STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G045	A. BUILDING _____ B. WING _____	C 09/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLYDE L. CHOATE MH & DEV CTR	**1000 NORTH MAIN STREET ANNA, IL 62906**

(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 INCIDENT REPORT INVESTIGATION INCIDENT OF 09/08/16 ==>> IL 88539 W104 and W154 INCIDENT REPORT INVESTIGATION INCIDENT OF 08/22/16 ==>> IL 88369 W104, W120 and W154	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's governing body has failed to ensure that policy and procedures are developed and implemented to assure that outside community workshops are provided with necessary information and training to meet the needs of the individuals served for 1 of 1 individual in the sample (R1) who eloped from his workshop site on 08/22/16; and Based on interview and record review, the facility's governing body has failed to ensure the rights of the individuals on the non certified units when they restricted the rights of 1 of 1 individual in the sample (R3) who allegedly touched another individual (R2) inappropriately on 09/08/16 while at the facility's onsite day program. Findings include:	W 104		

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

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A) The Behavior Intervention Plan dated 12/10/15 states that R1 is a 43 year old male with targeted behaviors of Noncompliance, Suicidal Behavior/Threats/Ideation, Self Injurious Behavior, Verbal and Physical Aggression, Property Destruction and history of Elopement.

Review of the facility's Investigative Report dated 08/31/16 states that on 08/22/16 the facility was notified by phone that at about 1:42 P.M., R1 had walked away from the workshop and was presently at the Emergency Room of a local hospital. This report states that after R1 eloped from the workshop, R1 damaged a hutch and a china cabinet at a downtown merchant's store with an estimated damage of $1,170. R1 then began walking in the street into oncoming traffic. R1 was apprehended and arrested by the local Police Department who took him to a local Emergency Room. While in the Emergency Room, R1 was placed in restraints after he damaged their computers and medical equipment. R1 was returned to the facility at 4:25 P.M. and was placed on 1:1 Special Observation.

Z1 (Workshop Coordinator) was interviewed on 09/08/16 at 3:11 P.M.. via telephone and stated, "R1 is new to the workshop and had not been here more than two weeks. To my knowledge there was no behavior program for him at workshop". Z1 stated, "No" when asked if workshop had been informed by the facility that R1 had history of elopement.

Z2 (QIDP-Qualified Intellectual Disabilities Professional of workshop) and Z3 (Coordinator of Rehabilitation Services) were interviewed on 09/09/16 at 12:00 P.M. and stated, "No" when asked if workshop had been informed that R1

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W 104	Continued From page 2	W 104		

had history of elopement and required constant supervision while at workshop. When Z2 and Z3 were asked if the facility had provided them with a behavior program for R1 to address his targeted behaviors, they stated, "No". Z2 stated that she and Z3 had met with E5 (Vocational Coordinator) prior to R1 starting workshop. Z3 stated that they were to talk with R1's QIDP, however when they had visited the facility, no one was available to meet with them. Z3 then provided the surveyor with the information that had been provided to them by the facility for R1.

Review of this information identified a DRAFT Individual Support Plan dated 11/02/15 identifying that a behavior plan was to be developed. No behavior intervention plan was contained within the packet.

E5 (Vocational Coordinator) was interviewed on 09/09/16 at 3:00 P.M. and stated that she had gathered information for the workshop for R1. E5 stated that she she was sure that a behavior program had been included within the information that she had given to workshop staff. When E5 was asked if the facility had a reproducible system which would identify what information had been given to workshop for R1, she stated, "No".

E4 (R1's QIDP) was interviewed on 09/09/16 at 3:30 P.M. and stated, "Usually the secretary sends workshop the information" when asked who at the facility was responsible to send out referral information as well as the individual plan and the behavior plan if applicable. E4 went on to say the Rehabilitation department would be responsible for sending the vocational information to the workshop. When E4 was asked who had provided the workshop with R1's information he

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stated, "I think E5 - Vocational Coordinator). When E4 was asked what level of supervision R1 was supposed to be on while he was at workshop he stated, "He should have been on same room supervision like he is here". When E4 was asked who communicated R1's level of supervision information to workshop staff, E4 stated that he didn't know and then stated, " We probably needed better communication". When asked if he was aware if workshop staff had been trained on R1's behavior intervention plan, E4 stated, "No".

During the Daily Status Meeting with E2 (Interim Assistant Center Director) on 09/14/16 at 4:30 P.M., E2 confirmed that the facility has just developed a draft checklist that will be used prior to the individual attending a community workshop. During this meeting, E2 confirmed that this checklist remains in the draft phase and had not been implemented prior to the surveyor's entrance into the facility.

B) R3's Individual Support Plan (ISP) dated 10/27/15 identifies that he is a 28 year old male function at a mild level of intellectual disability. R3 was admitted to the facility by Court Order on 12/08/09 to the facility's Forensic Unit and then transferred to a non-certified unit on 02/15/11.

Review of the Facility's Investigate Report dated 09/16/16, on 09/09/16 R2 alleged that R3 had touched her inappropriately. The facility concluded that there was no evidence to suggest abuse or neglect. E7 (Technician) was present at the time of the allegation and stated that no incidents had occurred. Recommendations were

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made within this report to retrain E6 (Residential Services Supervisor) because she was unsure of what to do regarding the allegation. This report also states that R3's rights were restored during the case, however there are no specifics as to why his rights were restricted since staff was present at the time of the allegation.

R3 was interviewed on 09/08/16 at 10:30 P.M. R3 denied any type of contact with R2 on 09/08/16 or any other date. R3 stated that he was placed on same room supervision with staff and that he was not allowed to even go outside to smoke. R3 stated that he would get his rights back on Friday (09/09/16).

R3's Behavior Intervention Plan dated 02/25/16 states that he has history of inappropriate sexual behavior and that, "After an incident of Inappropriate Sexual Behavior, R3 is to be placed on Same Room Supervision with no off unit mobility for 7 days (with the exception of attending work and consults)". Further review of this plan does not identify what staff are to do if there is an allegation of sexual inappropriate behavior without validity (staff present at the time the alleged incident occurred) and/or that his right to smoke will be restricted.

Per Telephone interview with E2 (Assistant Center Director who signed as completing the facility's Investigative Report) on 09/20/16 at 9:15 A.M., E2 stated that the facility report did note that R3's rights were restored during the course of the investigation. When asked what actions the facility had taken to retrain the staff who had restricted his rights, E2 stated that she wasn't sure yet as to if the facility will take action and

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W 104	Continued From page 5 what action the facility will take.	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to assure that outside community workshops are provided with necessary information and training to meet the needs of the individuals served for 1 of 1 individual in the sample (R1) who eloped from his workshop site on 08/22/16. Findings include: The Behavior Intervention Plan dated 12/10/15 states that R1 is a 43 year old male with targeted behaviors of Noncompliance, Suicidal Behavior/Threats/Ideation, Self Injurious Behavior, Verbal and Physical Aggression, Property Destruction and history of Elopement. Review of the facility's Investigative Report dated 08/31/16 states that on 08/22/16 the facility was notified by phone that at about 1:42 P.M., R1 had walked away from the workshop and was presently at the Emergency Room of a local hospital. This report states that after R1 eloped from the workshop, R1 damaged a hutch and a china cabinet at a downtown merchant's store with an estimated damage of $1,170. R1 then began walking in the street into oncoming traffic. R1 was apprehended and arrested by the local Police Department who took him to a local	W 120		

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Emergency Room. While in the Emergency Room, R1 was placed in restraints after he damaged their computers and medical equipment. R1 was returned to the facility at 4:25 P.M. and was placed on 1:1 Special Observation.

Z1 (Workshop Coordinator) was interviewed on 09/08/16 at 3:11 P.M. via telephone and stated, "R1 is new to the workshop and had not been here more than two weeks. To my knowledge there was no behavior program for him at workshop". Z1 stated, "No" when asked if workshop had been informed by the facility that R1 had history of elopement.

Z2 (QIDP-Qualified Intellectual Disabilities Professional of workshop) and Z3 (Coordinator of Rehabilitation Services) were interviewed on 09/09/16 at 12:00 P.M. and stated, "No" when asked if workshop had been informed that R1 had history of elopement and required constant supervision while at workshop. When Z2 and Z3 were asked if the facility had provided them with a behavior program for R1 to address his targeted behaviors, they stated, "No". Z2 stated that she and Z3 had met with E5 (Vocational Coordinator) prior to R1 starting workshop. Z3 stated that they were to talk with R1's QIDP, however when they had visited the facility, no one was available to meet with them. Z3 then provided the surveyor with the information that had been provided to them by the facility for R1.

Review of this information identified a DRAFT Individual Support Plan dated 11/02/15 identifying that a behavior plan was to be developed. No behavior intervention plan was contained within the packet.

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W 120	Continued From page 7 E5 (Vocational Coordinator) was interviewed on 09/09/16 at 3:00 P.M. and stated that she had gathered information for the workshop for R1. E5 stated that she she was sure that a behavior program had been included within the information that she had given to workshop staff. When E5 was asked if the facility had a reproducible system which would identify what information had been given to workshop for R1, she stated, "No".	W 120		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to ensure that all allegations are thoroughly investigated as evidenced for: 1 of 1 individual in the sample (R1) who eloped from his workshop site on 08/22/16 and for 1 of 1 individual in the sample (R3) who allegedly engaged in inappropriate sexual behaviors on 09/08/16. Findings include: A) The Behavior Intervention Plan dated 12/10/15 states that R1 is a 43 year old male with targeted behaviors of Noncompliance, Suicidal Behavior/Threats/Ideation, Self Injurious Behavior, Verbal and Physical Aggression, Property Destruction and history of Elopement. On 09/08/16 the facility's Investigative Report (dated 08/31/16) for the 08/22/16 incident was reviewed by the surveyor. This report states that the facility was notified by phone on 08/22/16 that	W 154		

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R1 had walked away from the workshop and was at the Emergency Room of a local hospital. This report states that after R1 eloped from the workshop, R1 damaged a hutch and a china cabinet at a downtown merchant's store with an estimated damage of $1,170. R1 then began walking in the street into oncoming traffic. R1 was apprehended and arrested by the local Police Department who took him to a local Emergency Room. While in the Emergency Room, R1 was placed in restraints after he damaged their computers and medical equipment. R1 was returned to the facility at 4:25 P.M. and was placed on 1:1 Special Observation.

Further review of the report states that R1 will not be allowed to return to the workshop until a special meeting can be held to discuss his behaviors. This report states that the investigation was considered closed, pending further information. In review of the facility's investigation, there is no documentation contained within this report identifying that:

* Workshop staff were interviewed during this investigation;
* Workshop staff alleged that they were not provided with R1's behavior intervention plan and that they were not informed that R1 was to be constantly supervised due to his risk of elopement;
* The facility does not have a reproducible system for accountability to determine what information had been shared between the facility and the workshop for R1;
* The facility had obtained the Police Report of the 08/22/16 incident;
* The facility had obtained the hospital Emergency Room Report; and that

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W 154	Continued From page 9 * The facility had contacted the Police Department and/or the county's State's Attorney's office for information regarding whether are not R1 will be charged with Criminal Damage to Property. E3 (Internal Security Investigator (ISI) - Temporarily Assigned) was interviewed on 09/14/16 at 1:45 P.M. in regards to the facility's investigation of the 08/22/16 incident involving R1. E3 stated that he still is a Security officer at the facility but has been filling in as the ISI since April of 2016. During this interview E3 stated, "No" when asked if he had interviewed workshop staff after this incident. E3 stated, "No" when asked if during his investigation of the 08/22/16 incident he had determined if R1's level of supervision was appropriate at the workshop and/or if workshop staff had been provided with R1's behavioral information to meet his needs while attending the workshop. E3 confirmed that no Police Report or Emergency Room Report had been included within his investigation. E3 also stated that he was not aware that R1's case had been turned over to the State's Attorney's Office for possible charges of Criminal Damage to Property. B) Review of the Facility's Investigate Report dated 09/16/16, on 09/09/16 R2 alleged that R3 had touched her inappropriately. The facility concluded that there was no evidence to suggest abuse or neglect. E7 (Technician) was present at the time of the allegation and stated that no incidents had occurred. Recommendations were made within this report to retrain E6 (Residential Services Supervisor) because she was unsure of what to do regarding the allegation. This report	W 154		

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also states that R3's rights were restored during the case, however there are no specifics as to what rights were restricted.

R3 was interviewed on 09/08/16 at 10:30 P.M. R3 denied any type of contact with R2 on 09/08/16 or any other date. R3 stated that he was placed on same room supervision with staff and that he was not allowed to even go outside to smoke. R3 stated that he would get his rights back on Friday (09/09/16).

R3's Behavior Intervention Plan dated 02/25/16 states that he has history of inappropriate sexual behavior and that, "After an incident of Inappropriate Sexual Behavior, R3 is to be placed on Same Room Supervision with no off unit mobility for 7 days (with the exception of attending work and consults)". Further review of this plan does not identify what staff are to do if there is an allegation of sexual inappropriate behavior without validity (staff present at the time the alleged incident occurred) and/or that his right to smoke will be restricted.

Per Telephone interview with E2 (Assistant Center Director who signed as completing the facility's Investigative Report) on 09/20/16 at 9:15 A.M. E2 stated that the facility report did note that R3's rights were restored during the course of the investigation. When asked what actions the facility had taken to retrain the staff who had restricted his rights, E2 stated that she wasn't sure yet as to if the facility will take action and what action the facility will take.

The facility's Investigative Report does not specifically address R3's rights violations, what actions the facility took to restore R3's rights,

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W 154	Continued From page 11 when these rights were restored and what actions the facility will take to prevent reoccurrence.	W 154		