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

LEWIS AND CLARK MANOR
Facility Name

0036905
I.D. Number

56 Chouteau Trace Parkway, Pontoon Beach, Illinois 62040
Address

Reviewed By

9/15/05
Date of Survey

Incident Report Investigation of 8/22/05
Type of Survey

Surveyed By

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 of 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
350.2700d)2)
350.3240a)d)

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 following operating the facility and shall be reviewed at least annually.

General Building Requirements-doors and windows

All exterior doors shall be equipped with a signal that will alert the staff if a patient leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

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

A FACILIY ADMINISTRATOR, EMPLOYEE, OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL ALSO REPORT THE MATTER TO THE DEPARTMENT. (Section 3-610 of the Act)

These Regulations were not met as evidenced by the following:

Based on interview and record verification, the facility neglected to take the necessary steps to prevent R1 from a reoccurrence of eloping and prevent potential harm when they:

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(Cont'd.)

1) Neglected to develop a procedure for a Missing Individual.
2) Neglected to have evidence that the elopement of R1 on the evening of 8/22/05 was thoroughly investigated.
3) Neglected to report the results of their investigation to the Illinois Department of Public Health (IDPH) within five working days of the incident.
4) Neglected to take corrective action in response to their investigation of R1's elopement to prevent its reoccurrence.
5) Neglected to provide sufficient direct care staff on the evening shift (2:00 p.m.-10:00p.m) of 8/22/05 when R1 eloped from the facility.

1) Per R1's 4/05/04, Individual Habilitation Plan (IPP), and the August Medication Administration Record (MAR), R1 is a 36 year old male who ambulates with the assistance of loft strand crutches and functions in the severe range of mental retardation with additional diagnosis of cerebral palsy, autistic disorder, urinary incontinence and hiatal hernia. R1 is non-verbal, but is able to communicate his basic wants and needs through shaking his head yes and no and by reaching/pointing to wanted items.

R1's routine medications include Fosamax 70mg, Ditropan XL 10mg, Risperdal 2mg, Oyst Cal D, Hyoscyamine ER 0.375mg, Lipitor 20mg, Remeron 30mg and Niacin 500mg.

R1's IPP states: Without 24-hour supervision, R1 would not attend to needed ADLs, take his medication, contact needed resources, keep his living area clean, take care of his money, eat, attend work, communicate with others, access the community or receive the active treatment and interaction necessary to become more independent.

Review of R1's behavioral plan, R1 has an objective: While following his daily schedule, R1 will reduce incidents of inappropriate behavior to 2 or less incidents per month for 6 consecutive months. R1's Operational Definition Includes: SIB (slapping self , poking eye), non-compliance, moaning for more than 1 minute following prompt, attempting to leave facility property, stealing food or drink.

Review of R1's Daily Chronological Sheets, from March 2004 until September 2004, R1 has attempted to elope to a neighborhood fast-food restaurant and was found there twice in that time period. On June 2, 2005, R1 had also attempt to elope to the restaurant.

Review of an incident report of 8/22/05 and interview with E2 on 8/29/05 at 11:30 p.m., E2 was scheduled to work from 8:00 a.m.-4:00 p.m., the day of 8/22/05, but due to a called off was extended until 8:00 p.m.. 3 staff worked that evening, 1 staff (E3) was responsible for cooking, (E4) was responsible for the 4:00 p.m. and 8:00 p.m. medication pass and E2 was on the floor for 13 individuals.

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E2 stated that she had assisted R1 with his shower on 8/22/05 after supper between 5:30 p.m.-6:00 p.m. The last time she saw R1, he was getting dressed. She stated, she then went down to the other side of the house to assist another client with their bath. The bathroom door was shut, so she had no visible access to the other clients. E2 went on to say, that around 7:15p.m.-7:30 p.m., E3 came down the hallway and let her know that a policeman was in the living room and asked if one of their clients were missing. At that time, E2 went down to R1's room and did not see R1. E2 got into the facility vehicle and drove down to the restaurant and found R1 sitting with the manger drinking a soda.

Interview with E3 on 8/29/05 at 2:30 p.m., E3 had been in the kitchen, cleaning up from the evening meal and then went down the hall to assist a individual with a shower. E3 was back in the kitchen, when he heard a few of the clients yelling, that there was a policeman at the door. E3 indicated: the last time he saw R1 was at the supper table.

Per interview with Z1 on 8/29/05 at approximately 5:30 p.m. , R1 entered the restaurant and went behind the counter and took an empty cup and then proceeded over to the soda fountain and helped himself to the soda. Z1 proceeded to say, at that time R1 was not bothering anybody, so they just left him alone. After an extensive period of time, R1 started to touch the customer's food and steal their drinks. At that time, Z1 notified the local authorities. Z1 stated that R1 was in the restaurant over an hour.

Per surveyors observation and the odometer reading, this restaurant is 0.2 miles from the facility and the restaurant front parking lot is adjacent to a busy State Highway (Route 111).

After R1 was returned to the facility, E2 notified E1 and E8, and E2 was instructed to fill out an incident report and to be R1's 1:1 until the midnight shift begins. The nurse on call was notified and also R1's guardian.

Per interview with E1 on 8/29/05 at approximately 10:00am, a notification was sent to IDPH and a 15 minute tracking sheet was started on 8/23/05. Reviewing the tracking sheet of 8/23/05, the facility did not implement the system until 5:30p.m. on 8/23/05. When asked when R1 returns home from day training, E1 responded at 2:00 p.m. The tracking system went into place 3 and a half hours after R1 returned from workshop.

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2) E1 stated per interview 8/28/05, that he felt that he completed an investigation by taking statements of the three staff on duty the evening of 8/22/05, that R1 eloped to the nearby restaurant. E1 was unaware that any other investigation needed to take place. There was no evidence that E1 interviewed the restaurant or the police, about how long R1 was actually there.

3) A fax was sent to IDPH on 8/23/05 at 3:55p.m. from the facility that states: "This evening, resident R1 eloped from the facility to the nearby restaurant. While there R1 helped himself to a patron's drink and the police were contacted. The facility was notified and R1 was transported back to the facility. R1 did not sustain any apparent injury or negative effects from this incident. The facility is taking measure to ensure that R1 remains on the facility grounds unless supervised by the staff. His guardian was also notified of this incident."

Per interview with E1 on 8/29/05, he was unaware that he needed to complete any type of investigation beside having the 3 staff on duty complete a written statement. E1 confirmed that no other report was sent to IDPH.

4) The facility's action taken in response to R1's elopement of 8/22/05 was to put in place a 15 minute tracking of R1's whereabouts. R1's location tracking sheets were put into place on 8/23/05. Documentation started at 5:30 p. m. When asked what time R1 returns home from day training, E1 responded, that R1 returns at 2:00 p.m. The facility implemented the tracking system 3 and half hour after R1 returned home from day training on 8/23/05. E1 also confirmed that as of 8/30/05, R1's behavioral program has not been revised.

E4 was interviewed on 8/29/05 at approximately 3:00 p.m. E4 stated: that on 8/22/05, she was responsible for passing 4:00 p.m. medication. After supper around 5:30 p.m., she went back into the med room to recheck the MAR. E4 then, went down to the laundry room to check on one of the client's laundry. E4 stated the door was closed to the laundry room and the last time she saw R1 was at supper.

E2 stated on 8/29/05, when there are three staff scheduled, one of those staff is responsible for cooking. The common area (living and activity area) is not monitored when the other staff are assisting the individuals in the bathroom. E2 also stated: "when a staff is in the bathroom with a client and the door is shut, it is difficult to hear if someone is coming in/out of the exterior doors even if the chimes (alarms) are activated." There is no evidence that staff supervised the whereabouts of R1.

CH/cp

CH/cp

CH/cp