STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G231	A. BUILDING _____ B. WING _____	06/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCPTIONAL CR & TRAINING CTR.	2601 WOODLAWN ROAD STERLING, IL 61081

(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 488	Continued From page 30 R23, R24, R25 and R26 ate their meals with varying levels of independence. Some could help themselves more than others, but all could have participated in family style dining at some level. During the breakfast meal on 6-2-09 between 6:28 A.M. and 8:58 A.M. water was served in pre-filled glasses to R1, R5, R9, R11 and R12. The clients were not given an opportunity to pour their own liquid even if it may have required hand over hand assistance. On 6/8/09 at 1:49 P.M., E10, QMRP was interviewed. E10 said yes she thought some clients were capable of family style dining. E10 said with the new way of serving food in bowls, versus using trays, individuals should be able to participate in family style dining.	W 488		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 390.620a) 390.810a) 390.1010a) 390.1316a)3) Section 390.620 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. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in the facility. The policies shall be available to the	W9999		

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W9999	Continued From page 31 staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 390.810 General a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. Section 390.1010 Service Programs a) The facility shall provide, either directly or through arrangements with an outside resource, as needed by the individual resident, all services necessary to maintain and promote good physical health and development. Section 390.1316 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 390.Appendix C. In addition, an unnecessary drug is any drug used: 3) without adequate monitoring. These Regulations were not met as evidenced by: Based on record review and interview the facility failed to implement their policy to prevent neglect for (R11) 1 of 1 outside the sample who eloped from the facility when they failed to: 1. Ensure R11 was adequately supervised after receiving an altering behavior medication. Findings include:	W9999		

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W9999	Continued From page 32 Per record review of the Physician Order Sheet dated 6-1-09 thru 6-30-09, R11 is a 24 year old male who is mobile using a wheelchair and nonverbal. R11 functions in the Profound range of Mental Retardation with a Slosson test IQ < 14 and an Inventory for Client and Agency Planning (ICAP) of 0 years and 11 months. Per the Individual Program Plan dated 10-25-08, R11's list of diagnoses includes Cerebral Palsy, Spastic Quadriplegia, Seizure Disorder, Psychotic, Constipation, Insomnia, and Ptyalism. Per record review of the functional assessment summaries in developmental areas dated 10-25-08 it states that R11 is totally dependent on the individual attention of caretakers to meet all of his needs. Under Motor Skills Assessment it states R11 can inconsistently pull himself along in his wheelchair using the railings along the wall. His preferred mode of movement is pushing off with his feet and moving the wheelchair backwards; however, he tends to push off hard and fast and usually will crash into people or things. Per record review of the Notification to Illinois Department of Public Health dated 5-13-09 it states, R11 was an unauthorized absence, was very agitated, and attempted to elope from the building but was redirected back into the building. Per record review of the Incident/Accident Investigation Summary dated 5-20-09 it states that on 5-13-09 at 7:25 AM E6 (Psychiatrist) gave a telephone order for an emergency one time dose of Haldol 5 mg by mouth for R11. This was due to aggressive and destructive behavior that staff was not able to redirect effectively. At	W9999		

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W9999	Continued From page 33 approximately 7:40 AM R11 received the emergency medication. At approximately 7:45 AM R11 eloped from the building but was redirected back into the building. Per record review of the Investigation Report for the incident involving R11 that occurred on 5-13-09 it is stated as follows: On 5-13-09 R11's behaviors escalated to the point were he was a "danger to himself and others". R11 received an emergency dose of Haldol and attempted to elope from the facility. R11's ICAP service score of 1 indicates the need for "total personal care and intense supervision". R11 has a behavior plan dated 12-15-08 for aggression, non compliance, and privacy invasion. According to this report a recreation of events that led to the elopement attempt stated that R11 was out of staff's vision for less than 2 minutes. R11 received his emergency medication at 7:40 A.M. Staff was monitoring him in the hallway outside of his bedroom. R11 at that time was in his wheelchair pushing himself backwards with his feet, going towards Dayroom South. E5 (Certified Nursing Assistant) stepped into a bedroom across from R11 and stepped back into the hall and did not see R11. R11 was located approximately 90 yards outside the doorway and was redirected back into the building. This report states that it was a very short duration that R11 was out of the building and he never left facility grounds. The facility is equipped with door alarms but has never needed to utilize the alarms to keep residents from eloping. The door alarms are used to promote security of residents and staff from the dangers of unauthorized personnel entering the building. The door alarms were all functional and were all being used as per facility	W9999		

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W9999	Continued From page 34 policy. According to the statement dated 5-13-09 at 10:00 A.M., E3 (Licensed Practical Nurse) stated that R11 had been displaying severe inappropriate behavior on the 6 AM-2 PM shift that she was working. At 7:25 AM E6 (Psychiatrist) gave an order for an emergency chemical restraint for R11 due to aggressive and destructive behaviors that staff were not able to redirect. At 7:40 AM R11 received the emergency dose of Haldol and E3 further stated that she "informed E5 assigned to R11 to closely monitor him for any ill effects from the medication as well as it's effectiveness in modifying his behaviors". E3 stated that she continued to pass medications to other residents in that area. A couple of minutes later E5 informed her they did not know where R11 was at. This statement further states, after a couple of minutes she was informed that R11 had been found outside. E3 assessed R11 for injury and instructed the staff to provide 1-1 supervision to R11. According to the statement dated 5-13-09 at 9:45 A.M., E4 (CNA) said she was assigned with E5 to provide personal care for R11. E4 stated that the night shift was providing 1 to 1 care for R11, who was already in an agitated state, rocking his wheelchair and grabbing at everything. E4 stated that R11's behavior had escalated after his bath and he became disruptive and destructive to property. E4 stated that she went to attend to another resident when she noticed R11 grabbing a plant by the southwest doorway into the parking lot. E4 could not leave the other resident but pulled the call light for help. E15 (CNA) came out of the conference room near the southwest doorway and redirected R11. E4 than stated she saw E5 looking for R11. E4 stated they looked outside	W9999		

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W9999	Continued From page 35 because they knew R11 could open the door. E4 said that E5 went out a foot or two and that she (E4) went out to the middle of the parking lot. E4 stated that she looked to the north and first saw the plant that R11 had earlier grabbed and destroyed, lying on the ground, then looked a little further and saw R11. E4 stated that she jogged to R11 and redirected him back into the building. E4 stated that it had been raining earlier but at the time she was outside it was not. According to the statement on 5-13-09 at 9:15 A.M., E5 stated that at 7:40 A.M.- 7:45 AM, she was in the hallway near R11's room and E3 (LPN) told her to monitor R11 as E3 had given an emergency medication to R11 for his behaviors. E5 stated that she stepped into another residents bedroom and stepped back into the hall and did not see R11. E5 stated that she looked into the remaining 3 or 4 residents bedrooms and informed E4 that she did not know where R11 was. E5 stated that she and E4 decided to check outside only because they knew that R11 could open the door. He had been pulling at the plant by the door earlier. E5 stated that she just stepped a couple of feet outside and scanned the immediate area. E4 went further out and looked and saw R11 farther down the lot and jogged down to get him. Per record review of the Resident Rights Policies and Procedures dated 02/09 it states neglect is defined as a failure in the facility to provide adequate medical, or personal care or maintenance. Under Prevention of Abuse, neglect, mistreatment, seclusion, financial exploitation it states the program may include but is not necessarily limited to the following: Monitoring staff on all shifts to identify inappropriate behaviors towards residents	W9999		

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W9999	Continued From page 36 including ignoring residents while giving care. Assessing, care planning, and monitoring of residents with needs and behaviors that may lead to conflict or neglect. Per record review of the Missing Individuals - Elopement policy dated 02/09 it states, each resident shall be accounted for at all times while under the care of the facility. Under procedure it states the level of supervision for each resident shall be noted in the individual's medical chart. Per record review of the Individual Program Plan dated 10-25-08 it states ICAP Service Score: 1 with a note written and dated 5-13-09, R11 requires total personal care and intense supervision with E2's initials. Per interview on 6-4-09 at 12:38 P.M. E1 (Executive Director) agreed on the severity of the incident with a huge potential for harm for R11. E1 acknowledged that the Missing Individuals elopement policy failed due to R11 not being accounted for at all times while under the care of the facility. Per interview with E2 (Quality Assurance Coordinator) on 6-3-09 at 11:06 AM when asked what is intense supervision stated " it is to have within visual site". When asked what was R11's supervision at the time of incident, E2 stated that R11 was "like a one to one". Per interview with E2 (Quality Assurance Coordinator) on 6-3-09 at 11:06 AM stated that E4 found R11 in the middle of the parking lot 90 yards away facing the southwest exit door. E2 stated that R11 moves his wheelchair backwards. When he was found, he had his back to	W9999		

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W9999	Continued From page 37 oncoming traffic in the parking lot. According to the record review of the Behavior Development Program dated 12-15-08 it states that R11 can be discreetly monitored when no maladaptive behaviors are present. 1:1 interaction should be reduced. Under Description of Target Maladaptive Behavior dated 5-13-09 it states elopement risk leaving supervised and/or safe areas with E1,s initials. E2 stated on 6-3-09 at 11:06 A.M. that R11 was having behaviors that day and was given an emergency medication. R11 should have been monitored more closely but 1:1 was not initiated. "He should have been in visual observation". E2 stated that E5 had gone into another residents room and when she came back out in the hallway "she realized that E5 lost visual observation of R11". According to the record review of the nurse's notes dated 5-13-09 it states the following: 5-13-09 6:00 A.M. R11 being very aggressive towards staff and facility property. Grabbing and pulling at staff. Grabbing at curtains and pulling them down staff attempted to redirect several times with little effect. 5-13-09 7:15 A.M. Resident continues to disrupt staff and facility property. Staff unable to redirect will call E6 (Psychiatrist). 5-13-09 7:25 A.M. Called E6 and orders 5 mg Haldol by mouth stat. 5-13-09 7:40 A.M. Haldol given by mouth with out difficulty resident in wheelchair going down the hall to day room and not grabbing at staff or property. 5-13-09 7:45 A.M. R11 attempted to elope, R11 was redirected by facility staff. Guardian	W9999		

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W9999	Continued From page 38 notified of medication and attempted elopement by message. Per interview with E2 on 6-3-09 at 11:30 A.M. stated that because R11 was getting crazy and redirection techniques were not effective. A telephone order was made for his behaviors. When asked if this is considered as an elopement, E2 stated that this is a "missing person more than elopement". When asked if this is considered as neglect stated "I don't think it does since there was no injury. It was 2 minutes out of visual that E5 did not have R11 in sight". When asked why the night shift staff had placed R11 into 1:1 stated "It is up to the nurse to determine if a 1:1 was needed" and since he was in an agitated state and awake he was a one to one. The day shift nurse decided not to have R11 into a one to one situation. When asked who was responsible for the supervision of R11 when the emergency medication was given E2 stated E3 (LPN) had medications to pass. R11 has had emergency medications before and therefore to keep an eye on adverse reactions it would have been E5's responsibility. When asked what exit and where R11 was found E2 gave this surveyor a reenactment of the incident. E2 had exited the southwest door that leads outside to the facility parking lot full of cars. R11 was found 90 yards away from this exit door, E2 had this area measured. E5 could not have seen R11 if she stepped out the southwest door due to the cars in the parking lot and the obstructed view of the facility's structure making the oncoming traffic lane narrower. This southwest parking lot has a shared entrance and exit out to the main road. E4 had found R11 due to going to the middle of the parking lot and looking towards the main road. E4 saw R11 face to face going backwards to the	W9999		

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W9999	Continued From page 39 oncoming traffic lane of the facility parking lot leading towards the main road and jogged to get him. R11 does not possess the skills to cross a road and is dependent on the facility for total care. (A)	W9999		