STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004030	A. BUILDING _____ B. WING _____	C 07/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK COUNTY SHELTERED CARE	**97 MAIN STREET, PO BOX 157 AUGUSTA, IL 62311**

(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
F 000	INITIAL COMMENTS Complaint Investigations: 0722733 / IL29486 ==> No Findings 0722765 / IL29523 ==> No Findings Incident Report Investigation: Incident of 6-19-07 (IL29642) ==> 330.330, 330.1120 a), and 330.3060 g).	F 000		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 330.330 330.1120a) 330.3060g) Section 330.1120 Personal Care a) Each resident shall have proper daily personal attention and care including ... Section 330.330 Definitions Personal Care - assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual. (Section 1-120 of the Act) Section 330.3060 General Building Requirements Every building shall:	F9999		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F9999	Continued From page 1 g) Have each exterior door equipped with a signal that will alert personnel in the area if a resident leaves the building. An exterior door that is supervised during certain periods during the day or night may have a disconnect device for part time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These REGULATIONS are not met as evidenced by: Based on record review, interviews, and observations the facility failed to supervise 1 of 3 sampled residents (R1). R1 left the facility unsupervised 11 times this past year. The facility also failed to keep exit doors alarmed when not under supervision. Findings include: R1's current Physician's order sheet dated July 2007 indicates that R1 has diagnoses including Paranoid Schizophrenia, Seizures, Depression, Anxiety, and Self inflicted gunshot wound to head. Physician's order sheet notes R1's admission date of 6/29/06. According to R1's nurse's notes, R1 has left the facility 11 times without staffs' knowledge since he was admitted on 6/29/06. Despite R1 eloping 11 times in the past year, there is no documented evidence that the facility staff were provided with specific instructions regarding interventions for R1. After two elopements R1's nurse's notes indicate that one time when R1 was bought back to the facility, the staff took his shoes away from him. The next time the staff took R1's shoes and jacket.	F9999		

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F9999	Continued From page 2 E1 (Administrator) stated at 10:45 A.M. on 7/11/07 that R1 was not appropriate for this facility, and that he was not safe to be outside unsupervised. E1 acknowledged that the three hallway exit doors are not continuously supervised while the alarms are turned off from 4:00 A.M. until 8:00 P.M. The three hallway exit doors were observed throughout the days of 7/11/07 and 7/12/07 unlocked and unsupervised. According to a document titled "Counseling and Consultation" dated 7/13/06 and referring to R1, E7 (Licensed Clinical Social Worker) writes at the end of the document, "In light of his past suicidal behavior it is recommended that staff keep (R1) under close observation even though he may appear very calm and in some respects harmless." E7 then writes on 9/21/06, "While he may not have specific plans at this time, I think this could change rapidly in light of his tenuous mental state. In my opinion his risk for a future suicide attempt is very high." R1's Nurse's Notes dated 3/30/07 indicate the following: R1 was discovered missing at 8:45 P.M. Staff notified E1, and the grounds were searched. E1 searched the town at 9:00 P.M. At 9:25 P.M. the Sheriff's Department was notified. Deputy Sheriff present at 9:55 P.M. R1 was found at 10:30 P.M. by the Deputy Sheriff on adjoining property. R1 was sleeping outside in the doorway of the the building next door. This distance was approximately 200 feet away from the facility. R1's Nurse's Notes dated 6/19/07 indicate the following: R1 was discovered missing at 10:30 P.M. when staff went to lock the doors after shift change. According to all staff interviews it was	F9999		

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F9999	Continued From page 3	F9999		

common for staff to shut off the door alarms around 10:00 P.M. until 10:30 P.M. for shift change. E1 was then called at 10:55 P.M. E1 drove the streets looking for R1 but could not find him. 911 called at 11:30 P.M. The Deputy Sheriff showed up and looked with night goggles on the grounds and neighboring buildings but could not find R1.

During interview with E1 on 7/13/07 at 9:30 A.M., E1 stated that there were over 20 rescue workers out looking for R1 the night of 6/19/07. Nurse's Notes go on to indicate that R1 was found by another group of rescue staff at 1:15 A.M. on the ground at the fairgrounds. E1 stated that it appeared R1 had fallen and twisted his ankle. R1 was having trouble walking. R1 was later sent to the hospital for x-rays of his ankle which was negative for fractures.

The distance was measured on 7/12/07 at 1:30 P.M. to be one half mile from the facility to the fairgrounds. R1 also had to cross a main road leading into town to get to the fairgrounds.

On 7/11/07 at 2:50 P.M. R1 was asked specific questions regarding the times he eloped from the facility but was unable to give answers that were relevant to the questions. R1 would start talking about something that had nothing to do with the questions he was being asked. At one point R1 stated, "I am going to die in a fire."

Initial tour of the facility noted that there was a main entrance door and three exit doors, one down each hallway. During interview with E1 on 7/12/07 at 9:40 A.M., E1 stated that the doors were only alarmed 8:00 P.M. until 4:30 A.M. and acknowledged that the doors were not

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F9999	Continued From page 4 continuously supervised when unalarmed. E2 (Licensed Practical Nurse) was interviewed on 7/12/07 at 2:00 P.M. E2 provided the following information: E2 did not think R1 was appropriate for shelter care placement because of his eloping and because he is not safe to be outside unsupervised. E2 thinks R1 gets out of the facility when the alarms are off for shift change around 10:00 P.M. (A)	F9999		