

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

THOMAS HERBSTTRITT HOUSE

0041905

Facility Name

T.D. Number

4003 N. RTES 1 & 17, P.O. BOX 260, MOMENCE, IL 60954

Address

Date of Survey: 03/23/2004

INCIDENT REPORT INVESTIGATION OF MARCH 10, 2004

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):

- 350.1230d)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.
- 350.2010a)2) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall:
Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.
- 350.3000d)2) All exterior doors shall be equipped with a signal that will alert the staff in a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is a constant 24-hour-a-day supervision of the door, a signal is not required.
- 350.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE, OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT.

These REGULATIONS are not met as evidenced by:

Based on review of incident report and investigation, record verification, and interview, the facility neglected to develop and implement written policies and procedures to ensure that staff monitor 1 of 1 client (R1) who is a known elopement risk. R1 eloped on 3/10/04 from the facility and was brought to the Emergency Room (ER) of a local hospital by the ambulance service which had been contacted by the local police. R1 was diagnosed with Mild Hypothermia. Rectal temperature at the ER was 93.9 Fahrenheit.

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"A" VIOLATION(S):

350.1230d)1) Findings include:

350.2010a)2)

350.3000d)2)

350.3240a)

(Cont.)

R1, per his Individual Habilitation Plan (IHP) dated 2/5/04, is a 67-year-old ambulatory male whose diagnoses include Mild Mental Retardation, Hypertension, Atherosclerotic Heart Disease, and Chronic Obstructive Pulmonary Disease.

Per the facility's investigation report dated 3/17/04, "R1 eloped from the facility on 3/10/04. He was found by the local police a little after 5:00am approximately 1.6 miles from the facility. Z1 reportedly saw R1 fall and responded. Z2, after seeing R1, revealed that he had earlier seen R1 at the gas station about 3:30am on 3/10/04. The local ambulance service was called and responded. R1 complained of pain to his left elbow and left hip. R1 was transported to the ER and diagnosed with Mild Hypothermia. The rectal temperature at the ER was 93.9 Fahrenheit at the time of admission. The county Dispatch Center notified E3, night supervisor at the facility, that R1 was being transported to the local hospital's ER. E3 spoke with E4, direct care staff, who then checked R1's bedroom and confirmed that R1 was absent".

A review of the ambulance report showed that R1's vital signs were taken at 5:20am which stated under temperature: COLD and under comments is states "Blankets. Extremely cold".

The facility's investigation report showed that "R1 takes approximately 10 minutes to change his clothes and 50 minutes to walk 1.6 miles--thus R1 could have left the facility between 2:00 and 2:30am".

R1 was interviewed on 3/12/04 at 1:32pm. R1 stated, "I was going to see my brother". R1 was asked which door he came out. R1 answered, "I went out the back door". Then added, "The alarm was broken".

E4, direct care staff, was interviewed via phone on 3/18/04 at 9:55am. E4 stated, "When I came in that night (3/10/04) through the south door (back door), the alarm didn't work. I already talked to E5, supervisor, the weekend before. She said she had noted it". Surveyor asked was this the first time R1 eloped, E4 stated, "Last Sunday morning (3/7/04) about 5:45am while I was cooking breakfast in the kitchen, another client told me that R1 turned the alarm off. Then I heard a shrieking alarm. Apparently R1 was trying to switch the alarm off. He told me he was trying to get some air". E4 added, "I wrote it in a medical concern form because I couldn't find a behavior form. I don't think Administrative Staff read it because it wasn't on a behavior report form". Surveyor asked how often was R1 monitored during the night, E4 stated, "we check on R1 every hour. We checked on him every hour that night. His bed looked like somebody was sleeping in it. When we checked to ensure that he is on his bed after E3 called me, we found out that R1 arranged the blankets in his bed to make it look as if someone is sleeping on it". Surveyor asked if R1 has a sleep log, E4 stated, "He had one, but I didn't know it was mandatory to fill it up".

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"A" VIOLATION(S):

350.1230d)1) E6, direct care staff, was interviewed via phone on 3/18/04 at 1:13pm. E6 stated, "I'm a floater for
 350.2010a)2) overnight shift. I'm not a regular staff at that house". E6 then added, "I came in through the south
 350.3000d)2) door, and the alarm wasn't working. E4 told me that a maintenance work request form has been
 350.3240a) made up already". E6 further stated, "I was not familiar with R1 running away. I was never told that
 (Cont.) he runs away. I have never worked with him".

E7, Qualified Mental Retardation Professional (QMRP), was interviewed via phone on 3/18/04 at 1:25pm. E7 was asked about the 3/7/04 incident. E7 stated, "I did not see the medical concern sheet until after the 3/10/04 incident. The nurse found it in the house on 3/7/04, wrote this needs to be on a behavior form, and it was left in the house". E7 was asked what was the policy regarding medical and/or behavioral concern forms. E7 stated, "Staff should have put it in my mailbox in the Manor or sometimes leave it in the home for me to get it when I go to there". E7 works Monday through Fridays. E7 was asked if he was aware of the malfunctioning door alarms. E7 answered, "I did my own investigation. There was no maintenance request form filled out. It was the battery that was dead. When I talked to staff, they told me the door alarm wasn't sounding right the weekend before R1 eloped. It sounded faint--like the battery was going dead". E7 added, "Nobody told me about it then". E7 was asked what was R1's supervision level. E7 stated "R1 is on a one-on-one during the morning and pm shifts and bed checks every 15-30 minutes during the night shift, and we have door alarms to monitor R1". Surveyor asked E7 if staff knows that R1 is an elopement risk. E7 stated, "staff should know". E7 further added, "We had a pre-IHP prior to R1 moving to this house, and we just had his IHP. I'm sure that was discussed". Surveyor asked E7 if there is a policy in place to ensure that non-regular staff will have knowledge of client's supervision levels in the home. E7 answered, "It's basically the supervisor's responsibility to inform the staff. They should be letting staff know what the clients' needs and supervision levels are".

A review of R1's pre-IHP meeting report dated 12/18/03 and his current IHP dated 2/5/04 showed that these documents did not address R1's supervision levels. It does mention that R1 has a targeted behavior of wandering off the property that is being address in his behavior intervention program.

A review of his behavior intervention program which was initiated on 12/8/03 showed that target behaviors includes non-compliance defined as failure to report to assigned area when paged to do so. Under Adaptive behavior training it includes "R1 is often late for class. R1 is often 30 minutes late in the morning and also after lunch. Staff is to check the bathrooms and R1's bedroom. If R1 is still not found contact the QMRP or supervisor on duty".

The behavior intervention program does not address R1's eloping during the night.