STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G355	A. BUILDING _____ B. WING _____	C 12/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD COURT	1430 STATE ROUTE 127 SOUTH JONESBORO, IL 62952

(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 149	Continued From page 3 turned the electronic monitoring alarm off without checking to see which individual had set the alarm off. E2 stated, " E7 heard the alarm and checked the front. E7 did not see anyone and shut the alarm off. She should have checked the three individuals (R3, R4 and R5) who wear electronic monitoring devices to determine who had set the alarm off..." Documentation in R3's Nurse's Notes for 12/04/06 identified that R3 walked out the front door of the facility at 3:55 P.M., but was within eyesight of staff. Review of the Special Supervision Forms did not identify that R3's supervision level was increased after he left the building without staff's knowledge on 12/03/06. No documentation was noted in R3's Nurse's Notes or on R3's Behavior Graph for 12/03/06 that would identify that R3 had left the facility without staff's knowledge. Review of the Special Supervision Form dated 12/04/06 identified that R3 was not placed on "Continuous Supervision" until 4:00 P.M. on 12/04/06. It was confirmed per interview with E1 (Qualified Mental Retardation Professional - QMRP) on 12/07/06 at 3:00 P.M. that R3's supervision level was not increased until 12/04/06.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS Section 350.610a) Section 350.620a) Section 350.670e) Section 350.670f)1)	W9999		

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W9999	Continued From page 4 Section 350.670f)3) Section 350.1060h) Section 350.1070 Section 350.3240a) Section 350.610 Management Policies a) The facility's governing body shall exercise general direction of the facility, and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served. 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 350.670 Personnel Policies e) All personnel shall have either training or experience, or both, in the job assigned to them. f) Orientation and In-Service Training 1) All new employees, including student interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; the importance of nutrition in general healthcare; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including student interns, shall complete an orientation	W9999		

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W9999	Continued From page 5 program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents. The employee's training and competency shall be documented. 3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. Section 350.1060 Training and Habilitation Services h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on interview and record review, the facility	W9999		

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W9999	Continued From page 6 has neglected to implement their own policy and procedures for supervision and special observation for 1 of 1 individual in the sample (R3) who left the facility on 12/03/06 without staff's knowledge. R3 wears an electronic monitoring device and has history of elopement. On 12/03/06, R3 left the facility and activated the electronic monitoring alarm with his electronic monitoring device. Staff shut off the alarm but neglected to determine who had activated the alarm. Staff did not discover that R3 had left the building until approximately 15 - 20 minutes later when he re-activated the door alarm when re-entering the facility. Findings include: Review of the facility's policy for Emergency Procedures for Missing Resident(s) identified, "The location of every resident must be known at all times. The location is to be known when residents are not in the presence of staff, in the facility or vicinity thereof. Appropriate measures shall be taken to determine the location of missing residents." Per review of the Behavior Treatment Plan for Elopement dated 10/19/06, R3 is a 47 year old male who functions at a profound level of mental retardation. R3 requires a guardian and functions at a 2 year and 6 month level. Review of the restrictive procedure identifies that R3 wears an ankle electronic monitoring device. The Incident Report dated 12/03/06 identified, "... 1:30 P.M. R3 wandered out of building unattended by staff, was noticed by staff when he re entered front door. Investigation Immediately Started. R3 out of building a few minutes..."	W9999		

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W9999	Continued From page 7 Review of the Preliminary Reporting Form dated 12/03/06, documentation identified, "Staff, E5 and E6 were out back taking a cigarette break when E5 pointed out that R3 had just come in the front door alone. Staff (E5) came back in the building to see if anyone knew why he was unattended. E7 said she had shut off alarm because she didn't see anyone. Staff (E5) had R3 take off coat and go have a seat..." Per telephone interview with a representative from the Southern Illinois Airport Weather Service, the temperature was 21 degrees (Farenheit) on 12/03/06 at 1:00 P.M. Review of the facility's Investigation identified that E6 had completed a Witness Statement dated 12/03/06 which identified that R3 was possibly out of the building in excess of 15 to 20 minutes without staff's knowledge. E6 wrote, "I had went outside and smoked a cig. (cigarette) and when I came back in I sat down and the --- alarm went off and some one turned it off. Well I went to look outside and saw nothing. Well about 15 to 20 mins. (minutes) I saw R3 walk in alone." Further review of the facility's Investigation identified that five direct care staff (E5 (as needed -certified), E6, E7, E8 and E9 (non certified) and the cook were on duty during the time that R3 left the building. Per interview with E2 (Director of Nursing) on 12/07/06 at 9:40 A.M., E2 confirmed that four of the five direct care staff working on 12/03/06 were new and not certified. E2 stated, "E7 had worked for two weeks at the facility and E9 had worked at the facility for one week. It was E6 and	W9999		

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W9999	Continued From page 8 E8's second day working. E5 is certified but only works at the facility on an as needed basis." During this interview, E2 confirmed that during her investigation, it was determined that E7 had turned the electronic monitoring alarm off without checking to see which individual had set off the alarm. E2 stated, "E7 heard the alarm and checked the front. E7 did not see anyone and shut the alarm off. She should have checked the three individuals (R3, R4 and R5) who wear electronic monitoring devices to determine who had set the alarm off..." Documentation in R3's Nurse's Notes for 12/04/06 identified that R3 walked out the front door of the facility at 3:55 P.M., but was within eyesight of staff. Review of the Special Supervision Forms did not identify that R3's supervision level was increased after he left the building without staff's knowledge on 12/03/06. No documentation was noted in R3's Nurse's Notes or on R3's Behavior Graph for 12/03/06 that would identify that R3 had left the facility without staff's knowledge. Review of the Special Supervision Form dated 12/04/06 identified that R3 was not placed on "Continuous Supervision" until 4:00 P.M. on 12/04/06. It was confirmed per interview with E1 (Qualified Mental Retardation Professional - QMRP) on 12/07/06 at 3:00 P.M. that R3's supervision level was not increased until 12/04/06. (A)	W9999		