

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

COLONIAL PLAZA

0039552

Facility Name

I.D. Number

618 WEST GOODNER, NASHVILLE, ILLINOIS 62263

Address

Date of Survey: 04/07/2004

## COMPLAINT INVESTIGATION

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):**

- 350.700a)1)2) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police, or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department.
- Notification shall be made by phone call to the Regional Office within 24 hours of each incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by phone call to the Department's toll-free complaint registry number.
- A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence.
- 350.1060e) 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.
- 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)

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**"A" VIOLATION(S):**

350.700a)1)2) These REGULATIONS are not met as evidenced by:

350.1060e)

350.1230d)1)

350.3240a)

(Cont.)

Based on observation, interview, and file verification, the facility failed to prevent neglect when they neglected to develop and/or implement policies and procedures to provide a system which would ensure the safety, and protect the rights of all residents, in that the facility did not:

- 1) Prevent R1 from eloping from the facility.
- 2) Report R1's elopements to the Illinois Department of Public Health (IDPH).
- 3) Thoroughly investigate all of R1's elopements.
- 4) Take corrective action to prevent further elopements by R1.
- 5) Develop and implement a program to address R1's elopement behavior.
- 6) Address the behavior of R1 using alcohol, knowing that R1 is prescribed several psycho tropics.
- 7) Develop a behavior program for restricting R1's smoking.
- 8) Obtain signed consents from Human Rights Committee and R1's guardian before implementing a restrictive intervention (smoking) without a program.

The facility also neglected to ensure the safety of R2, and protect the right of privacy of other residents, in that the facility did not:

- 1) Complete pre-screening assessments on R2.
- 2) Develop interim programs to meet R2's assessed needs.
- 3) Develop and implement a program to address R2's elopement behavior.
- 4) Report R2's elopements to the Illinois Department of Public Health (IDPH).
- 5) Thoroughly investigate all of R2's elopements.
- 6) Develop and implement a program to protect the rights of other residents from R2's behavior of violating the residents' right to privacy when they are using their bedrooms and bathrooms.
- 7) Take corrective action to prevent further elopements or violations of right to privacy by R2.
- 8) Provide staff training on appropriate interventions to prevent R2's elopements instead of staff blocking the doorway with a sofa.

Findings include:

A) R1 is a 32-year-old female who functions in the mild range of mental retardation according to the facility roster provided on 03/29/04. R1 has additional diagnoses of Bipolar Disorder and Intermittent Explosive Disorder. There is no Individualized Service Plan (ISP) available in R1's chart when the chart was reviewed on 03/29/04. R1 was admitted to the facility on 01/12/04.

In an interview on 03/30/04 at 8:56 a.m., E2 was asked if there was an ISP for R1. E2 explained that the computer had crashed, and the facility was waiting for a program to fix it. When asked if a handwritten plan or backup disk was available, E2 replied, "Not that I know of."

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350.700a)1)2) During an interview on 03/30/04 at 10:01 a.m., E1 was asked if there was an ISP for R1. E1 stated  
 350.1060e) she was "still working on it". E1 added that she had started working at the facility on 12/02/03, and  
 350.1230d)1) had "stuff to catch up on." E1 did state that she had developed and implemented programs for R1  
 350.3240a) including bathing, reading, money management, and smoking.  
 (Cont.)

R1 does have an Interim Plan/Assessment for the targeted behaviors of uncooperative or argumentative behaviors, and verbal/physical aggression.

R1 has a new Individual Treatment Plan, which is undated, to manage R1's behaviors. The Plan addresses the targeted behaviors which include manipulative behavior, making up stories, bumping head on wall, and eloping from workshop. R1 has a history of psychiatric admissions before and since her admission to this facility on 01/12/04, and is prescribed psycho tropic medications.

R1's new Individual Treatment Plan for behavior management includes the psycho tropic medications prescribed but not the dosage range. There is also a Medication Reduction Plan, but it is not specific in the criteria to meet in order to initiate a reduction or in the specific dosage range by which the medications will be reduced. This plan has not yet been approved in writing by the Human Rights Committee or the Guardian.

1) During observations on 03/29/04 and 03/30/04, R1 repeatedly threatened to leave the facility. R1 reportedly packed her suitcase (which was observed sitting by the door in the living room), called the police for a ride, called a taxicab company for a ride to New Baden, IL, walked off the property a short distance (approximately ten feet) several times and returned each time.

A review of the Behavior Documentation for March indicates several episodes of elopement. Two elopements on 03/14/04 culminated in the police being called twice in response to her dangerous behaviors (hanging on cars, and threatening to lie down in the street and overdose on medication). R1 was transported to the hospital for evaluation at that time. R1 eloped on 03/25/04 and went to the bank with a blank check she had previously taken, and cashed it for \$29. R1 again eloped on 03/26/04 and the "QMRP grounded her." On 03/27/04, R1 eloped to the local grocery store and the police were called and brought her home.

In an interview on 03/29/04 at 2:47 p.m., R1 reported several times when she has left facility grounds to go places without staff supervision. R1 stated she walks to the local grocery store, the bank, and the convenience store by herself.

During a review of R1's chart on 03/29/04, a risk assessment for Community Awareness and Safety was not noted. E6, Administrator, was asked to provide this document on 04/06/04 and was unable to find that it had been done.

2) During a review of the facility Policy and Procedure Manual on 03/30/04, there was no specific policy or procedure for Elopement, but there was a Missing Persons Procedures page which indicated the Qualified Mental Retardation Professional (QMRP) will contact family/friends for information and then perform a

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350.700a)1)2) search along with other staff. The procedure provides for the notification of police after the individual  
 350.1060e) has been missing for eight hours, and the notification of the Illinois Department of Public Health  
 350.1230d)1) (IDPH) after 60 hours (two and a half days). The procedure also indicates the incident is to be  
 350.3240a) documented and an incident report is to be completed within 24 hours.  
 (Cont.)

As part of the Entrance to the Complaint, all incident reports for January, February and March were requested. There were no incident reports involving elopements provided by the facility.

In an interview on 03/30/04 at 10:02 a.m., E1 was asked if R1's elopements had been reported to IDPH. E1 stated, that yes, if the police were involved, the elopements were reported.

According to the Edwardsville Regional Office on 03/31/04 at 12:20 p.m., no reports of elopement from the facility had been received in 2004.

3) In a telephone interview at 10:55 a.m. on 03/31/04, E1 was asked if she had investigated all elopements and written reports of the investigations. E1 answered, "No, I have not."

4) In an interview with R1 at 2:47 p.m. on 03/29/04, R1 talked freely of her unauthorized walks into town to purchase items she wants, and to withdraw money from her account, which she expressed was her right to do. R1 stated she was "grounded for leaving to get the money from the bank." R1 stated she did not have a program for grounding her, and that there were no house rules that provided for grounding as a consequence for elopement.

When R1's file was reviewed on 03/29/03, there was no Behavior Management Program which included an intervention of "grounding" and no Human Rights Committee or guardian approval for this restrictive intervention.

5) During an interview on 03/31/04 at 10:55 a.m., E1 stated that R1 had a Behavior Management Program for eloping from workshop, but did not have a program for eloping from the facility. A review of R1's chart verified that R1 did not have a program to address R1's elopement behavior from the facility.

6) According to the March 2004 Medication Administration Record (MAR), R1 is prescribed Seroquel 200mg two tablets two times a day, Celexa 20mg at bedtime, and Depakote ER 500mg two tablets at bedtime.

In an interview at 2:47 p.m. on 03/29/04, R1 stated she had walked to the convenience store on a number of occasions and purchased beer to drink. R1 specified that she had one beer Thursday, two beers Friday and that she (R1) did not take her medications Friday because she had been drinking. R1 stated she had told staff that she (R1) had done it, but there had been no consequences. R1 also stated, "I'm going to have one today and there's not a damn thing they can do."

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350.700a)1)2) In an interview at 10:55 a.m. on 03/31/04, E1 was asked if she was aware that R1 had been getting  
 350.1060e) beer. E1 stated that R1 had "told me that the other day." E1 added that it had not been reported to  
 350.1230d)1) her by staff. E1 was asked if she had questioned staff about it and was told that they were only  
 350.3240a) aware of what (R1) told them, but that they didn't see it. No investigation was done according to E1.  
 (Cont.)

7) During file verification, a Smoking Schedule was observed in R1's records. The schedule allowed for cigarettes at 3:00 p.m., 4:30 p.m., 6:00 p.m., 8:00 p.m., 10:00 p.m., and 12:00 midnight. R1 is allowed to take 4 cigarettes to workshop. On weekends and holidays, the schedule provides for cigarettes at 6:00 a.m., 8:00 a.m., 10:00 a.m. and 12:30 p.m. in addition to the regular schedule.

In an interview at 10:55 a.m. on 03/31/04, E1 stated the Smoking Schedule went into effect right after the Human Rights Committee (HRC) meeting on 02/29/04. E1 further stated that she had obtained the mother/guardian's verbal consent and started the schedule shortly after that. E1 acknowledged that a formal program had not been written to address the restriction of rights. A review of R1's chart on 03/29/04 verified that there was no formal written behavior program for this restriction.

E1 provided Human Rights Committee meeting notes dated 02/09/04 which list an agenda item as: (R1) "Smoking, refusing to go to work." Under Committee Recommendations: (R1) - "smoking schedule." is the only notation. The Quarterly Behavior Management Program Review form dated 02/10/04, signed by the committee members, does not mention the smoking restriction.

8) In an interview at 10:55 a.m. on 03/31/04, E1 stated that written, signed consents had not been obtained from the guardian or the HRC for a formal restrictive smoking program.

During a review of R1's file, there was no evidence of written informed consent of a formal restrictive smoking program.

B) R2 is a 23-year-old male, admitted on 03/23/04, who was reported by the facility on the facility roster provided on 03/29/04, as functioning in the moderate range of mental retardation. During an interview on 03/30/04 at 10:02 a.m., E1 stated this determination had been made based on an interview with the mother/guardian. A piece of notebook paper dated 02/04/04, with handwritten notes was provided by E1 to verify what the mother reported during that conversation. There were no other diagnoses reported at that time, and it was reported that R2 had "no behaviors." R2 is a 6'4" African-American male who weighs approximately 260 pounds.

1) When R2's chart was requested, E1 stated that R2 did not have a chart yet, but provided all the information available at the time. A review of this information on 03/29/04 determined it was faxed copies of school records from the Public School System in an adjoining state, and contained evaluations from the years 2000 and 2001. A fax cover sheet dated 03/11/04 from the referral source used by the facility, and written by Z3 states, "Here is some info on (R2). I have not officially screened him, but he appears eligible."

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350.700a)1)2) According to the testing material provided by the Public School System, the Psychological Evaluation  
 350.1060e) indicated the Stanford Binet LM 3rd Edition was administered on 03/08/01 with an IQ of 15. The  
 350.1230d)1) Vineland Adaptive Behavior Scale indicated a Composite Score for an Age Equivalent of two years  
 350.3240a) four months. Other tests place R2 as functioning at less than two years old. The conclusions  
 (Cont.) indicate R2's "level of general intellectual ability measures within the Severely Mentally Retarded  
 Range. Mental age is 3 - 0." According to the 89 Illinois Administrative Code, Chapter I, Sub-chapter  
 d, Section 144 Table E, an assessment of IQ under 20 and Adaptive Behavior Scale below three  
 years nine months, both indicate a functioning level of Profound Mental Retardation.

The only current information available was a Physical Examination performed on 03/08/04 which indicated the one diagnosis of Mental Retardation and a note "Sleeps poorly at night. Otherwise, no other significant findings."

In an interview on 03/30/04 at 10:02 a.m., E1 was asked if any Pre-Screening had been done on R2. E1 replied, that the referral agency had sent his school records, and that she had provided the surveyor with all they had.

During an interview on 04/06/04 at 3:40 p.m., E2, administrator, acknowledged that a Risk Assessment for Community Safety/Awareness had not been performed for R2.

2) In the 10:02 a.m. interview on 03/30/04, E1 also stated no assessments had been done on R2 yet, because "He's only been here a week." When asked if there was any plan of care or programs to meet R2's needs, E1 stated, "Not as yet."

R2 was observed to be at the facility on 03/29/04 while the other residents were attending the day training site. No programming was observed being offered to R2. No assessments, plan of care, or programs were included in the information provided by the facility.

During a telephone interview on 04/05/04 at 9:30 a.m., Z2, indicated several calls to the Nashville Police Department regarding R2's elopement behavior and complaints of trespassing. On 03/28/04 and 03/31/04, R2 was found to be trespassing on the porch of a local citizen. This citizen was described as being "mad. Real mad!" On 03/30/04, R2 entered the home of an elderly female local citizen. This citizen has a heart condition and was recuperating from back surgery at the time. According to Z2, this elderly woman ended up in the hospital as a result of the trespass.

3) When asked in an interview on 03/30/04 at 10:02 a.m. if R2 had any programs for his maladaptive behaviors or elopements, E1 stated that there was not, but that she had a Behavior Specialist coming that week to write a plan. No behavior or elopement programs were included in the information provided by the facility.



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350.700a)1)2) 03-26 3:00p.m. "Running in and out of house and up and down hallways".  
 350.1060e) "Fell asleep on (R8's - female) bed".  
 350.1230d)1) 03-28 6:00p.m. "Constantly walking in (R9's and R10's) room".  
 350.3240a) "Distracting staff while they were trying to change (R10)".  
 (Cont.)

A review of R2's records does not produce any programming for R2's violation of the rights of others. Per interview on 03/30/04 at 10:02 a.m., E1 stated that R2 did not have any programs for his behaviors as yet, but that a Behavior Specialist was coming this week to write a plan.

7) During an interview on 03/29/04 at 2:47 p.m., R1 stated that the new resident (R2) "keeps taking off and I have to go get him." "He (R2) comes in the bathroom when you take a bath and into your bedroom when you try to go to sleep." "They block the doors with the sofa and chairs to keep him in."

In an interview at 3:30 p.m. on 03/29/04, R3 was asked if staff blocks the doors. R3 replied, "Yes, for him (R2), so he can't get out. He'll (R2) walk off." When asked if R3 can get out of the house, R3 answered, "Yes, I go to the front door to go out. It's not blocked. He (R2) doesn't know that."

During interviews on 03/30/04 beginning at 7:55 a.m. with R4, R5, R6, R7, and R8, each resident verified that staff did block the doors to keep R2 from getting out.

When arriving at the facility at 7:30 a.m. on 03/30/04, the door was observed to be closed and staff and residents were visible inside. The door is solid on the bottom half and windows on the top half. The sofa was observed to be positioned in front of the door, blocking it, and a female resident (R8) was seated on it. R2 was observed sitting in a large chair to the right of the door. Staff and residents helped move the sofa aside to allow entry by the surveyor.

The staff person dispensing medications, E2, was then asked why the sofa was blocking the door. E2 replied, "I don't know. To keep him in." E2 nodded in the direction of R2.

A review of Behavior Documentation for March 2004 indicates that R2's behaviors continued unchecked. No programs were developed with interventions to prevent the behaviors and to meet the needs of all residents.

8) A review of Behavior Documentation for March 2004, documents staff attempts to deal with R2's behaviors. In addition to the entries quoted in subsections 5 and 6 above, staff entered comments such as:

03-24 8:46p.m. "(R2) is still very hyperactive".  
 "Keeps trying to run off".  
 "Won't listen to staff".  
 "Staff recommend that due to his uncontrollable behavior and disruption of the residents  
 that his mother be talked to about possible admission to Murray Center".  
 03-24 12:11p.m. "Still giving staff problems".

"Still refusing to go to his room".

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350.700a)1)2) 03-26 3:00p.m. "Continued not to listen".  
 350.1060e) 03-27 6:00p.m. "Refused to come inside. Residents want him gone."  
 350.1230d)1) 03-27 8:00p.m. "All tried to retrieve (R2) and he refused to come".  
 350.3240a) 03-28 6:20p.m. "Tried to massage staff and pressed down on neck, cutting off airway."  
 (Cont.)

Regarding the examples A 1-8 and B 1-8 addressed in this document, the Policies and Procedures of the facility were reviewed, in particular, those dealing with abuse and neglect. The policies provided by E1 did not describe what constitutes abuse and neglect. It was found there was either nothing in place to protect the residents from the neglect cited herein, or the policies were inadequate or not followed.

(A)