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	IL6000079	A. BUILDING: _____ B. WING _____	10/25/2023

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Z 000	COMMENTS Complaint Investigation #2348647/IL165590 Facility Reported Incident of 8-3-23/IL165600	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.1210b)2) 350.1230d)1) 350.2700d)2) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. . Section 350.1210 Health Services b) The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: 2) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse.	Z9999		

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Z9999	Continued From page 1 Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. Section 350.2700 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a patient leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant twenty-four (24) hour a day supervision of the door, a signal is not required. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. (Section 2-107 of the Act) These requirements were not met as evidenced by,	Z9999		

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Based on observation, record review and interview, the facility failed to prevent incidents of elopement for 1 of 1 individual with a known history of elopement (R1) in the sample of three, by their failures to:

-Follow supervision level and
-Ensure door alarms were activated.

These failures resulted in R1 eloping away from the facility to a busy street on 8/3/23 and 10/11/23.

Findings include:

The 2/22/23 Individual Support Plan (ISP) identifies R1 as a non-verbal individual who functions within the Profound Range for Individuals with Intellectual Disabilities. R1 has additional diagnosis including Autism, Anxiety, and Bipolar Disorder. R1's ISP also includes, "I (R1) am fully mobile. I (R1) am able to climb stairs, enter and exit my bed and board vehicles without assistance."

R1's Behavioral Support Plan (BSP) dated 12/14/22 identifies target behavior that includes elopement.

R1's Comprehensive Functional Assessment dated 2/22/23 documents a mark next to the word never for the following, " I can ask for directions if I need them. I can choose clothing that is appropriate for the weather. I maintain personal space when talking to others. I am able to state or write my telephone number. I am able to state or write my address. I only get in vehicles with people I know. I walk away from strangers who

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approach me. I am able to identify police when out in the community. I cross the street at the cross walks. I stop and look both ways before crossing the street/railroad tracks. I check for traffic before crossing alleys, driveways, and parking lots. I follow safety signs (Danger). I ask for help when in danger. I ask for directions if lost. I recognize health and safety hazards. I travel safely at home and in my community."

On 10/17/23 at 3:04 pm, E2 (House Manager) confirmed R1 is non-verbal.

Facility Abuse and Neglect Policy dated 3/1/23 includes, "The facility shall be operated in a manner which ensures that individual are not subjected to neglect or to physical, verbal, sexual, psychological abuse or punishment."

Facility Operating Procedure Policy dated 12/14/22 includes, "5. Alarms shall be on at all times to ensure the safety of all individuals, staff, and visitors."

1) R1's BSP dated 12/14/22 includes, "To decrease the potential for elopement incidents that pose a safety risk to R1, staff will increase the amount of supervision being provided to her (R1) to line of sight. This means that staff will be able to visually see R1 at all times during while she (R1) is awake. Staff will also ensure that the alarms are on at all times."

Investigation Report dated 8/3/23 includes, "A. Date and time incident occurred: 8/3/23-Actual time is unknown in which the incident occurred. E1 (Administrator) received a phone call from E5 (Direct Support Person/DSP) that R1 had eloped from the facility and was being returned to the facility by the police department. Collection of

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Z9999	Continued From page 4 Evidence: E6 (DSP) admitted to having knowledge of other staff member E5 being in the car asleep during time of incident while she (E6) was passing meds. E5 admitted to being asleep while in the car during the period in which R1 was found." Sheriff Office Incident Report dated 8/3/23 includes, "Incident Time: 6:35 am. Narrative: On Thursday, 8/3/23, I (Z1/Sheriff Deputy) responded to reference to a female that was walking on the side of the road. I (Z1) arrived and contacted the female. The female was identified as R1 who resides at a facility. Contact was made with the facility, and they requested R1 be brought back to the facility." R1's 30 Minute Bed Check, there is no documentation from 11:00 pm on 8/2/23 to 6:00 am on 8/3/23. On 10/18/23 at 8:47 am, E2 confirmed the main street near the facility is a busy street. On 10/18/23 at 8:39 am, there is a train track near the facility with a sign that documents, "Trains may exceed 80 mph (miles per hour)." On 10/18/23 at 10:20 am, E3 (DSP) confirmed the train tracks near the facility is used by both passenger and freight trains. On 10/17/23 at 11:35 am, Z1 confirmed on 8/3/23 Z1 responded to a call of a person walking on the side of the road near the facility. When Z1 arrived, a community person had R1 in their vehicle. Z1 confirmed R1 was 2-3 blocks away from the facility. Z1 then confirmed he was unsure who R1 was or where she lived. Z1 was able to figure out where R1 lived and drove R1	Z9999		

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Z9999	Continued From page 5 back to the facility. On 10/18/23 at 9:20 am, E6 confirmed from 2:00 am-3:00 am, E5 and E6 were outside in their vehicles. At 3:00 am, E6 walked over to E5's car and knocked on the window because E5 was asleep. E6 then notified E5 that she was going back inside the facility. E6 confirmed when she came into the facility at 3:00 am, the door alarm sounded. E6 left the door cracked open for E5. E6 then shut the door alarm off which caused the door she left cracked to be disarmed. E6 stated, "I thought E5 was coming in behind me. I went into the medication room to pass meds. I saw R1 between 4:30 am-5:00 am. At 5:30 am, the phone was ringing. When I went to answer the phone, I saw E5 coming inside the facility. The police were on the phone asking if R1 was in the building." E6 confirmed the police know R1 by name. E6 stated, "They know her R1 by name because she elopes so much." E6 then confirmed she went to check and R1 was not in the facility. E6 confirmed the police brought R1 back and R1 was wearing a t-shirt, pajama pants, socks and one shoe. On 10/18/23 at 10:57 am, E6 confirmed E5 and E6 were the only two staff members working from 11:00 pm-7:00 am on 8/3/23. E6 then confirmed the facility door that she entered at 3:00 am and kept cracked open for E5 was the door on the women's side. E6 also confirmed R1 is a non-verbal individual. E6 confirmed she was unaware that R1 was line of sight while awake and 30-minute checks while asleep. On 10/18/23 at 1:42 pm, E2 confirmed all individuals at the facility require a staff member to be present inside the facility while at home. E2 also confirmed during the investigation on 8/3/23,	Z9999		

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Z9999	Continued From page 6 E2 was made aware that E5 and E6 were not inside the facility on 8/3/23, leaving individuals inside without supervision. On 10/17/23 at 8:45 am, R1-R3 were at the facility. Surveyor opened the door on the women's side and no alarm sounded. On 10/17/23 at 10:10 am, R1-R3 left facility with E3 and E4 (Cook/DSP) out the women's side door. No alarm sounded. On 10/17/23 at 10:53 am, R1-R3 walked into the facility through the women's side door. No alarm sounded. On 10/17/23 at 10:43 am, E2 confirmed he disabled the door alarm around 8:00 am because individuals were leaving and R3 goes in and out all day to smoke. E2 also confirmed the door alarms should be on at all times. 2) Facility Group Training Record dated 8/7/23 includes, "Topic(s): Effective Immediately, R1 is a one on one. Assigned staff shall be with R1 at all times to include when R1 goes to the restroom or when R1 goes to her bedroom. Staff should know R1's location at all times." On 10/16/23 at 2:56 pm, Z2 (Community Person) confirmed on 10/11/23 she was driving down the street near the facility. Z2 then stated, "About two blocks away from the facility, I saw R1 walking down the middle of the road, in the rain, with slippers on. Cars were dodging and honking at R1." Z2 then confirmed that she pulled over, no staff were near or in sight of R1. R1 then got into Z2's car. Z2 then stated, "Approximately 5-10 minutes after R1 got into my car, a van pulled up.	Z9999		

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A female got out of the van, walked over to my car and without saying anything attempted to open the back door. I saw the female had another facilities shirt on, so I asked if R1 lived at the other facility. The female told me no while continuing to attempt to open the back door. The female would not identify herself." Z2 then confirmed that she told the female that she was not going to let R1 go with her until the police arrived. Z2 then stated, "The female got back in the van and left, leaving R1 alone with me." Z2 confirmed when the police arrived they knew where R1 lived and Z2 followed the police officer's car to the facility. When they arrived at the facility, the female that attempted to get R1 out of her car was standing outside the facility.

On 10/17/23 at 9:29 am, E3 confirmed last week sometime, R1 had eloped. E3 was unsure of the exact date. E3 also confirmed when R1 eloped, E3 was R1's one to one. E3 confirmed she had to use the bathroom and had R1 sit outside the bathroom door. While E3 was in the bathroom, R1 took off out the door. E3 confirmed that she lost sight of R1 and found her in a community person's car down the street near the facility.

On 10/17/23 at 9:33 am, E2 confirmed last week, unsure of exact day, R1 took off out the facility door. E2 also confirmed R1 was out of sight and E3 found her about two blocks away from the facility. E2 then confirmed when R1 eloped last week, E2 and E3 were the only staff working and at no time was E2 asked to take over R1's one to one supervision. E2 confirmed individuals should not be left with strangers. E2 also confirmed no staff training has been done regarding this incident.

On 10/17/23 at 11:35 am, Z1 confirmed on

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Z9999	Continued From page 8 10/11/23 a call was received that a person was in the street near the facility. Z1 then confirmed as he was coming up to the scene, the facility van was passing him and leaving the scene. Z1 confirmed when he arrived on scene, R1 was in Z2's car and there were no staff present. Z1 had Z2 follow him and take R1 back to the facility. On 10/17/23 at 3:17 pm, E3 told R1 to put her shoes on. R1 took off down the hall to her bedroom. No staff were in-sight of R1. On 10/18/23 at 8:45 am, R1 was sitting in the day room on the women's side. No staff in-sight of R1. On 10/18/23 at 8:55 am, E4 confirmed she was R1's one to one and because the door alarm was going off, E4 went to reset the alarm. E4 then confirmed she thought R1 followed her to reset the door alarm. On 10/18/23 at 10:02 am, E2 confirmed one to one means a staff person is always insight of that individual. (B)	Z9999		