not follow facility policy and did not count individuals before leaving the parking lot in Washington. They arrived at the movies with 9 individuals but left with only 8 individuals. When asked on 07/02/04 at 4:15 p.m. what happened that night [06/03/04] at the movies, R2, who functions in the Mild range, stated [R1] "was left there; they [staff] didn't count heads".

2. The facility did not provide staff with training to proactively meet R1's needs when he is experiencing his monthly mood cycle, is withdrawn, and is in the community.

R1's diagnoses on the POS for June 2004 include Bipolar Disorder, Obsessive-Compulsive Disorder, Depression, and Psychosis and list Anafranil 100mg at HS; Depakote *ER* 100mg at 6 p.m., Risperdal 2mg at 6 p.m., and Zonegran 300mg at HS for control of behaviors. R1's IPP describes behaviors of R1's exposing himself, being physically and verbally aggressive, and showing symptoms of depression which include being withdrawn and lethargic. These behaviors are described as occurring in monthly cycles.

When interviewed on 07/02/04 at 3:30 p.m., E4 speculated that on the night on 06/03/04,[R1] "was going through one of his moods and he [was] real quiet . . . we think when [E3] went into the ladies restroom [to get R3 and R4 at the movies] that [R1] might have sneaked into the men's room". When asked how R1 behaves when he is "in one of his moods", E4 explained that R1 "gets real quiet, doesn't talk, doesn't answer questions, likes to sleep a lot". E4 also said that R1's moods occur about "1 week every month" and

that on 06/03/04, R1 sat next to E4 in the movies and fell asleep. When interviewed on 07/02/04 at 10:10 a.m., E3 explained that R1 "gets in his moods about once a month". A review of the Nurse's notes clearly shows that R1 is lethargic, sleeping a lot, and refusing to join in activities on a monthly cyclic basis. When interviewed on 07/07/04 at 9:20 a.m., Z1, R1's guardian, confirmed that R1 "has mood swings. When he's in the lower part of that -- the depressed phase -- he would not talk to anyone, not even family."

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350.1060a) **E3 was asked during her interview on 07/02/04 at 10:10 a.m. if R1 had any special needs when**

350.1230d)1) **he's "in one of his moods". E3 stated that "when he's in one of his special moods, we watch him**

350.3240a) **so that he doesn't tear up his stuff". When asked again if there were any special needs when R1**

(Cont'd) **was on outings, E3 replied "no". E4 replied to the same question that staff try to get R1 into activities and get him out of the house, but there were no other interventions that she knew about. When asked on 07/02/04 at 2:10 p.m. if staff had any special instructions on what to do on outings when R1 is "in one of his moods", E1, the RSD, stated that "initially [R1's] behaviors involved depression, withdrawal, and when he began to go on outings he was still quiet. No other special instructions. Dealing with the cycles is new to us."**

R1 is diagnosed with and is treated for symptoms of Bi-polar Disorder and is described by family and staff as having cyclic down moods involving his being withdrawn and lethargic, but the facility did not give staff instructions to provide R1 with any special supervision when he is exhibiting these symptoms while on community outings.

3. The facility did not provide programming for R1 to be willing and able to provide necessary identifying information if lost in the community.

R1 is a 27 year old verbal and ambulatory man who is listed on his Individual Program Plan [IPP] dated 12/29/03 as functioning in the Moderate Range. According to the IPP, R1 was living with his grandparents in nearby Washington when he was admitted to this facility on 12/01/03. According to his "Community Resources" assessment, R1 requires "assist" in all aspects of accessing community resources.

When asked on 07/01/04 at 12:40 p.m. if R1 was on any program to be able to state his home address and telephone number, or if he carried an identification card, E1, the RSD, replied

that R1 has thrown away his identification and his billfold when he is in "his mood", and that prior to the incident on 06/03/04, R1 was not receiving programming to learn the name, address, and telephone number of the group home; but that on 06/04/04 the program was written and implemented.

The files, Z1 (R1's guardian), and direct care staff (E3, E4 and E5) all describe R1's behavior during his "down" cycle as being quiet and uncommunicative. On 07/02/04 at 3:55 p.m., an attempt to interview R1 was made. R1 was asked what his name was. After a 3-minute silence, the question was repeated. After another 2 minute silence, R1 was asked if there was anything he wanted to say. After another several minutes of silence, R1 was asked if his name was [name given], and R1 nodded affirmative. No additional response could be elicited, and the interview was ended at 4:05 p.m. In the presence of a stranger, R1 would not state his name.

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When asked on 07/07/04 at 9:20 a.m. if R1 carried any identifying information, Z1 (R1's guardian) stated that when R1 was "in his down phase, he refuses to carry anything in his pocket". Z1 explained that he did not seem to know the name, address, and telephone number of the facility when he was in the ER on 06/03/04, but knew that he now lived in Pekin.

The facility has not developed an alternate method of having R1's carrying identifying information even in a discardable format such as written on a piece of paper.

Prior to the incident of R1's being left behind and being either unable or unwilling to provide emergency responders with identifying information, R1 had not received any training to learn the name, address, and telephone number of the facility. The facility had not attempted to educate R1 on the importance of providing that information in emergency situations.

(A)

Marigold Estates Aviol.TP.cp