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	14G269	A. BUILDING ______ B. WING ______	C 06/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY TERRACE	**43 BROADWAY CHICAGO HEIGHTS, IL 60411**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS COMPLAINT INVESTIGATION - #0981899 / IL41182	W 000		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to ensure individuals were protected from neglect when the facility failed to provide adequate supervision for 1 of 7 individuals (R1), identified as attending a community outing, who was left unattended in a locked vehicle in a locked garage for approximately 60 to 90 minutes. Findings include: Refer to W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W 122		7/5/09
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: STATE LICENSING FINDINGS 360.620a)	W 149		7/5/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1	W 149		

350.3240a)
350.3240b)
350.3240d)

Section 350.620 Resident Care Policies

a) 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 followed in operating the facility and shall be reviewed at least annually.

Section 350.3240 Abuse and Neglect

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

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

d) A facility 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 ase evidenced by:

Based on interview and record review, the facility failed to ensure individuals were protected from neglect when the facility failed to:
1) ensure appropriate supervision was maintained for one of seven individuals (R1),

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W 149	Continued From page 2 missing from the facility after a community outing. 2) ensure that upon realizing R1's absence from the home, that the Administrator was immediately notified of the incident. 3) ensure that the incidddent was timely reported to the Illinois Department of Public Health. Findings include: In review of the facility's Policy and Procedure Manual, Policy 5.24 Administration Investigative Committee dated 06/17/03 states the following: "Neglect: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." "Procedure A) Any facility employee or agent who witnesses or suspects a violation of resident rights, abuse or neglect as well as injuries of unknown source shall immediately report the matter to facility management using the following protocol: 1. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: Administrator, Executive Director, Director of Operations. 2. The employee or agent will document the incident on a Progress Note (Form #GP-15) prior to leaving the shift." In review of the Annual Individual Service Plan dated 9/25/08, R1 is a 42 year old female with diagnoses that include Severe Mental Retardation, Tonic Clonic and Partial Complex Seizures, Insertion VNS Vagal Neuro Stimulator. R1 functions in the 3 year, 5 month range of adaptive behaviors, and requires assistance in dressing and personal care. She has tremors in her right hand when grasping objects. R1 can	W 149		

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W 149	Continued From page 3 ambulate independently but has an unsteady gait. R1 can verbally communicate with others, but may be difficult to understand. She does not always inform staff when she is sick, and cannot understand basic safety signs or safety issues. She has a behavior development program to address kicking, biting, property destruction, throwing objects, stealing, non compliance and excessive sleeping. In January, 2008, R1 had a Vagal Neuro Stimulator surgically implanted due to the frequency and severity of her seizures. R1 wears a helmet during waking hours for protection due to falling during her seizure activity. R1 has a bed rail for protection while sleeping. Review of R1's seizure frequency for April, 2009 noted that R1 had documented seizure activity on 4/13/09, 2 seizures on 4/14/09, 4/16/09, 4/17/09, 2 seizures on 4/20/09, 4/21/09, and 3 seizures on 4/24/09. In interview with E1, Qualified Mental Retardation Professional(QMRP) on 5/28/09 at 3:15pm, she stated that the home has had no allegations of abuse, neglect or mistreatment in the past two month period and no unusual incidents have occurred during the past two months. E1 stated at 5:35pm on 5/28/09 that several individuals of the home had participated in attending a community play on 4/29/09. E1 attended the play driving her own vehicle and taking three individuals in her car. Direct Service Persons (DSP) E2 and E4 took several individuals in the facility van. She recalled they attended the play which everyone enjoyed, and a head count was done when they left the play. All who went on the trip were accounted for before they returned to the home sometime after 10pm. E1 said she could not recall exactly what time	W 149		

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W 149	Continued From page 4	W 149		

they arrived back at the home. E1 was on her way home from the outing when the house staff called to say that they could not find R1. (Review of the Attendance Archive Time Card for E1 for 4/29/09 reflects E1arriving to work at 7:41pm and leaving at 11:04pm). E1 stated that R1 fell asleep in the van on the way home and did not get out of the van till staff came out to the locked garage and found her asleep in the locked van. E1 said that R1 was safe and was maybe left in the van for 5 to 10 minutes at the most. E1 was asked who located R1, and E1 said she thought it was E2. When asked if the agency had a policy on checking the van for accountability after use, E1 said yes, and that she had reviewed that policy with E2 after this incident. When asked if any progress notes (P15's) had been written regarding this incident, E1 stated she did not know and would have to look and see. When asked if an investigation had occurred regarding R1 being missing from the home, E1 stated no, since she was only missing a few minutes. When asked if E7, Executive Director had been contacted about this incident, E1 stated she did not call E7, and was not sure if direct care staff had called her.

In review of facility's Policy and Procedure Manual, Policy 6.13 Program, dated 6/2/88 states the following:
"The facility shall provide appropriate care and supervision in all areas of programming during key program times.
Purpose A) To provide residents with quality care and supervision. Purpose B) To insure staff accountability for all areas of resident programming. STAFF DUTIES AND ROLES A: Team Leader's Role: The Team Leaders shall be ultimately responsible for meeting the

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W 149	Continued From page 5 programmatic and supervisory needs of the residents. The Team Leaders shall be responsible for the general supervision and care of the residents assigned to their team, and also be responsible for conducting activities.....and transporting programs and documentation of the same, daily. Team Leaders shall assume responsibility for their group of residents during their working shift....that staff member shall either be with the resident or know where the resident is." In a follow-up interview with E1 on 5/29/09 at 12:50pm when asked if the staff (Team Leaders) who attended the outing had particular individuals to be responsible for in accordance with agency policy, E1 stated since everyone was seated together at the play, staff were not assigned any particular individuals to be responsible for. While R1 had no documentation of attending the play, E1 did have a ticket stub for the evening. E1 confirmed that according to the Attendance Archive Time Card for 4/29/09, E1 punched out of work at 11:04pm leaving E2 alone in the home until E6 came into work at 11:28pm to relieve her. E1 stated again she believed E2 had called her to report that R1 was missing from the home on 4/29//09. E6, Direct Service Person was interviewed on 5/29/09 at 3:10pm. According to her Attendance Archive Time Card for 4/29/09 E6 worked 5:56pm to 10:58pm. E6 remained home from the outing to the play, but E6 could not recall who went to the play or who remained at home that evening. E6 thought maybe 4-6 individuals remained home, and E6 passed the 8pm medications for those that remained at home. When asked what time the others returned from the trip, she stated	W 149		

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W 149	Continued From page 6 she could not recall as it was a month ago. E6 said since she was working alone, she had to remain in the house till relieved by another staff member. In an interview with E4, DSP on 5/29/09 at 2:40pm, she stated she worked on 4/29/09, and drove the van to the play. She recalled there were 3 staff, 2 vehicles and was unsure how many individuals of the home attended. In review of the activity sheets, E4 stated she did not document any individuals participating for the evenings event, as she was responsible for giving them their medications when they returned home from the outing. She recalled getting home "late", perhaps 10 or 10:15pm. E4 said she put the van in the garage. She wrote down the mileage but did not check the van to insure everyone was out of it. E4 stated the staff that takes the individuals off the van, (DSP E2), usually would check to see that everyone is out. E4 locked the van, and said E2 locked the garage door, while E4 came into the home and started giving medications to those that went on the trip, including R1. E4 said the medication pass may have taken about 15 minutes to complete. E4 said she usually leaves at 10:30pm, but since the medications had to be given, she left shortly after finishing giving the medications. E4 said that "R1 was missing maybe 3 to 5 minutes tops", and E2 went out to the van and found R1 was asleep. E4's Attendance Archive Time Card for 4/29/09 notes arrival to work at 2:25pm and punching out at 10:45pm. In review of the Physician's Orders and Medication Administration Sheets for R1 for the month of April, 2009, R1's medications of	W 149		

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Carbamazepine 300mg at 4pm and Oyster Shell 500mg. were signed as being given by DSP E4 on 4/29/09. The 9pm medications of Oyster Shell 500 mg, and Hour of Sleep medications of Lamotrigine 100 mg., Clonazepam .5mg, Divalproex Sod ER 1000mg, and Risperidone .5 mg were signed as being given by DSP E6 on 4/29/09. It is doubtful that R1 received the 9pm and hour of sleep medications as documented on the evening of 4/29/09.

In an interview with Direct Service Person (DSP), E2 on 5/28/09 at 5:10pm, she confirmed that she attended the outing of 4/29/09, and knew R1 had attended and enjoyed the outing without any behaviors. She stated she has never known anyone to be lost, or found in the van asleep. E2 documented the community outing of 4/29/09 on Form GP9 as "Play--Enjoyed--2 hours" for each of the following individuals: R3, R4, R5, R6, R7, and R8. R1's GP9 does not reflect attending the play on 4/29/09.

In a follow-up interview with E2, DSP on 5/29/09 at 4:15pm, she stated that after DSP E4, DSP E6 and QMRP, E1 had left for the evening (Il:04pm), she was alone in the home. E2 walked through the house and thought R1 was in bed when she left work on 4/29/09 at 11:30pm when she clocked out. She said that R1's railing is usually up on one side of the bed due to R1 having seizures at night, and she thought she saw R1 in her bed. She stated she did not call E1 to tell her of R1's absence from the home on the evening of 4/29/09. She believed that DSP E5 who came into work at 11:28pm to relieve her, had found R1 asleep in the van after E2 had left work. When asked how she learned that R1 was found in the van asleep, E2 stated she overheard

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other staff of the home talking about it.

In observation of the garage, at 4:30pm on 5/29/09, it is a single car garage, with no windows in the building. Both the garage door, and the door leading into the garage were locked. The van was present and locked.

In an interview with E5, DSP on 6/1/09 at 8:35AM she stated she worked alone on 4/29/09 clocking into the home at 11:28pm She stated she checked the home around 11:30pm and saw that R1 was not in her bed. E5 said R1's bed was perfectly made, and did not look like she had been in it at all that evening. She checked the house calling R1's name, looking in all the rooms of the home without seeing R1. She checked the medication log and noted that R1's meds were marked as being given for the 9pm dosages, and then she called E1 to see if R1 had gone on a home visit or somewhere else. E1 told her that R1 had returned from the outing. E1 told E5 she would call E2 and see if she knew where R1 was. E1 returned the phone call shortly afterwards, and told E5 to go check the van. E5 said she went outside calling for R1, unlocked the garage, calling her name the entire time. She unlocked the van, calling for R1, who popped upright from the last seat in the van behind the drivers seat. R1 was happy to see E5 giving her a big hug, and went into the home at 11:55pm. E5 reported as they exited the garage, the pharmacy delivery person was coming to make a delivery to the home. R1 was taken inside, and E5 took her vital signs and R1 seemed to be fine. She helped R1 get ready for bed. When asked if E5 had a bed check sheet for R1, she stated yes, and located the sheet in a binder. The Nightly Bed Check GP-83 noted hourly checks for all 16

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W 149	Continued From page 9 individuals of the home. The sheet has a comment made by E5 as follows: "at 11:40 while doing bed check, R1 was not in her bed or anywhere else in the facility. I notified RSD to see about her whereabouts. It was unknown. I then found R1 on the van locked in the garage at 11:55." E5 was asked if R1 was capable of opening up the van on her own, and E5 said she doubted that R1 would be able to, as she needs assistance to dress and undress herself in the mornings. In a phone interview with E7, Executive Director at 2:20pm on 5/29/09, she was asked if she was aware anyone from the home was missing for any period of time in the past. E7 stated she knows that staff did not do a van check according to the Activity Quarterly Policy 5.33 dated 11/08, that reviews the need to do a head count as individuals get off of the van. E7 stated she was not made aware that R1 was found asleep in the van until yesterday, 5/28/09, and that she is now looking into the incident.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to immediately report an incident of neglect to the Administrator and the Department of Public Health (IDPH) in accordance with State law for	W 153		7/5/09

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W 153	Continued From page 10 one of one client (R1), found missing from the facility after a community outing. Findings include: In review of the Annual Individual Service Plan dated 9/25/08 R1 is a 42 year old female with diagnoses that include Severe Mental Retardation, Tonic Clonic and Partial Complex Seizures, Insertion VNS Vagal Neuro Stimulator. R1 functions in the 3 year, 5 month range. She can ambulate independently but has an unsteady gait. R1 can verbally communicate with others, but may be difficult to understand. She does not always inform staff when she is sick, and cannot understand basic safety signs or safety issues. Review of R1's seizure frequency for April, 2009 noted that R1 had documented seizure activity on 4/13, 2 seizures on 4/14, 4/16, 4/17, 2 seizures on 4/20, 4/21, 3 seizures on 4/24/09. E1 stated in an interview at 5:35pm on 5/28/09 that several individuals of the home had participated in attending a community play on 4/29/09. E1 attended the play driving her own vehicle and taking three individuals in her car. Staff members E2 and E4 took several individuals in the facility van. She recalled they attended the play which everyone enjoyed, and a head count was done when they left the play. All who went on the trip were accounted for before they returned to the home sometime after 10pm. E1 said she was on her way home from the outing when the house staff called to say that they could not find R1. (Review of the Attendance Archive Time Card for E1 on 4/29/09 reflects arriving at the facility at 7:41pm and leaving at 11:04pm). E1 stated that R1 fell asleep in the van on the way home and did not get out of the	W 153		

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W 153	Continued From page 11 van till staff came out to the locked garage and found her asleep in the locked van. E1 said that R1 was safe and maybe left in the van for 5 to 10 minutes at the most. E1 was asked who located R1, and E1 said she thought it was E2. When asked if the agency had a policy on checking the van for accountability after use, E1 said yes, and that she had reviewed that policy with E2 after this incident. When asked if any progress notes (P15's) had been written regarding this incident, E1 stated she did not know and would have to look and see. When asked if an investigation had occurred regarding R1 being missing from the home, E1 stated no, since she was only missing a few minutes. When asked if E7, Executive Director or the Illinois Department of Public Health (IDPH) had been contacted about this incident, E1 stated she did not notify E7. E1 was not sure if direct care staff had called E7. In a phone interview with E7, Executive Director at 2:20pm on 5/29/09, she was asked if she was aware anyone from the home was missing for any period of time in the past. E7 stated she knows that staff did not do a van check according to the Activity Quarterly Policy that reviews the need to do a head count as individuals get off of the van. E7 stated she was not made aware that R1 was found asleep in the van until yesterday, 5/28/09, and that she is now looking into the incident and will report it to IDPH.	W 153		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.3240a) 350.3240b)	W9999		

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W9999	Continued From page 12 350.3240d) Section 350.620 Resident Care Policies a) 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 followed in operating the facility and shall be reviewed at least annually. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility 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: Based on interview and record review, the facility failed to ensure individuals were protected from neglect when the facility failed to: 1) ensure appropriate supervision was maintained for one of seven individuals (R1), missing from the facility after a community outing. 2) ensure that upon realizing R1's absence from	W9999		

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the home, that the Administrator was immediately notified of the incident.
3) ensure the incident was timely reported to the Illinois Department of Public Health.

Findings include:

In review of the facility's Policy and Procedure Manual, Policy 5.24 Administration Investigative Committee dated 06/17/03 states the following:
"Neglect: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."
"Procedure A) Any facility employee or agent who witnesses or suspects a violation of resident rights, abuse or neglect as well as injuries of unknown source shall immediately report the matter to facility management using the following protocol:
1. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: Administrator, Executive Director, Director of Operations.
2. The employee or agent will document the incident on a Progress Note (Form #GP-15) prior to leaving the shift."

In review of the Annual Individual Service Plan dated 9/25/08, R1 is a 42 year old female with diagnoses that include Severe Mental Retardation, Tonic Clonic and Partial Complex Seizures, Insertion VNS Vagal Neuro Stimulator. R1 functions in the 3 year, 5 month range of adaptive behaviors, and requires assistance in dressing and personal care. She has tremors in her right hand when grasping objects. R1 can ambulate independently but has an unsteady gait. R1 can verbally communicate with others,

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but may be difficult to understand. She does not always inform staff when she is sick, and cannot understand basic safety signs or safety issues. She has a behavior development program to address kicking, biting, property destruction, throwing objects, stealing, non compliance and excessive sleeping. In January, 2008, R1 had a Vagal Neuro Stimulator surgically implanted due to the frequency and severity of her seizures. R1 wears a helmet during waking hours for protection due to falling during her seizure activity. R1 has a bed rail for protection while sleeping. Review of R1's seizure frequency for April, 2009 noted that R1 had documented seizure activity on 4/13/09, 2 seizures on 4/14/09, 4/16/09, 4/17/09, 2 seizures on 4/20/09, 4/21/09, and 3 seizures on 4/24/09.

In interview with E1, Qualified Mental Retardation Professional(QMRP) on 5/28/09 at 3:15pm, she stated that the home has had no allegations of abuse, neglect or mistreatment in the past two month period and no unusual incidents have occurred during the past two months.

E1 stated at 5:35pm on 5/28/09 that several individuals of the home had participated in attending a community play on 4/29/09. E1 attended the play driving her own vehicle and taking three individuals in her car. Direct Service Persons (DSP) E2 and E4 took several individuals in the facility van. She recalled they attended the play which everyone enjoyed, and a head count was done when they left the play. All who went on the trip were accounted for before they returned to the home sometime after 10pm. E1 said she could not recall exactly what time they arrived back at the home. E1 was on her way home from the outing when the house staff

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called to say that they could not find R1. (Review of the Attendance Archive Time Card for E1 for 4/29/09 reflects E1arriving to work at 7:41pm and leaving at 11:04pm). E1 stated that R1 fell asleep in the van on the way home and did not get out of the van till staff came out to the locked garage and found her asleep in the locked van. E1 said that R1 was safe and was maybe left in the van for 5 to 10 minutes at the most. E1 was asked who located R1, and E1 said she thought it was E2. When asked if the agency had a policy on checking the van for accountability after use, E1 said yes, and that she had reviewed that policy with E2 after this incident. When asked if any progress notes (P15's) had been written regarding this incident, E1 stated she did not know and would have to look and see. When asked if an investigation had occurred regarding R1 being missing from the home, E1 stated no, since she was only missing a few minutes. When asked if E7, Executive Director had been contacted about this incident, E1 stated she did not call E7, and was not sure if direct care staff had called her.

In review of facility's Policy and Procedure Manual, Policy 6.13 Program, dated 6/2/88 states the following:
"The facility shall provide appropriate care and supervision in all areas of programming during key program times.
Purpose A) To provide residents with quality care and supervision. Purpose B) To insure staff accountability for all areas of resident programming. STAFF DUTIES AND ROLES A: Team Leader's Role: The Team Leaders shall be ultimately responsible for meeting the programmatic and supervisory needs of the residents. The Team Leaders shall be

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responsible for the general supervision and care of the residents assigned to their team, and also be responsible for conducting activities.....and transporting programs and documentation of the same, daily. Team Leaders shall assume responsibility for their group of residents during their working shift....that staff member shall either be with the resident or know where the resident is."

In a follow-up interview with E1 on 5/29/09 at 12:50pm when asked if the staff (Team Leaders) who attended the outing had particular individuals to be responsible for in accordance with agency policy, E1 stated since everyone was seated together at the play, staff were not assigned any particular individuals to be responsible for. While R1 had no documentation of attending the play, E1 did have a ticket stub for the evening. E1 confirmed that according to the Attendance Archive Time Card for 4/29/09, E1 punched out of work at 11:04pm leaving E2 alone in the home until E6 came into work at 11:28pm to relieve her. E1 stated again she believed E2 had called her to report that R1 was missing from the home on 4/29//09.

E6, Direct Service Person was interviewed on 5/29/09 at 3:10pm. According to her Attendance Archive Time Card for 4/29/09 E6 worked 5:56pm to 10:58pm. E6 remained home from the outing to the play, but E6 could not recall who went to the play or who remained at home that evening. E6 thought maybe 4-6 individuals remained home, and E6 passed the 8pm medications for those that remained at home. When asked what time the others returned from the trip, she stated she could not recall as it was a month ago. E6 said since she was working alone, she had to

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remain in the house till relieved by another staff member.

In an interview with E4, DSP on 5/29/09 at 2:40pm, she stated she worked on 4/29/09, and drove the van to the play. She recalled there were 3 staff, 2 vehicles and was unsure how many individuals of the home attended. In review of the activity sheets, E4 stated she did not document any individuals participating for the evenings event, as she was responsible for giving them their medications when they returned home from the outing. She recalled getting home "late", perhaps 10 or 10:15pm. E4 said she put the van in the garage. She wrote down the mileage but did not check the van to insure everyone was out of it. E4 stated the staff that takes the individuals off the van, (DSP E2), usually would check to see that everyone is out. E4 locked the van, and said E2 locked the garage door, while E4 came into the home and started giving medications to those that went on the trip, including R1. E4 said the medication pass may have taken about 15 minutes to complete. E4 said she usually leaves at 10:30pm, but since the medications had to be given, she left shortly after finishing giving the medications. E4 said that "R1 was missing maybe 3 to 5 minutes tops", and E2 went out to the van and found R1 was asleep. E4's Attendance Archive Time Card for 4/29/09 notes arrival to work at 2:25pm and punching out at 10:45pm.

In review of the Physician's Orders and Medication Administration Sheets for R1 for the month of April, 2009, R1's medications of Carbamazepine 300mg at 4pm and Oyster Shell 500mg. were signed as being given by DSP E4

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W9999	Continued From page 18 on 4/29/09. The 9pm medications of Oyster Shell 500 mg, and Hour of Sleep medications of Lamotrigine 100 mg., Clonazepam .5mg, Divalproex Sod ER 1000mg, and Risperidone .5 mg were signed as being given by DSP E6 on 4/29/09. It is doubtful that R1 received the 9pm and hour of sleep medications as documented on the evening of 4/29/09. In an interview with Direct Service Person (DSP), E2 on 5/28/09 at 5:10pm, she confirmed that she attended the outing of 4/29/09, and knew R1 had attended and enjoyed the outing without any behaviors. She stated she has never known anyone to be lost, or found in the van asleep. E2 documented the community outing of 4/29/09 on Form GP9 as "Play--Enjoyed--2 hours" for each of the following individuals: R3, R4, R5, R6, R7, and R8. R1's GP9 does not reflect attending the play on 4/29/09. In a follow-up interview with E2, DSP on 5/29/09 at 4:15pm, she stated that after DSP E4, DSP E6 and QMRP, E1 had left for the evening (ll:04pm), she was alone in the home. E2 walked through the house and thought R1 was in bed when she left work on 4/29/09 at 11:30pm when she clocked out. She said that R1's railing is usually up on one side of the bed due to R1 having seizures at night, and she thought she saw R1 in her bed. She stated she did not call E1 to tell her of R1's absence from the home on the evening of 4/29/09. She believed that DSP E5 who came into work at 11:28pm to relieve her, had found R1 asleep in the van after E2 had left work. When asked how she learned that R1 was found in the van asleep, E2 stated she overheard other staff of the home talking about it.	W9999		

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W9999	Continued From page 19 In observation of the garage, at 4:30pm on 5/29/09, it is a single car garage, with no windows in the building. Both the garage door, and the door leading into the garage were locked. The van was present and locked. In an interview with E5, DSP on 6/1/09 at 8:35AM she stated she worked alone on 4/29/09 clocking into the home at 11:28pm She stated she checked the home around 11:30pm and saw that R1 was not in her bed. E5 said R1's bed was perfectly made, and did not look like she had been in it at all that evening. She checked the house calling R1's name, looking in all the rooms of the home without seeing R1. She checked the medication log and noted that R1's meds were marked as being given for the 9pm dosages, and then she called E1 to see if R1 had gone on a home visit or somewhere else. E1 told her that R1 had returned from the outing. E1 told E5 she would call E2 and see if she knew where R1 was. E1 returned the phone call shortly afterwards, and told E5 to go check the van. E5 said she went outside calling for R1, unlocked the garage, calling her name the entire time. She unlocked the van, calling for R1, who popped upright from the last seat in the van behind the drivers seat. R1 was happy to see E5 giving her a big hug, and went into the home at 11:55pm. E5 reported as they exited the garage, the pharmacy delivery person was coming to make a delivery to the home. R1 was taken inside, and E5 took her vital signs and R1 seemed to be fine. She helped R1 get ready for bed. When asked if E5 had a bed check sheet for R1, she stated yes, and located the sheet in a binder. The Nightly Bed Check GP-83 noted hourly checks for all 16 individuals of the home. The sheet has a comment made by E5 as follows: "at 11:40 while	W9999		

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doing bed check, R1 was not in her bed or anywhere else in the facility. I notified RSD to see about her whereabouts. It was unknown. I then found R1 on the van locked in the garage at 11:55." E5 was asked if R1 was capable of opening up the van on her own, and E5 said she doubted that R1 would be able to, as she needs assistance to dress and undress herself in the mornings.

In a phone interview with E7, Executive Director at 2:20pm on 5/29/09, she was asked if she was aware anyone from the home was missing for any period of time in the past. E7 stated she knows that staff did not do a van check according to the Activity Quarterly Policy 5.33 dated 11/08, that reviews the need to do a head count as individuals get off of the van. E7 stated she was not made aware that R1 was found asleep in the van until yesterday, 5/28/09, and that she is now looking into the incident.

(A)