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(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 #1521135/IL75411	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 interview and record review, the facility failed to implement their system to prevent neglect when the facility failed to: 1) provide appropriate supervision when an individual who was on a trial visit (R1) eloped from the facility and entered a neighbor's house 2) conduct a thorough investigation and provide a list of considerations relevant to prevention of further incidents for 1 of 1 individual who while on a trial visit at the facility, eloped from the facility and entered a neighbors house without staff being aware of it. (R1) Findings Include: Refer to deficiencies cited at: W149-Policies and Procedures that prohibit neglect W153-Report to authorities in accordance with state law	W 122		

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

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W 122	Continued From page 1 W154-Must have evidence all alleged violations are investigated W157-Must take corrective action.	W 122		
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: Based on interview and record review, the facility failed to implement their system to prevent neglect when the facility failed to: 1) provide appropriate supervision as specified in policy 5.39 Missing Individuals when an individual who was on a trial visit (R1) eloped from the facility and entered a neighbors house 2) conduct a thorough investigation and provide a list of considerations relevant to prevention of further incidents per policy 5.49 Safety Committee. for 1 of 1 individual who while on a trial visit at the facility, eloped from the facility and entered a neighbor's house without staff being aware of it. (R1) Findings Include: Facility Policy 5.24 "Investigative Committee" dated "Revised 11/08" defines Neglect as "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."	W 149		

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1) Facility policy 5.39 "Missing Individuals" states, "The facility shall provide appropriate supervision for all individuals served. Staff shall be aware of the location and activities of all individuals in their care, whether in direct visual contact or not. The proximity of the supervision shall provide reasonable safety and yet afford the individual sufficient independent activity and judgment to foster growth and independence by allowing him/her the dignity of some reasonable risk. Where risks of injury are high and likely benefits to the individual low, staff shall exercise greater supervision."

A facility "Safety Committee" report dated 2/8/15, under the section titled "Summary Of Incident" states, "Visiting individual [R1] had come for a visit on 2/6/15 to see if [the facility] would be an appropriate place for him to reside. On 2/7/15, [R1] left the building several times despite staff prompting. [R1] eloped to a neighbor's house at one point. Staff was immediately notified and immediately went to the neighbor's house with another resident's guardian and [R1] came back to [the facility]. The administrator, the QIDP [Qualified Intellectual Disabilities Professional] and the family were notified. The visit was terminated and the family picked [R1] up on 2/7/15."

The Safety Committee report lists "Staff Involved" as E3 and E4 [both direct care staff]. E3 was interviewed on 3/05/15 at 2:50pm. When asked approximately when this occurred, E3 stated between 11:00am and 11:30am.

A facility form titled "General Notes", dated 2/07/15 and written by E3 states that R1 "liked to

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go in and out of the home and walk up and down our sidewalks around the house and driveway. This happened several times throughout the morning. When asked to put on a coat and shoes [R1] refused." It also states that after going to the neighbor's home to get R1 to come back to the facility, staff "talked [R1] into coming back after several attempts, and apologized to the neighbor several times."

An adaptive behavior assessment dated 2/11/14, under the section titled "Community Living Skills" states, "Stays in an unfenced yard for ten minutes when expected without wandering away--Does Fairly Well--or 3/4 of the time may need to be asked." It also states, "Crosses nearby residential streets, roads and unmarked intersections alone--Never or Rarely--even if asked." The broad independence score is listed as 4 years 1 month.

Per observation of the neighborhood of the facility on 3/05/15 at 2:30pm, the neighbors home that he went to is directly across the street from the facility with the front door of the neighbors home facing a side street that runs perpendicular to the facility. R1 would have had to go across the street in front of the facility and across the neighbors yard to access the front door.

Per an undated ISP which was part of R1's referral packet, R1 had a cognitive assessment done 4/08/10 with an IQ score of 40, is 19 years old and has diagnoses of Pervasive Developmental Disorder, Attention Deficit Hyperactivity Disorder and Autism Spectrum. It also states that R1 "is never left alone at home or in the community. At school, [R1] has a one on one aid every day."

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A written statement provided to surveyor by E3 on 3/05/15 states that R1 kept "going outside and back inside. Staff asked him to put his coat and shoes on which he refused. Staff asked [R1] to come inside because it was cold. He would come in and go back out walking around the house up and down sidewalks and up and down driveway."

A written statement provided to surveyor by E4 on 3/05/15 states that "Staff was having trouble with [R1] staying in the home. He kept going in one door and out the other + back in another door."

E3's written statement of 3/05/15 states, "Another residents mother [R3's mother Z1] came to pick her up, as they were walking out the little boy across the street ran over and said 'my mom told me to come get you someone escaped from you house and is in our house'. Staff [E3] followed him back to his house and residents mother [Z1] followed. [R1] was standing in the kitchen refusing to leave asking for his grandma and brother. Staff and resident's mom [Z1] finally got him to come back home after asking several times."

E3 [Direct Care Staff] was interviewed on 3/05/15 at 2:50pm. When asked if R1 had his shoes on before he left, E3 stated, "No, he refused his shoes or coat." E4 was interviewed on 3/05/15 at 3:10pm. When asked if R1 had his shoes or coat on, E4 [Direct Care Staff] stated, "No, he refused to wear coat. He was told to put shoes and socks on."

Z1 [R3's mother/witness] was interviewed by phone on 3/06/15 at 10:03am. Z1 stated that R3 was not wearing a coat or shoes but was in his

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"sock feet." Z1 stated that she and E3 were in the small sitting area between the door to the dining room and the living room. Z1 stated that R1 said hi to her then went into the dining room area. Z1 stated that E3 was helping to get her daughters meds for a home visit and E4 was either in the dining room or kitchen area. When asked where R1 went after he said hi, Z1 stated he went into the dining room area. When asked if he came back throught into the living room area, Z1 stated, "No he didn't." Z1 stated that he "went out around the house." Z1 stated that she accompanied E3 over to the neighbors house to help bring R1 back.

Z2 [R1's mother] was interviewed on 3/06/15 at 9:31am by phone. When asked if R1 suffered any injuries from his elopement on 2/07/15, Z2 stated, "No, he just took off in his pajama shorts and a shirt." Z2 stated that his socks were wet. Z2 stated that it was cold and there was snow out. Z2 stated that he had taken off from them and "really just started doing that."

E3 was interviewed on 3/05/15 at 2:50pm. When asked when did you first meet R1, E3 stated that morning when she got to the facility around 7:30am. When asked what training she had received regarding his abilities or needs, E3 stated that he is hyper and gets in peoples face. E4 was interviewed on 3/05/15 at 3:10pm. When asked when she first met R1, E4 stated the night before. When asked what training she had received regarding his abilities or needs, E4 stated he was hyper gets in peoples face, try to keep him away from other individuals.

E2 [Facility Representative] was interviewed on 3/06/15 at 9:45am. E2 was asked, if there was a

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problem with him leaving the building several times despite prompting should you have been notified regarding increased supervision? E2 stated, "How soon were those incidents? I think [E1 QIDP] was notified." E1 [Qualified Intellectual Disabilities Professional, QIDP] was interviewed on 3/06/15 at 10:55am. When asked it she was notified by staff prior to R1's elopement, of problems with R1 going in and out, for the need to increase supervision for R1, E1 stated no.

Facility staff failed to provide adequate supervision for R1 after repeated incidents of R1, who was in the facility on a trial visit, leaving the building inappropriately dressed on a cold day resulting in him eloping from the facility grounds and getting into a neighbors home.

2) Facility policy 5.49 "Safety Committee" with a Revised date of 11/08, under the section titled "Purpose" states, "The Safety Committee assists Administration by ensuring practices and policies regarding individual's safety meet regulatory standards and quality outcomes." Under the section titled "Procedure" it states, "3. The committee will review all documentation associated with the incident/accident. Any pertinent information will be transferred onto the Safety Committee Report."

It also states, "4. The committee shall conduct any necessary interviews or inquiries to identify if patterns or trends exist" "7. The committee will attempt to determine the cause of the injury and provide a list of considerations relevant to prevention of further incidents/accidents."

A facility "Safety Committee" report dated 2/8/15,

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under the section titled "Summary Of Incident" it states, "Visiting individual [R1] had come for a visit on 2/6/15 to see if [the facility] would be an appropriate place for him to reside. On 2/7/15, [R1] left the building several times despite staff prompting. [R1] eloped to a neighbor's house at one point. Staff was immediately notified and immediately went to the neighbor's house with another resident's guardian and [R1] came back to [the facility]. The administrator, the QIDP [Qualified Intellectual Disabilities Professional] and the family were notified. The visit was terminated and the family picked [R1] up on 2/7/15."

Under the section titled "Committee Findings" it states, "Staff notified administrator as per protocol as well as family. The visit was terminated immediately following an incident of [R1] leaving the grounds unauthorized."

Under the section titled "Committee Considerations" it states, "Resident was determined not to be a good fit for [the facility]. Resident poses safety issues as he does not want to stay in the facility or on facility grounds. Visit was terminated 2/7/15 following incident. Administrator was notified immediately as was family. The family came and picked up [R1]."

2a) E2 [Facility Representative] was interviewed on 3/06/15 at 9:45am. When asked if the safety committee investigation was the only investigation into this incident, E2 stated yes that she did not do a formal investigative committee investigation. When asked if she had interviewed all witnesses, E2 stated that she did not interview the family member that was here [Z1]. E2 verified that Z1 did go across the street with the staff member

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[E3]. E1 was interviewed on 3/06/15 at 9:00am. When asked if she was a part of the safety committee review, E1 stated yes. When asked if the safety committee interviewed Z1, E1 stated, "No we did not."

E2 was asked if the investigation determined approximately what the temperature was outside on that day. E2 stated, "No, but is was cold." When asked if the investigation determined where the two staff were when R1 left the house, E2 stated, "They were here in the building with a resident getting ready to leave." When asked if both of the staff were with the resident, E2 stated, "Yes, both were in the building. I'm not sure exactly where both were. [E3] was with [R3's] mom [Z1]."

E2 was asked if both staff being in the building was a problem with R1 outside, E2 stated, "I don't think it was something specific I put in there."

2b) E2 [Facility Representative] was interviewed on 3/06/15 at 9:45am. When asked if, as a result of the investigation into R1's elopement on 2/07/15, has there been any retraining of staff regarding supervision, E2 stated no. When asked if the facility has developed a plan to prevent a reoccurrance of an incident like this, E2 stated yes. That it had to do with the screening process including "add additional staff when doing screening in the future." When asked if this is in writing somewhere, E2 stated, "No I don't have it in writing anywhere."

E1 [QIDP] was interviewed on 3/06/15 at 10:45am. When asked if part of her job duties is supervision of direct care staff, E1 stated yes. When asked if there has been any

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W 149	Continued From page 9 recommendation for retraining staff on supervision, E1 stated no but there has been training on policies but not on this specific incident. When asked if there has been any retraining done as a result of this incident, E1 stated, "Not specific to this incident." When asked what changes have been put into place to prevent something like this from happening again, E1 stated that they train on policies on a regular basis but not on this specific incident. When asked if there has been training since the incident of 2/7/15, E1 said yes. Training records were reviewed. On 2/09/15 the facility held training on "Abuse and Neglect", facility policies including 5.24, 5.39, Evacuation/Disaster Policy and Procedures, hot water system failure, seizure monitoring, and Gathering/Mustering Areas. On 2/27/15 training was held for policies including 5.24 and 5.39 again. E3 [Direct Care Staff] was interviewed on 3/05/15 at 4:15pm. When asked if she had received any retraining regarding supervision, E3 stated no. E4 [Direct Care Staff] was interviewed on 3/05/15 at 4:20pm. When asked if she had received any retraining regarding supervision, E4 stated no.	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.	W 153		

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This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to report to the Department an incident of possible neglect in accordance with Illinois Administrative Code 350.3240 when they failed to notify the department of an incident of elopement in which an individual in the facility on a trial visit eloped from the facility and entered a neighbors house (R1) for 1 of 1 individual who eloped to a neighboring house. (R1)

Findings Include:

Illinois Administrative Code 350.3240d) states, "A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department."

A facility "Safety Committee" report dated 2/8/15, under the section titled "Summary Of Incident" states, "Visiting individual [R1] had come for a visit on 2/6/15 to see if [the facility] would be an appropriate place for him to reside. On 2/7/15, [R1] left the building several times despite staff prompting. [R1] eloped to a neighbor's house at one point. Staff was immediately notified and immediately went to the neighbor's house with another resident's guardian and [R1] came back to [the facility]. The administrator, the QIDP [Qualified Intellectual Disabilities Professional] and the family were notified. The visit was terminated and the family picked [R1] up on 2/7/15."

A facility form titled "General Notes", dated 2/07/15 and written by E3 [Direct Care Staff] states that R1 "liked to go in and out of the home and walk up and down our sidewalks around the house and driveway. This happened several

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W 153	Continued From page 11 times throughout the morning. When asked to put on a coat and shoes [R1] refused." It also states that staff "talked [R1] into coming back after several attempts, and apologized to the neighbor several times" A written statement provided to surveyor by E4 on 3/05/15 states that "Staff was having trouble with [R1] staying in the home. He kept going in one door and out the other + back in another door." A written statement provided to surveyor by E3's on 3/05/15 states, "Another residents mother [R3's mother Z1] came to pick her up, as they were walking out the little boy across the street ran over and said 'my mom told me to come get you someone escaped from you house and is in our house'. Staff [E3] followed him back to his house and residents mother [Z1] followed. [R1] was standing in the kitchen refusing to leave asking for his grandma and brother. Staff and resident's mom [Z1] finally got him to come back home after asking several times." E1 [Qualified Intellectual Disabilities Professional] was interviewed on 3/06/15 at 9:00am. When asked if the Department was notified of this incident, E1 stated she was not sure if the Department was notified. E2 [Facility Representative] was interviewed on 3/06/15 at 9:45am. When asked if the Department was notified of this incident, E2 stated no.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to conduct a thorough investigation for 1 of 1 individual who while on a trial visit at the facility, eloped from the facility and entered a neighbors house without staff being aware of it. (R1)

Findings Include:

A facility "Safety Committee" report dated 2/8/15, under the section titled "Summary Of Incident" states, "Visiting individual [R1] had come for a visit on 2/6/15 to see if [the facility] would be an appropriate place for him to reside. On 2/7/15, [R1] left the building several times despite staff prompting. [R1] eloped to a neighbor's house at one point. Staff was immediately notified and immediately went to the neighbor's house with another resident's guardian and [R1] came back to [the facility]. The administrator, the QIDP [Qualified Intellectual Disabilities Professional] and the family were notified. The visit was terminated and the family picked [R1] up on 2/7/15."

A facility form titled "General Notes", dated 2/07/15 and written by E3 [Direct Care Staff] states that R1 "liked to go in and out of the home and walk up and down our sidewalks around the house and driveway. This happened several times throughout the morning. When asked to put on a coat and shoes [R1] refused." It also states that staff "talked [R1 into coming back after several attempts, and apologized to the neighbor several times"

A written statement provided to surveyor by E4 on

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(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 154	Continued From page 13	W 154		

3/05/15 states that "Staff was having trouble with [R1] staying in the home. He kept going in one door and out the other + back in another door."

An adaptive behavior assessment dated 2/11/14, under the section titled "Community Living Skills" states, "Stays in an unfenced yard for ten minutes when expected without wandering away--Does Fairly Well--or 3/4 of the time may need to be asked." It also states, "Crosses nearby residential streets, roads and unmarked intersections alone--Never or Rarely--even if asked." The broad independence score is listed as 4 years 1 month.

Per an undated ISP which was part of R1's referral packet, R1 had a cognitive assessment done 4/08/10 with an IQ score of 40, is 19 years old and has diagnoses of Pervasive Developmental Disorder, Attention Deficit Hyperactivity Disorder and Autism Spectrum. It also states that R1 "is never left alone at home or in the community. At school, [R1] has a one on one aid every day."

Under the section titled "Committee Findings" it states, "Staff notified administrator as per protocol as well as family. The visit was terminated immediately following an incident of [R1] leaving the grounds unauthroized."

Under the section titled "Committee Considerations" it states, "Resident was determined not to be a good fit for [the facility]. Resident poses safety issues as he does not want to stay in the facility or on facility grounds. Visit was terminated 2/7/15 following incident. Administrator was notified immediately as was family. The family came and picked up [R1]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G224	A. BUILDING _____ B. WING _____	C 03/18/2015

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W 154	Continued From page 14 E2 [Facility Representative] was interviewed on 3/06/15 at 9:45am. When asked if the safety committee investigation was the only investigation into this incident, E2 stated yes that she did not do a formal investigative committee investigation. When asked if she had interviewed all witnesses, E2 stated that she did not interview the family member that was here [Z1]. E2 verified that Z1 did go across the street with the staff member [E3]. E1 was interviewed on 3/06/15 at 9:00am. When asked if she was a part of the safety committee review, E1 stated yes. When asked if the safety committee interviewed Z1, E1 stated, "No we did not." E2 was asked if the investigation determined approximately what the temperature was outside on that day. E2 stated, "No, but is was cold." When asked if the investigation determined where the two staff were when R1 left the house, E2 stated, "They were here in the building with a resident getting ready to leave." When asked if both of the staff were with the resident, E2 stated, "Yes, both were in the building. I'm not sure exactly where both were. [E3] was with [R3'] mom [Z1]." E2 was asked if both staff being in the building was a problem with R1 outside, E2 stated, "I don't think it was something specific I put in there."	W 154		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by:	W 157		

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W 157	Continued From page 15	W 157		

Based on interview and record review, the facility failed to take corrective action to prevent further incidents of elopement for 1 of 1 individual who while on a trial visit at the facility, eloped from the facility and entered a neighbors house without staff being aware of it. (R1)

Findings Include:

A facility "Safety Committee" report dated 2/8/15, under the section titled "Summary Of Incident" states, "Visiting individual [R1] had come for a visit on 2/6/15 to see if [the facility] would be an appropriate place for him to reside. On 2/7/15, [R1] left the building several times despite staff prompting. [R1] eloped to a neighbor's house at one point. Staff was immediately notified and immediately went to the neighbor's house with another resident's guardian and [R1] came back to [the facility]. The administrator, the QIDP [Qualified Intellectual Disabilities Professional] and the family were notified. The visit was terminated and the family picked [R1] up on 2/7/15."

A facility form titled "General Notes", dated 2/07/15 and written by E3 [Direct Care Staff] states that R1 "liked to go in and out of the home and walk up and down our sidewalks around the house and driveway. This happened several times throughout the morning. When asked to put on a coat and shoes [R1] refused." It also states that staff "talked [R1 into coming back after several attempts, and apologized to the neighbor several times"

Per an undated ISP which was part of R1's referral packet, R1 had a cognitive assessment done 4/08/10 with an IQ score of 40, is 19 years

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W 157	Continued From page 16	W 157		

old and has diagnoses of Pervasive Developmental Disorder, Attention Deficit Hyperactivity Disorder and Autism Spectrum. It also states that R1 "is never left alone at home or in the community. At school, [R1] has a one on one aid every day."

Under the section titled "Committee Findings" it states, "Staff notified administrator as per protocol as well as family. The visit was terminated immediately following an incident of [R1] leaving the grounds unauthroized."

E2 [Facility Representative] was interviewed on 3/06/15 at 9:45am. When asked if, as a result of the investigation into R1's elopement on 2/07/15, has there been any retraining of staff regarding supervision, E2 stated no. When asked if the facility has developed a plan to prevent a reoccurrance of an incident like this, E2 stated yes. That it had to do with the screening process including "add additional staff when doing screening in the future." When asked if this is in writing somewhere, E2 stated, "No I don't have it in writing anywhere."

E1 [QIDP] was interviewed on 3/06/15 at 10:45am. When asked if part of her job duties is supervision of direct care staff, E1 stated yes. When asked if there has been any recommendation for retraining staff on supervision, E1 stated no but there has been training on policies but not on this specific incident. When asked if there has been any retraining done as a result of this incident, E1 stated, "Not specific to this incident." When asked what changes have been put into place to prevent something like this from happening again, E1 stated that they train on policies on a

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W 157	Continued From page 17 regular basis but not on this specific incident. E3 [Direct Care Staff] was interviewed on 3/05/15 at 4:15pm. When asked if she had received any retraining regarding supervision, E3 stated no. E4 [Direct Care Staff] was interviewed on 3/05/15 at 4:20pm. When asked if she had received any retraining regarding supervision, E4 stated no.	W 157		