Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000079	A. BUILDING: ______ B. WING ______	R-C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIASA MANOR	110 NORTH ALBY COURT GODFREY, IL 62035

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Z 000	COMMENTS	Z 000		
	Second Certification Revisit to Complaint 2444156/IL173646, 2445150/IL175047, 2445229/IL175150 and Investigation of Facility Reported Incidents of 2-2-24, 5-26-24/IL175070			
Z9999	FINDINGS	Z9999		

Statement of Licensure Violations

350.620a)
350.1210a)
350.1230d)1)2)
350.1230e)

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

a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or resident's representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental health, psychosocial, and habilitation needs that are identified in the resident's comprehensive assessment that allows the resident to attain or

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maintain the highest practicable level of independent functioning and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or resident's representative, as applicable. (Section 3-202.2a of the Act)

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.
2) Basic skills required to meet the health needs and problems of the residents.

e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities.

These requirements were not met as evidence by:

Based on observation, record review, and interview, the facility failed to:

-Implement R1's supervision level, resulting in:
-R1 eloping from the facility on 8/23/24 and
-one to one supervision not being provided on 8/29/24 due to lack of staffing.
-Implement R2-R7's supervision level, resulting in R2-R7 being left at the facility unsupervised on 8/29/24.
-Ensure facility door alarm is armed at all times.

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-Ensure all staff were trained on R1's Behavior Plan, as documented in the facility plan of correction with completion date of 8/22/24.

This has the potential to impact all nine individuals residing at the facility (R1-R9).

Findings include:

Facility Roster dated 7/2/24 identifies nine individuals reside at the facility (R1-R9).

The 4/22/24 Individual Support Plan (ISP) identifies R1 as an individual who functions within the Profound Range for Individuals with Intellectual Disabilities. R1's ISP includes, "I (R1) am non-verbal."

R1's Behavior Support Plan (BSP) dated 8/4/23 includes, "In the past month, (R1) has begun eloping from the facility creating a dangerous situation for herself (R1) and others. To decrease the potential for elopement incidents that pose a safety risk to (R1), staff will increase the amount of supervision being provided to (R1) one-to-one. This means that staff will be with (R1) at all times while she (R1) is awake. Target Behaviors: Elopement: leaving the facility without staff knowledge. Interventions/Methods Specific to Each Target Behavior: Elopement:1. Staff should search the facility for (R1). 2. If (R1) cannot be located on facility grounds, staff should notify their immediate supervisor and treat the situation as a missing person and follow the missing persons policy as trained. 3. Once (R1) is located, staff should check (R1) for injury and notify all parties that she has been located. Any staff working directly with (R1) must be

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trained on the Behavior Support Plan prior to working with her to address behavioral issues. "

R1's Comprehensive Functional Assessment (CFA) dated 10/17/23 documents a mark next to the word never for the following, " I (R1) can ask for directions if I (R1) need them. I (R1) can choose clothing that is appropriate for the weather. I (R1) maintain personal space when talking to others. I (R1) am able to state or write my (R1) telephone number. I (R1) am able to state or write my (R1) address. I (R1) only get in vehicles with people I (R1) know. I (R1) walk away from unfamiliar animals. I (R1) walk away from strangers who approach me (R1). I (R1) am able to identify police when out in the community. I (R1) cross the street at the cross walks. I (R1) stop and look both ways before crossing the street/railroad tracks. I (R1) check for traffic before crossing alleys, driveways, and parking lots. I (R1) follow safety signs (Danger). I (R1) ask for help when in danger. I (R1) ask for directions if lost. I (R1) recognize health and safety hazards. I (R1) travel safely at home and in my (R1) community."

On 8/28/24 at 10:08 am, E6 (Direct Support Person/DSP) confirmed R1 is non-verbal.

Facility Abuse and Neglect Policy dated 3/1/22 includes, "The facility shall be operated in a manner which ensures that individuals are not subjected to neglect or to physical, verbal, sexual, psychological abuse or punishment. 3. In the event of any alleged physical abuse, neglect or mistreatment, the individual served shall be examined by the nurse and/or physician immediately, depending upon the severity of the

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Z9999	Continued From page 4 individual's physical condition." Facility One-to-One Coverage Policy dated 3/1/22 includes, "The facility must provide sufficient direct care staff to manage and supervise individuals in accordance with the Individual Support Plan. The facility shall provide one-to-one staff coverage for individuals who demonstrate an excessive degree of aggression, destructive, suicidal, or self-injurious behavior, elopement risks and/or have severe medical problems." 1a) R1's General Event Report dated 8/23/24 includes, "All staff was present, one was one on one with (R1), one was cleaning the kitchen and one was doing a task requested by (E3/House Manager). (R1) managed to slip by her one on one staff. (R1) escaped out of the house, there were multiple witnesses saying that (R1) was in the street walking to the gas station. Staff was asked where was (R1) and was on the way out of the door running towards (R1), the train was close and the arms was down. (R1) had managed to get under the arms and made her (R1) way to the gas station, by the time staff got there (R1) was on the floor eating cookies. Staff called (E3), so (E3) can come in the van because staff was unable to walk (R1) back home. The police was called. Staff was able to get (R1) in the van and into the house." Sheriff Department Incident Report dated 8/23/24 includes, "Contacted: (E3). Subject: (R1). Deputy Narrative: 8/23/24 08:57:56 (8:57 am) Brown hair whi (white) shirt grnish (greenish) blu (blue) pants no shoes walking in middle roadway towards train tracks-train approaching. 8/23/24	Z9999		

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08:58:26 (8:58 am) went thru tracks before train got there. 8/23/24 09:24:54 (9:24 am) (R1) was found by the group home employees at local gas station and taken back to the group home. Spoke with (E3) who advised (R1) was not being properly supervised and (R1) left the home on foot."

Railroad Track approximately 0.1 miles from the facility has two signs next to the track that include, "Trains May Exceed 80 MPH (miles per hour). No Train Horn."

Road next to the facility has a sign posted that document, "Speed Limit 40."

On 8/29/24 at 12:17 pm, E3 confirmed the track next to the facility is used by freight and passenger trains. E3 also confirmed the road next to the facility is busy and stated, "Very."

On 8/28/24 at 8:20 am, E7 (DSP) confirmed R1 had an incident of elopement on 8/23/24 while E7, E9 (DSP) and E10 (DSP) were at the facility. E7 stated, "(E9) was working on inventory for (E3). I (E7) was in the kitchen. (E10) was in the dining room. The alarm door was shut off because day training individuals were leaving for day training. (E10) asked me (E7) where (R1) went. A guy in a black truck said (R1) was in the street. I (E7) saw (R1) down the middle of the street heading toward the train tracks. The arms were down, and I (E7) could see the front of the train coming. I (E7) could see the front of the train. (R1) ducked under the arm and crossed. We had to wait for the train to pass. We found (R1) in the gas station sitting on the floor eating cookies. (R1) was barefoot the whole time." E7

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then confirmed it was a freight train that was on the railroad tracks.

On 8/28/24 at 9:45 am, E9 confirmed she (E9) was working at the facility on 8/23/24 when R1 eloped. E9 stated, "I (E9) was doing inventory of a room. (E10) was supposed to be (R1's) one-to-one. I (E9) was in R4's room. I (E9) heard the van driver for day training say (R1) went that way pointing down the street. (E7) and I (E9) were behind (R1). A train was coming and (R1) ducked under the arms. We (E7 and E9) had to wait for the train to pass because the train was too close for us to get across. I (E9) went to the gas station and (R1) was there."

On 8/28/24 at 10:08 am, E6 confirmed E2 (Registered Nurse Training/RN-T) was not notified of R1 eloping on 8/23/24 and stated, "I (E6) don't think they know the protocol."

On 8/29/24 at 9:42 am, E2 confirmed staff did not make E2 aware of R1 eloping from the facility on 8/23/24.

1b) Email from E1 (Staff Development) dated 8/29/24 includes, "Resident Supervision: (R1): 1:1 (one to one), (R2-R9): 1:8 (one to eight)."

R2-R7 ISP's do not identify supervision level.

Facility Staff Schedule documents E4 (DSP) and E5 (DSP) worked from 11:00 pm on 8/28/24 until 7:00 am on 8/29/24.

On 8/28/24 at 10:40 am, R1 was standing in the hallway near the facility south door. No staff were in sight of R1.

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Z9999	Continued From page 7 On 8/29/24 at 8:03 am, E3 stated, "The midnight staff left at 7:00 am. I (E3) got here around 7:40 am and no staff were here. Six individuals were home alone. (R1) and (E4/DSP) are missing, and I (E3) can't get ahold of (E4)." On 8/29/24 at 8:04 am, during walk through of facility, R1 was not inside. On 8/29/24 at 8:15 am, E3 stated, "(E4) called and (R1) ran, and they (R1 and E4) are over by the pond." On 8/29/24 at 8:20 am, approximately 0.1 miles south of the facility R1 was sitting in the road, barefoot, and E4 standing next to R1. On 8/29/24 at 8:25 am, E4 stated, "I've (E4) been out here for approximately 45 minutes. I (E4) was supposed to be gone. All the staff left me at 7:00 am. (E5) was with me (E4) til (until) 7:00 am. (R1) was at the door, I (E4) was loading the day training bus. The bus driver said you got a runner. I (E4) ran after (R1)." On 8/29/24 at 8:40 am, R2-R7 were inside the facility. E4 confirmed when R1 ran and E4 followed, R2-R7 were left at the facility unsupervised. On 8/29/24 at 10:33 am, E3 confirmed when E5 left at 7:00 am, leaving E4 the only staff at the facility, R1 was not a one-to-one supervision. On 8/29/24 at 1:45 pm, Z1 (Day Training Van Driver) confirmed she witnessed R1 leave the facility. Z1 stated, "I (Z1) saw an individual run	Z9999		

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out and run toward the weeds. I (Z1) honked and said I (Z1) need a staff. Staff came out and I (Z1) told her someone's running. Staff said she's the only one here and took off. I (Z1) waited five minutes because I (Z1) saw individuals inside the facility, but I (Z1) had to go. (R8) and (R9) were on the bus with me (Z1)."

On 8/29/24 at 4:14 pm, E1 confirmed individuals should be supervised at all times.

2) R1's Behavior Support Plan (BSP) dated 8/4/23 includes, "Staff will also ensure that the alarms are on at all times."

On 8/28/24 at 8:57 am, R6 and R7 walked out of the south door of the facility and got on the bus for day training. No alarm sounding.

On 8/28/24 at 10:42 am, R1 and E9 walked out of the south door of the facility. No alarm sounding.

On 8/28/24 at 10:48 am, R4 opened the facility south door, no alarm sounding.

On 8/28/24 at 11:00 am, surveyor exited south facility door, no alarm sounding.

On 8/29/24 at 8:38 am, facility south door opened by E4, no alarm sounding.

On 8/29/24 at 10:51 am, E1 exited facility south door, no alarm sounding.

3) Facility Plan of Correction with completion date of 8/22/24 includes, "Staff that supports a behaviorally challenged individual shall be

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trained in state approved crisis intervention techniques, as well as the individual's current Behavior Support Plan, prior to implementation of the plan."

Facility unable to produce evidence of staff training for crisis intervention techniques and individuals current Behavior Support Plan.

On 8/28/24 at 8:36 am, E1 confirmed training has not been complete and stated, "Training is scheduled for next week."

On 8/29/24 at 4:14 pm, E1 confirmed R1-R4 have a BSP, and data is being collected to develop a BSP for R6.

On 8/28/24 at 8:20 am, E7 confirmed she's received no training since R1's elopement of 8/23/24 and stated, "What training?"

On 8/28/24 at 9:45 am, E9 confirmed she has not received training on any individuals BSP's.

On 8/29/24 at 2:15 pm, E11 (DSP) confirmed she has not received training on any individuals BSP's.

(A)