STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G344	A. BUILDING _____ B. WING _____	C 10/05/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK-WRIGHT HOME	34377 NORTH ALMOND ROAD GURNEE, IL 60031

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W 149	Continued From page 5 front door that information might not be reliable due to R1's poor short term memory. E1 provided surveyor with a copy of the maintenance check of the doors -which indicated the doors were working properly. The facility investigation stated the alarms could not be heard in the break room due to the dryer making a loud noise. During interview with E1, Coordinator,(10/2/06 - 12:30 p.m.) she stated several changes have been made as a result of the elopement incident. E1 said there were too many staff on break, that is the root of the issue and why R1 got past so many staff. All staff interviewed, (E1, E3, E4, E5, E6, E7, Z2) stated the incident should not have occurred. E6 said (10/3/06 - 2:50 p.m.) there is sufficient protocol in place to prevent R1's elopement.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060a)d)e)h) 350.1070 350.3000d)2) 350.3240a) Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. d) There shall be evidence of training and	W9999		

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W9999	Continued From page 6 habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) 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. h) 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 a Qualified Mental Retardation Professional. Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. Section 350.3000 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if 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 constant 24 hour a day supervision of the door, a signal is not required. Section 350.3240 Abuse and Neglect	W9999		

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W9999	Continued From page 7 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requuirements were not met as evidenced by the following: Based on observation, interview and file review the facility failed to implement protocols to prohibit neglect for one individual, R1, when staff failed to prevent R1's elopement. R1 was found by an unidentified person who returned R1 to the facility before staff were aware of his absence. Findings include: According to the clinical record, R1 is a 43 year old male whose diagnoses include, Mood Disorder due to Brain Damage, Moderate Mental Retardation, Post Traumatic Organic Brain Damage, History of Seizure Disorder and Cerebral Palsy (Bilateral Hemiplegia). R1 has a Behavior Management Program (BMP) dated 12/21/05; targeting elopement, pica and tantrums. The Functional Analysis Summary states: "(R1) is more likely to leave the building in his wheelchair when he is not involved in an activity that he enjoys or when the staff members are preoccupied with the other clients in the facility. He has poor short-term memory, possibly due to traumatic brain injury, and he cannot remember how to return to his facility." Restrictive procedures include Time out, Physical escort, psychotropic medication and an alarm system. The BMP defines attempts at leaving the building as any time (R1) sets off the door alarms when unsupervised or attempts to elope	W9999		

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W9999	Continued From page 8 through his bedroom window. The Individual Program Plan (IPP) states R1 (needs) "24 hour supervision as he is an elopement risk." The Social History states: "Eloping attempts happen sometimes on a daily (sic) and tantrums occur sometimes on an hourly basis." Data shows 108 incidents of elopement attempts from January through August 2006. The Psychological report states: "(R1's) adaptive skills are lower than his intellectual abilities due largely to his physical limitations. He is able to walk and transfer with assistance. (R1) can ambulate his wheelchair independently. He is able to speak and communicate his basic needs. (R1) requires assistance with dressing, bathing, and using the toilet. He is able to feed himself. He lacks community survival skills. The maladaptive behavior of greatest concern is (R1's) insistence upon going outside. The fenced in back yard and regular opportunities to go outside have helped improve this behavior. However when he is prevented from doing what he wants, (R1) can become quite agitated." Z1, R1's guardian, was interviewed 10/3/06 at 10:20 a.m. He said R1 got out of the facility in the past and was across the street in the park. Z1 could not remember when it happened. Interviews were conducted with E1, coordinator, (10/2/06 - 12:30 p.m.), E3, nurse, (10/3/06 - 9:50 a.m.), E4 (10/3/06 - 11:55 a.m.), E5 (10/3/06 - 2:30 p.m.), and E6 (10/3/06 - 2:50 p.m.), habilitation staff, E7, nurse (10/3/06 - 3:22 p.m.) and Z1, guardian (10/3/06 - 10:20 a.m.). All of the persons interviewed indicated R1 spends most of his time at his family's home and is only	W9999		

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W9999	Continued From page 9 in the facility 2 to 3 days per week. E7 stated (10/3/06 - 3:22 p.m.) R1's sole purpose is to leave the facility and go home. All employees interviewed stated R1 is very clever and watches staff for an opportunity to leave the facility. On 10/2/06 and 10/3/06, surveyor observed that there are eight alarmed exit doors in the facility. R1's bedroom door also has a keyed alarm which is activated at night per interview with E1, coordinator, (10/3/06 - 11:00 a.m.), and confirmed by interviews with habilitation aides E4 (10/306 - 11:55 a.m.), and Z2 (10/3/06 - 10:30 a.m.), and nurse, E3 (10/3/06 - 9:50 a.m.). R1's bedroom window is adjusted so that it opens partially to prevent R1's exit from the window. The facility incident investigation documents on 8/20/06, R1 was returned to the facility at approximately 1:15 p.m. by an unidentified male who was wearing a uniform. The facility called the local law enforcement agencies and there is no police report of the incident. Facility staff did not obtain the man's identity and did not discover where R1 was found. Facility staff, E4, E5, E6, E7 and Z2 were not aware that R1 had left the home. R1's elopement created the potential for harm to him because of his physical disabilities and lack of community survival skills. The facility's investigation noted that after residents had lunch, the nurse, E7, took 9 individuals outside in the facility's gated back yard. The door to the dining room exits to the gated back yard. The alarmed door to the dining room was propped open and a piece of cardboard was used to cover the sensor which deactivated the alarm. E7 confirmed during interview with surveyor on 10/3/06 at 3:22 p.m.,	W9999		

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W9999	Continued From page 10	W9999		

that she propped the door open on 8/20/06. E6, Hab Aide reported to surveyor on 10/3/06 at 2:50 p.m. that the door is frequently propped open so that "walkers and other individuals can come in and out of the facility."

It is the facility's protocol to alarm all of the exit doors because of R1's elopement behavior. The staff on duty failed to implement the facility's protocol.

The facility protocol is to initiate a 15 minute roll call. E1, coordinator, stated staff is to visually observe each individual and document on a roll call log. The roll call log for all individuals was reviewed and was not filled in for the time period between 1:00 p.m. and 2:30 p.m. R1's whereabouts are not documented for the time period between 12:30 p.m. and 2:30 p.m.

E5, Habilitation Aide (interviewed 10/3/06 - 2:30 p.m.) said the roll call log is assigned to one staff daily. E5 said Z2 was assigned the roll call log for 8/20/06. Z2 (interviewed 10/3/06 - 10:30 a.m.) stated she was not familiar with the facility's protocols since she is an agency staff. E1, coordinator, said (10/3/06 - 11:45 a.m.) all agency staff are required to read the communication log and become familiar with the programs for all individuals. Staff failed to implement the facility protocol for using the 15 minute roll call on 8/20/06.

On 10/3/06 at 3:22 p.m., E7, nurse stated that on 8/20/06 she brought R1 back into the facility because he wanted to leave the back yard, she was unsure of the time. At that time there were 2 staff in the common area. E7 was not sure who they were but thought it might have been E4 and

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W9999	Continued From page 11 E5. E5 said (10/3/06 - 2:30 p.m.) he came to the common area at approximately 12:15 p.m. Since the assigned staff was not there, he stayed in the common area because he was assigned for the 12:30 p.m. time period. E5 said he stayed in the common area until R1 was returned by the uniformed man. The facility investigation dated 8/25/06, states that E4, E6 and Z2 took breaks during the time the incident occurred. E7 said when the man came to the facility with R1; E4, E6 and Z2 were on break. Interview with E1 (10/3/06 - 11:45 a.m.) indicated that the level of supervision for all of the individuals is visual observation due to the level of functioning and physical disabilities of the individuals. E5 was monitoring the common area. He said (10/3/06 - 2:30 p.m.) he was managing the behavior of another individual and his attention was distracted from the doors to the facility. E7 said (10/3/06 - 3:22 p.m.) she was outside monitoring the individuals in the back yard. The staff failed to implement the supervision protocol requiring all individuals to be visually observed. The facility investigation states R1 did not exit the building from the propped open dining room door. When R1 was asked which door he used to exit, he pointed to the front door. E5 said (10/3/06 - 2:30 p.m.) that even though R1 pointed to the front door that information might not be reliable due to R1's poor short term memory. E1 provided surveyor with a copy of the maintenance check of the doors which indicated the doors were working properly. The facility investigation stated the alarms could not be	W9999		

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W9999	Continued From page 12 heard in the break room due to the dryer making a loud noise. During interview with E1, Coordinator, (10/2/06 - 12:30 p.m.) she stated several changes have been made as a result of the elopement incident. E1 said there were too many staff on break, that is the root of the issue and why R1 got past so many staff. All staff interviewed, (E1, E3, E4, E5, E6, E7, Z2) stated the incident should not have occurred. E6 said (10/3/06 - 2:50 p.m.) there is sufficient protocol in place to prevent R1's elopement. (A)	W9999		