

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>14G212</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>10/15/2013</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOMESTEAD HOUSE</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>905 NORTH JEFFERSON</b><br><b>WEST FRANKFORT, IL 62896</b>          |                      |   |
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| W 149<br>W9999   | Continued From page 35 facility's policy for "Missing Persons".<br>FINAL OBSERVATIONS<br><br>LICENSURE Violations:<br><br>350.620a)<br>350.1210<br>350.1220j)<br>350.1220m)<br>350.1230b)7)<br>350.1230d)1)<br>350.3240a)<br>350.3240e)<br><br>Section 350.620 Resident Care Policies<br><br>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.<br><br>Section 350.1210 Health Services<br><br>The facility shall provide all services necessary to maintain each resident in good physical health. | W 149<br>W9999  |   |                      |   |

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| W9999  | <p>Continued From page 36<br/>Section 350.1220 Physician Services</p> <p>j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident</p> <p>m) A resident who becomes unmanageable shall promptly be examined by a physician or a psychiatrist. A psychologist and members of other appropriate professional disciplines should be consulted, as necessary.</p> <p>Section 350.1230 Nursing Services</p> <p>b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:<br/>The DON shall participate in:</p> <p>7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator,</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 37</p> <p>employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observation, interview and record review, the facility failed to ensure that individuals are provided with necessary staff supervision to prevent incidents of elopement (whereabouts unknown by staff) from the facility as evidenced for 1 (R1) who has eloped from the facility three times in the past thirty days (08/28, 09/04 and 09/15/13). The facility has failed to:</p> <p>1) Provide necessary staff supervision to prevent R1 from eloping from the facility and entering businesses and/or residences during the evening/night time hours on two separate occasions (08/28/13 and 09/04/13) resulting in 911 calls to the police department from the business owner and/or homeowner(s);</p> <p>2) Intervene when indicated, constituting neglect when staff failed to follow R1, but rather sent</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 38</p> <p>another individual (R4) to follow him after he left the facility on 09/15/13 at 6:30 A.M. R1 was found eleven hours later sitting in a locked truck approximately 1.5 miles from the facility. After being found, R1 required emergency medical intervention and was sent to the Emergency Room for evaluation for dehydration;</p> <p>3) Complete and/or update the comprehensive functional assessment for community safety to reflect R1's current incidents of elopement behaviors and to address his history of making poor decisions when in the community (i.e. jumping out of the facility van, home invasion and locking himself in a truck for an undetermined amount of time);</p> <p>4) Develop and implement a behavior intervention program as based on the comprehensive assessment to address R1's elopement behaviors inclusive of the necessary level of supervision to prevent future incidents of elopement;</p> <p>5) Ensure that staff are CPI (Crisis Prevention Institute) trained and are competent to deal with R1's aggressive behaviors often leading to his attempts at leaving the facility and/or elopement; and</p> <p>6) Provide 1:1 staff supervision across all environments to prevent further potential incidents of elopement when at the facility and/or when at the facility's off site day training program.</p> <p>7) The facility failed to implement the facility's policy for "Missing Persons" for 1 (R1) who eloped from the facility on 08/28/13, 09/04/13 and again on 09/14/13 and staff of the facility</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 39</p> <p>failed to have reproducible evidence that the facility's policy was implemented when they failed to ensure that:</p> <ul style="list-style-type: none"> <li>- Incident/Accident Reports are completed for each incident of elopement/missing person as per the facility's policy; and</li> <li>- The Administrator of the facility is notified when R1's whereabouts are unknown to staff.</li> </ul> <p>Findings include:</p> <p>On 09/04/13 at 8:49 P.M., the facility was notified by the city's police department that R1 had entering a private residence resulting in a 911 call from the owner of the home. The police were dispatched to the scene regarding a "suspicious intruder" and R1 was found to be the intruder. R1 was taken to the police station and E1 (Residential Services Director - RSD) was called to the police station to pick him up. Z1 (Responding Officer) stated that she had informed E1 that R1 ran the chance of being shot by a homeowner when entering their homes at night. Z1 stated that she had stressed the seriousness of R1's elopements to E1 and that this was the second time that they (the police) had responded to a 911 call about R1. Prior to 09/04/13 incident, R1 eloped from the facility without staff's knowledge on 08/28/13 and entered a downtown business requesting help. The business owner called 911 and the police notified the facility that a gentleman stating that his name was R1 had been located and would be</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 40</p> <p>returned to the facility. After these two incidents, the facility failed to develop and implement a plan to address R1's elopement behaviors inclusive of the necessary level of supervision needed to prevent further elopement incidents. As a result of this failure, on 09/15/13, R1 eloped from the facility after staff sent another individual to follow him to return him to the facility. R1 was not located until eleven hours later, approximately one and half miles from the facility sitting in a locked truck. R1 required, "Advance Life Support" due to possible dehydration after he was found by an unnamed person, sitting in a locked truck for an undetermined amount of time.</p> <p>After 09/15/13, R1 was placed on 1:1 staff supervision at the facility with visual checks at night. R1 was not placed on 1:1 staff supervision while at the facility's day training site. On 09/24/13, R1 eloped from the facility's day training site and made it down the driveway, near the highway before being stopped by staff. As of 09/27/13 at 11:20 A.M., R1 was not observed to be one to one staff supervised while at the facility's off site day training program, nor has the facility developed a behavior intervention plan to address R1's elopement behaviors. The facility's and the facility's off site day training program's documentation identifies that R1 often becomes aggressive prior to his attempts of elopement. As of 09/27/13, staff of the facility are not CPI (Crisis Prevention Institute) trained to deal with R1's aggressive behaviors. Record review identifies that after R1's continued elopement attempts, the facility failed to develop and implement a plan to address R1's elopement behaviors.</p> <p>In review of the Universal Notes for the month of August, 2013 the following entries were noted in</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 41</p> <p>R1's record:</p> <p>08/23/13 8:30 P.M. "R1 walked down hallway and opened the door to go outside... He did go back in..."</p> <p>08/25/13 "R1 slept all night got up and 4:00 A (A.M.) R1 went outside and started yelling and cursing at the people next door. Yelling for them to get the "F*c*" out of here." 7:00 Client cont. to yell outside at neighbors 1:1 given did stop after several attempts... Staff came in at 3 P.M. R1 was extremely agitated... R1 proceeded to begin to curse at the neighbor boy who was outside playing basketball heading across the street staff who was mowing got him back to the house... R1 then left his room going back out front to sit in the chair once again becoming agitated and talking loudly and cursing. House manager was then called she came due to staff not being able to get R1 to come in and go to bed...(continued) he (R1) came inside, went to bed only to get back up redress completely and try to go back outside again. He was redirected to his room for 1 on 1..."</p> <p>08/26/13 6:30 A.M. "Approx while staff was helping other clients get ready R1 walked across the street messing with the black mustang. R6 came and got staff to let them know. Staff called R1 back telling him that he needed to get away from the car and he argued that it was his car too..."</p> <p>08/28/13 (11p - 7A) "R1 slept all night until staff wake him up at 5:30 A.M. R1 is eating breakfast and talking to himself. No problems noted at this time."</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 42</p> <p>08/29/13 8:30 P.M. "Staff tried to assist R1 to bed. He became irate yelling at staff and saying that he was leaving the facility. Staff explained to client that it was late and dark outside that in the A.M. we would talk.. Client screamed, "No" hitting staff member in the face and ran out of his bedroom yelling that he was leaving. Staff tried to stop him for leaving out the door and than when R1 kicked and hit staff member again and throwing himself on the ground several times. Staff member x2 finally calmed him down and he eventually agreed to go to his bedroom. 1:1 given without success..."</p> <p>08/30/13 "Evening Shift During this shift client (R1) tried to elope x 3. Each time 1:1 was given without success. Staff encouraged client to take a walk with them to calm down without success with that. Client showed aggression towards this staff x1, no physical contact was made other staff was quick to take him to a different area to calm down. Whole time 1:1 was given without success cont. (continued) with behaviors."</p> <p>No further documentation is noted for the month of August 2013 regarding any other incidents of elopement and/or attempts of elopement.</p> <p>On 09/27/13 the surveyor was presented with a police report from the local police department identifying that R1 had eloped from the facility on 08/28/13 without staff's knowledge.</p> <p>** The Police Department Detail Call Sheet dated 08/28/13 19:10:27 (7:10 P.M.) states,</p> <p>"Adv (advised) of a male that came up stating he did not want to die and foaming at the mouth. He</p> | W9999   |   |                      |   |



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| W9999  | <p>Continued From page 43</p> <p>(caller) stated they took him in to try and calm him down but they cannot understand him." This report then states that an ambulance and a squad car were dispatched to Z2's business located on East 9th Street. The report states that the facility was contacted to, "See if he belongs there. He is stating his name is R1." It then states, "They (the facility staff) adv yes they are missing a R1." R1 was then transported back to the facility at 7:43 P.M."</p> <p>The Verizon Map phone application indicates that if leaving the facility, R1 walked 0.6 miles to arrive at the 200 block of the East Main Street address. This application indicates that it would have taken R1 approximately 12 minutes to walk to this location from the facility.</p> <p>In review of R1's Universal Notes for 08/28/13 as compared to the police report with the same date, there is no documentation noted (in R1's Universal Notes) for 08/28/13 regarding R1's elopement incident.</p> <p>A memorandum dated 08/29/13 (which was provided by the facility on 09/27/13) states, "Do (due) to R1 leaving the facility after telling staff on duty that he was going to bed it has become necessary that staff have visual contact with him at all times until further notice. Staff that are working the 2-6 pm will be responsible for monitoring R1 visually at all times for the entire shift. Staff that work 2-9 pm will take over the visual monitoring at 6pm until 9 pm. Staff that work 3-11 will monitor from 9pm - 11pm. Staff that work 11-7 during hours of sleep will check on him every 15 minutes. Over the weekend staff that work 7am - 3 pm and 8 am - 4 pm can trade off every couple of hours. The same will be</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 44</p> <p>enforced for the evening shift 2pm - 9pm and 3pm -11pm. The 11am - 7am will remain the same as throughout the week. If anyone has any questions or suggestions, please feel free to discuss it with me. All staff are to sign off after reviewing. R1 is ultimately your responsibility as assigned." It is noted that this memorandum is signed by E2, E3, E4, E5, E6, E7, E8, E9 and E10.</p> <p>E1 (RSD) was interviewed on 09/27/13 at 3:45 P.M. and stated, "I started visual monitoring after R1 began trying to leave the facility at night." When E1 was asked if R1 had any incidents of elopements prior to 08/29/13 she stated, "He had made attempts but staff had followed him and been with him during his elopement attempts. At this time, E1 was presented with the Police Report for 08/28/13 which shows that R1 had left the facility without staff's knowledge and had been returned to the facility by the police. E1 then stated, "I don't remember that incident."</p> <p>In review of the Universal Notes for the month of September, 2013 the following entries were noted:</p> <p>09/01/13 "R1 has stayed in his room all evening. He has tore up things in his room. He has took every thing from the closet he move the mattress of his room mates bed and tried to take the bed apart. He has barricaded himself in his room by putting all of his room mates things against the door. Refused to eat supper or snack... Refused to clean off his bed when staff asked him to so that he could go to bed... he refused to even lay down at all. Staff (E2/DSP) will monitor him".</p> <p>09/02/13 "R1 woke up around 2:30 A.M. and went</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 45<br/>to dumpster this staff redirected back to bed."</p> <p>09/04/13 6:45 P.M. "R1 walked away from facility. Staff went looking for him. Staff noticed that he was walking up the alley towards the facility. He came up to house and walked out on the deck and set down. Staff walked outside and gave one on one. He told staff, "I wanted to go get a soda so I did. Staff continued to monitor him. 8:27 P.M. R1 went out the side entrance and walked towards the dumpster. When staff asked him what was going on he became upset and began yelling and cursing at staff. Staff gave one on one. He was upset yelling and screaming at staff. He went inside facility screaming and yelling at staff. He shoved staff before he came inside. Staff followed R1 inside the facility. He walked into the living room and walk to the door of the living room and walked outside and yelled, "F*c* you B*t*h" and walked down the road. Staff told him to come back. R1 keep walking down the street. Staff called QMRP (Qualified Mental Retardation Professional) (E1) and told her what had happened. QMRP came to facility and went to look for R1. When she was at facility she received a phone call the police had picked R1 up. QMRP went and picked R1 up and brought R1 back to facility and gave one on one. He went to sleep at 11:50 P.M."</p> <p>**The Police Department Detail Call Sheet dated 09/04/13 at 20:38:43 (8:38 P.M.) states,</p> <p>"Call No (number): 13 0000010284 Type Suspicious Person... East 5th Street...</p> <p>Caller adv that a man just walked into her house and is still inside..." This report then identifies that the police department responded and was on</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 46</p> <p>the scene within two minutes of the phone call. Seven minutes later this report identifies that the officers were enroute to the police department with R1. It then states that the facility was notified at 8:49 P.M. that R1 was at the police station and that someone needed to come to the station and pick him up. At 9:02 P.M. this report states that E1 (RSD) came to the station and picked up R1.</p> <p>The Verizon Map phone application indicates that if leaving the facility, R1 walked 0.3 miles to arrive on East 5th street. This application states that if would have taken him approximately six minutes walking from the facility.</p> <p>Z1 (Police Officer) was interviewed on 09/27/13 at 2:25 P.M. and stated, "I talked with E1 (RSD) when she picked R1 up at the station on 09/04/13. I told her that he (R1) runs the risk of being shot and killed when he is entering people's houses that don't know him. I tried to stress how serious this is and that the facility needed to keep an eye on him and monitor him more closely. If he enters the wrong persons house, it could turn really bad..."</p> <p>After 09/04/13, there is no documentation in R1's record identifying that a behavior program was developed to address his elopement behaviors.</p> <p>In continued review of R1's Universal Notes, the following entries were noted:</p> <p>09/05/13 (no time specified) "... R1 began walking staff followed. R1 began cursing at staff House manager was call she met up and R1 to come back to the house."</p> <p>09/06/13 "R1 walked outside he told staff that he</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 47</p> <p>could leave when he wanted he also told staff that he did not want to live here anymore. He walk(ed) down the street staff went with him. He was given several prompts to come back. He refused to listen to staff he walked and cursed and yelled at staff, at one point he came at staff raising his arms and hit staff x 3. Staff redirected him. He did stop hitting staff but he still yelling and cursed at staff. Other staff (unidentified) drove up to where R1 and staff standing. R1 went with other staff (unidentified) back to the facility..."</p> <p>09/07/13 5:30 P.M. "R1 was setting on deck when he got up and walked down to the yard then off of the property... He went to a resident (unknown) home and talked the man who was outside with his dogs... Staff finally got R1 to come out of the mans yard and walk with staff... While we were walking he began yelling and cursing louder. Walked by some people who were having a BBQ (barbecue) with family. R1 walked up in there yard and began talking then asking about his grandpa. The ladies that he talked to told R1 that they would walk him if he wanted. He said, "No I don't. Want to go back." QMRP (Qualified Mental Retardation Professional) (E1) was called. R1 got in her car with staff and returned back to the facility." 9:20 P.M. R1 got up from chair in quiet room and walked outside and walked off from facility. Staff went with him. He..." No further entry is noted for this date.</p> <p>09/09/13 9:20 P.M. R1 was laying on couch and decided to get up and go to his room. Staff went down to his room with him. He was packing his ball caps in a travel bag... Staff walked with R1 into living room and ask him to set down he refused and started heading out front room door.</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 48</p> <p>Staff blocked the door. R1 began upset Still yelling and cursing staff... 10:20 P.M... Staff ask R1 to sit down on the couch and relax. He looked at staff and said, "I hate you are a F*c*t*g B*t*h! I don't want to be here any more!" He shoved staff and started towards the door. Staff blocked the door. He shoved staff hit her in the nose then laid down..."</p> <p>09/10/13 "... (R1) started walking away stating, "I don't want to live here anymore. I'm walking away and continued to walk down the street being followed by another staff."</p> <p>"2-10 PM R1 was in his room staff stepped out to help another client. R1 took off walking. Staff followed in the van. R1 got in the van then became agitated jumping out of the van at a stop sign. Staff parked van and followed. R1 would not listen to staff and while rambling R1 walked into the street almost getting hit by a car. Staff got R1 out of the street. House manager got R1 into her car bringing R1 back to the facility where he again tried to leave he was restrained by staff and given his meds and brought into the house where he has had 1 on 1 staff sitting with him. He only tried to leave once more but has calmed down and watched TV with staff..."</p> <p>09/11/13 "5:30 P.M. R1 walked out to set on deck with other staff. R1 walked off from deck and started walking out of the yard. Staff gave one on one. He did come back on the deck and staff assisted him in coming back into the house. HS (Hours of Sleep) meds (medications) were given. R1 went to sleep at 9:30 P.M."</p> <p>No further entries are made in R1's Universal Notes until 09/19/13 even though R1 eloped from the facility on 09/14/13.</p> | W9999   |   |                      |   |

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| W9999  | Continued From page 49<br><br>The facility's policy and procedures for, "Response to Abuse and Neglect" with a review date of 06/16/08 defines neglect as, "The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition". This policy also states that the RSD (Residential Services Director) shall, "Remove the accused employee pending the outcome of the investigation".<br><br>The Investigative Report dated 09/16/13 states, "At approximately 6:30 A.M. (on 09/14/13), E2 (Direct Support Staff - DSP) contacted E7 (DSP) via cell phone and stated, "R1's left and there is nothing I can do. She (E7) asked her (E2) what? E7 asked her if she (E2) had not attempted to redirect him. E2 told her that she had another resident following him... I (E1/RSD) then contacted E2 at the facility and had questioned her as to what had happened. She stated, "She had been visually monitoring R1 when she turned away and he was at the door". I (E1) asked her (E2) if she had tried to redirect him away from the door and she said that she had done nothing, but visually watched him walk away and that she had told another resident (unidentified) to follow him. I (E1) informed E2 that it was neglectful on her part for allowing him (R1) to walk away and then sending another resident after him... I (E1) told her (E2) to stay there until R1 was found..."<br><br>The Police Department Detail Call Sheet dated and timed 09/14/13 06:40:00 (6:40 A.M.) states that R1 was located at 4:38 P.M. sitting in a locked truck. An ambulance was requested due | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 50</p> <p>to the hot weather and since it was unknown as to how long R1 had been sitting in the truck.</p> <p>The website, www.wunderground.com states that the high temperature for 09/14/13 was 75 degrees with 100% humidity.</p> <p>The Transporter Report dated 09/14/13 states that upon their arrival, R1 was found to be, "... cac (cachectic - bad condition, fatigue, weakness) hot dia (diaphoretic - sweating excessively, commonly associated with possible shock), pale. PD (police department) found the pt sitting in a closed truck by the PD. Unknown time that the pt has been sitting in the truck. Pt hx (history of) autism. Pt walked away from a group home this morning and has not been seen since. Pt verbal and worried about being in trouble... Cardiac mont (monitor) placed and vitals taken see report..."</p> <p>The Vitals Information of this report states:</p> <p>17:05 Cardiac Rhythm Sinus Tachycardia BP (blood pressure) 107/70 Pulse Rate 160<br/>17:15 Cardiac Rhythm Sinus Tachycardia BP 93/44 Pulse 141<br/>17:22 Cardiac Rhythm Sinus Tachycardia BP 99/63 Pulse 130<br/>17:28 Cardiac Rhythm Sinus Tachycardia BP 110/70 Pulse 125</p> <p>The Transporter Report goes on to state that after R1 required cold packs under his arm pits and an IV (intravenous) line for hydration. E1 (RSD) was interviewed on 10/02/13 at 9:15 A.M. and confirmed that R1 was taken to the hospital by ambulance and released to his mother (Z3) later in the evening.</p> | W9999   |   |                      |   |



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| W9999  | <p>Continued From page 51</p> <p>No Incident/Accident Report was provided to the surveyor during this investigation survey regarding R1's elopement incident for 08/28/13 as per the facility's policy. Further record review does not reflect documentation showing that the facility's Administrator (E12) was notified of R1's elopement from the facility on 08/28/13 as per the facility's policy.</p> <p>In review of R1's facility records, there is no documentation that he eloped from the facility on 09/14/13, nor is there an Incident/Accident report for 09/14/13 as per the facility's policy.</p> <p>Review of E2's Time Care for the time period of 09/08 - 09/14/13 identifies that E2 continued to work until 17:42 (5:42 P.M.). The facility's policy states that the RSD (E1) is to remove the employee pending outcome of the investigation.</p> <p>E1 (RSD) was interviewed on 10/02/13 at 9:15 A.M. and stated, "I don't know why I didn't remove E2 when I talked to her on the phone on 09/14/13. I wasn't thinking". When E1 was asked the facility's policy is in regards to neglect, she stated, "E2 was negligent, I know that. I said it in my report. The policy states that she should have been removed and I didn't do that until 5:42 P.M." During this interview, E1 confirmed that the facility failed to implement their own policy and procedures for neglect in regards to R1's elopement from the facility on 09/14/13.</p> <p>Z3 (R1's mother) was interviewed by phone on 09/27/13 at 6:00 P.M. and stated, "I didn't know anything about him leaving from the facility until I talked with the police on 09/14/13. The facility did not call me and let me know."</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 52</p> <p>E1 (RSD) was interviewed on 10/02/13 at 9:15 A.M. and stated, "No" when asked if the facility had reproducible evidence showing that R1's guardian had been notified that R1 was missing from the facility and had required police involvement on 08/28 and 09/04/13. During this interview E1 stated that she continually texts Z3 and informs her of what's going on with R1. E1 was asked then informed by the surveyor that text notification to the guardian (Z3) were acceptable if the facility could provide evidence that the guardian received the texts. After E1 scrolled through her phone text messages, she stated, "I must have deleted those text to her (Z3)".</p> <p>As based on review, the facility failed to have reproducible evidence showing that the facility contacted Z3 of R1's elopement incidents of 08/28 and/or 09/04/13 as per the facility's policy.</p> <p>A Police Department Detail Call Sheet with Call No. 13 0000010670 states:</p> <p>"Type: Missing Adult Date/Time 09/14/13 06:40:00 (6:40 A.M.)</p> <p>Comments: 1044 Missing Person R4 a pt (patient) at "*o*s*a* H*u*e" - (name of the facility) came running in the foor (door) advising she has been running after R1 who ran off from the "*o*s*a* H*u*e" and they sent her to chase him down. She advised he is over on the south side of the midway and has on a brown shirt and jeans and cowboy boots. She did not know what had went on that he ran off..."</p> <p>This report goes on to state that police units 49</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 53 and 53 were advised that R1 was missing.</p> <p>"0650 I called "o*s*a* H*u*e" and asked what his last name is and she advised... R1. She (unidentified)had no further info at that time.</p> <p>1001 E1, Service Director from "o*s*a* H*u*e" came in and asked if we have seen R1 anywhere yet. She advised they have not located him yet either. She advised he has on a black t-shirt, blue jeans and a ball cap she thinks. He is thin, about 5'9" or 5'10" tall and dark blond hair. He also has on his cowboy boots and when you talk to him he mainly mumbles or rambles. She said you can make out some words. He should also have a Mardi-Gras Necklace on.</p> <p>Units advised</p> <p>1052: Z3 (R1's mother) in to enter her son as missing.</p> <p>10:54 ISP (Illinois State Police) calling in reference to Z3... Advised that she (Z3) was told to come here and get him (R1) entered as missing.</p> <p>1119 Entry made into LEADS (Illinois Law Enforcement Agencies Data System).</p> <p>Incident/Offense Report Supplemental</p> <p>At apprx. 16:38 hours (4:38 P.M.) caller advised they saw the missing person (R1) on Facebook and believe he is at "i*g*n*" Auto Sales sitting a black Chevrolet dually truck on the south side of the south lot. Upon officer arrival, R1 was found to be sitting in the vehicle. Officer requested an</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 54</p> <p>ambulance due to the hot weather and R1 had been sitting in the vehicle--doors to truck were locked. Ambulance personal arrived and transported R1 to "r*n* *n Hospital" (name of hospital) code Advance Life Support (ALS) emergent, due to possible dehydration. It is unknown how long R1 has been in the vehicle."</p> <p>The Narrative/Protocols Used section of the Transporter Report dated 09/14/13 states that R1 was found laying down in the back seat of the patrol car at the time of their arrival. This form states, "PT (patient) cac (cachectic - bad condition, fatigue, weakness) hot dia (diaphoretic - sweating excessively, commonly associated with possible shock), pale. PD (police department) found the pt sitting in a closed truck by the PD. Unknown time that the pt has been sitting in the truck. Pt hx (history of) autism. Pt walked away from a group home this morning and has not been seen since. Pt verbal and worried about being in trouble... Cardiac mont (monitor) placed and vitals taken see report..." This report goes on to state that after R1 was loaded onto the cot and into the ambulance, cold packs were placed under his arm pits and a that an IV (intravenous) was started.</p> <p>The Vitals Information of this report states:</p> <p>"17:05 Cardiac Rhythm Sinus Tachycardia BP (blood pressure) 107/70 Pulse Rate 160;<br/>17:15 Cardiac Rhythm Sinus Tachycardia BP 93/44 Pulse 141;<br/>17:22 Cardiac Rhythm Sinus Tachycardia BP 99/63 Pulse 130; and<br/>17:28 Cardiac Rhythm Sinus Tachycardia BP 110/70 Pulse 125"</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 55</p> <p>The Verizon Map phone application indicates that the auto sales dealership where R1 was found is located in the 1600 block of East Main street and is 1.5 miles from the facility. This application states that it would have taken R1 approximately twenty nine minutes to arrive at this location if walking directly from the facility.</p> <p>There is no record of R1's elopement incident in his Universal Notes for 09/14/13.</p> <p>E1(RSD) was interviewed on 10/02/13 at 9:15 A.M. and stated, "No" when asked if the facility had documentation or Incident Reports for R1's elopement incidents for 08/28/13, 09/04/13 and/or for 09/14/13 as per the facility's "Missing Persons" policy.</p> <p>In continued interview with E1 on 10/02/13, she stated, "No" when asked if staff of the facility are completing Incident/Accident Reports when R1 is missing from the facility as per the facility's policy for "Missing Persons". E1 also stated, "No" when asked if the facility had reproducible evidence showing that the Administrator (E12) has been notified that R1 was missing from the facility on the dates of 08/28, 09/04 and 09/14/13 as per the facility's policy for "Missing Persons".</p> <p>The facility "Missing Persons Search Procedure" with a review date of 06/14/11 states,</p> <p>"1. If the whereabouts of an individual, known to be present that day, becomes unknown, the staff should make a search of the building and grounds.</p> <p>2. If the person is not found, the RSD (Residential</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 56</p> <p>Services Director) should check with individuals in the surrounding area/grounds.</p> <p>3. If, after thorough search of Steps 1 and 2 the person is still missing, the Administrator should be notified...</p> <p>6. If is determined by the RSD or designee that assistance from an outside agency is needed, the staff shall notify: Police 911 Parent/Guardian...</p> <p>8. Any incidents of missing persons should be noted in the individual file and an Incident/Accident report completed."</p> <p>Record review identifies that R1 was seen by the Mental Health Nurse Practitioner on 09/19/13 for complaints of insomnia, wandering off and aggressive behaviors. R1 was diagnosed with Depression Disorder, Recurrent Episode Severe w/o (without) Mention of Psychotic Behavior, Autism Current or Active State and Anxiety Disorder. Medication orders were received for:</p> <p>"Abilify 5 mg (milligram) tablet with one half being taken daily by mouth for seven days - Then increase to 1 mg daily; Lorazapem 0.5 mg tablet twice daily and two tablets at bedtime; and Hydroxyzine two 10 mg tablets at bedtime for insomnia".</p> <p>Further record review for R1 does not identify that the facility developed a behavior plan to address his elopement behaviors and/or to address the medications ordered on 09/19/13.</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 57</p> <p>In continuing review of R1's Universal Notes for the month of September 2013, the following entries are noted:</p> <p>09/19/13 "3/11 Evening Shift = During this shift, R1 has been anxious irritated and aggressive towards staff. R1 refused to eat his supper. He has been talking non stop this shift... he also ripped the screen out of his window and tried to climb out to get outside. Staff 1:1 at all times this shift. R1 continually pacing this shift. Several interventions tried none successful. Continues with behaviors at this time. 9:38 P.M. "</p> <p>09/21/13 "Evening Shift 3-11 ... At times client was opening his window attempting to climb out to elope cursing staff and saying that he was leaving. Client was not easily redirected by staff numerous times." Further documentation identifies that R1 was taken to the Emergency Room for psychiatric evaluation.</p> <p>In review of the Physician's Orders dated 09/22/13, orders were received for R1 to be placed on 1:1 staff supervision.</p> <p>After R1 was to be placed on 1:1 staff supervision, R1 attempted to elope from the facility's off site day training program on 09/24/13.</p> <p>R1's Observation Notes dated 09/24/13 states, "Staff was alone and unable to leave other individuals. I hollered down hall no one heard me nor responded. I headed towards phone to call another room and have them get R1 but another staff had got him he went outside staff said and was running to highway. This staff talked with R1 about the dangers of the highway no further incidents."</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 58</p> <p>On 09/27/13, the surveyor visited the facility's off site day training program. The driveway of the day program runs directly to highway 10. The speed limit in front of the driveway is posted for 55 miles per hour.</p> <p>R1 was observed at the facility's off site day training program at 11:20 A.M. R1 walked back and forth between two classrooms, mumbling to himself. without intervention. No one to one staff supervision was noted to be in placed at this time.</p> <p>At 11:45 A.M., E11 (Facility's Day Training Qualified Intellectual Disabilities Professional) was interviewed regarding R1 and stated, "We really don't have too many problems with R1. He had an incident of attempting to run away on 09/24/13." When E11 was asked if R1 received 1:1 staff supervision and/or close monitoring, she stated, "No. We generally just keep an eye on him and he generally just goes between the two classrooms". When E11 was asked if the day training program had a behavior program to address R1's elopement behaviors, she stated, "No".</p> <p>During review of the facility's off site day training program notes, it was also noted that R1 has had multiple incidents of physical aggressive incidents towards his peers and/or staff which includes:</p> <p>09/03 - 09/04/13 "R1 is absent today due behaviors at home."<br/>09/05/13 "R1 is absent today."<br/>09/10/13 "R1 had some behavior issues today... became physically aggressive kicking this staff X 3. This staff (unidentified day training staff)</p> | W9999   |   |                      |   |



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| W9999  | <p>Continued From page 59</p> <p>helped guide R1 to the floor. R1 layed on floor yelling... He (R1) then got up ran out of the room. Staff followed him into hall and staff again helped guide R1 onto the floor. After several min (minutes) R1 calmed down and returned to the room..."</p> <p>09/12/13 "R1 had some issues today... he began to yell and cry. He then ran over and slapped staff (unidentified day training staff) in the back. Staff asked R1 to please sit down... asked R1 again to be seated and calm down... Staff to R1 if you don't sit in seat in Quiet area that he would escort him to seat... R1 walked up to peer (R5) told him to stop and then smacked peer in back of head..."</p> <p>09/13/13 "R1 had some issues today. While this staff (unidentified day training staff) was preparing lunch for a peer (unidentified), R1 walked by staff and smacked him in the back..."</p> <p>09/16 - 09/20/13 "R1 is absent today."</p> <p>09/24/13 "... R1 hit staff (unidentified day training staff) twice in face. That staff took R1 down held him for about 30 sec. (seconds)... This staff (unidentified day training staff) that was holding his hands was trying to calm R1 down. Staff (unidentified) let him go and R1 smacked the staff (unidentified) again on the arm. Staff (unidentified) held him again for around 10 sec. R1 stayed on floor and was crying and cussing..."</p> <p>09/24/13 "R1 kicked a peer (unidentified) in the ribs on the bus..."</p> <p>09/27/13 "... R1 pushed staff (unidentified day training staff). He then kicked staff (unidentified) several times in the back of staff's right leg..."</p> <p>R1's Individual Program Plan (IPP) dated 08/15/13 identifies that R1 functions at a severe level of intellectual functioning due to his diagnosis of Autism.</p> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 60</p> <p>In reviewing R1's ICAP (Inventory for Client and Agency Planning) assessment for his community access skills, this assessment states:</p> <ul style="list-style-type: none"> <li>- Acts appropriately without drawing negative attention while in public places with friends... Does very well - always or almost always - without being asked</li> <li>- Responds appropriately to most common signs, printed words or symbols... Does, but not well - or 1/4 of the time - may need to be asked</li> <li>- Locates or remembers telephone numbers and calls friends on the telephone... Never or rarely - even if asked</li> <li>- Crosses nearby residential streets, roads, and unmarked intersections alone. Does very well - always or almost always - without being asked</li> </ul> <p>Under the section of the ICAP marked Problem Behavior, this assessment identifies that R1 NEVER is and/or has</p> <ul style="list-style-type: none"> <li>- Hurtful to himself or others;</li> <li>- Unusual or repetitive behaviors;</li> <li>- Socially offensive behavior; and/or</li> <li>- Uncooperative behavior(s).</li> </ul> <p>This assessment also states that R1 is and/or demonstrates:</p> <ul style="list-style-type: none"> <li>- Destructive to property by throwing things away at least one to 3 times a month and that it is slightly serious; a mild problem;</li> <li>- Disruptive by interrupting, clinging, pestering at least one to 10 times a day and that it is considered a slightly serious; a mild problem; and</li> </ul> | W9999   |   |                      |   |

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| W9999  | <p>Continued From page 61</p> <p>- Withdrawal or Inattentive behavior by showing little concentration at least one to 10 times a day and that this is considered a slightly serious; a mild problem.</p> <p>In the section of the IPP entitled Protection and Promotion of Resident's Rights it states, "Resident has access and use of community resources. Leaves the facility without supervision to utilize these.</p> <p><input checked="" type="checkbox"/> yes<br/><input type="checkbox"/> no</p> <p>R1 is not familiar with the community nor its resources...</p> <p>Programming designed to assist the resident in alleviating the restrictions...</p> <p>R1 will participate in a goal for community for accessing the community and its resources. However R1 is capable of going for a walk within a two block radius..."</p> <p>In review of R1's assessments included within his IPP, there is nothing noted which identifies that his elopement behaviors were a problem at the time of his 08/15/13 meeting. No modifications have been made to R1's IPP even though R1 has had elopement attempts and documented incidents of elopement from the facility on 08/28, 09/04 and 09/14/13.</p> <p>E1 (RSD) was interviewed on 10/02/13 at 9:15 A.M. and stated, "R1 is on a community access program to identify pedestrian sign which was developed at the time of his IPP". When E1 was asked if R1 was safe to go out walking within a</p> | W9999   |   |                      |   |

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| W9999  | Continued From page 62<br>two block radius of the facility without supervision, she stated, "No." E1 was then asked if comprehensive community safety assessment has been completed by the facility and updated to reflect R1's current incidents of elopement behaviors, she stated, "No." When E1 was asked if the facility had developed a behavior program to address R1's elopement and/or physical aggressive behaviors, she stated, "No". E1 was then asked if staff of the facility are trained in crisis intervention techniques to address R1's aggressive behaviors and she stated, "No".<br><br>(A) | W9999   |   |                      |   |