STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G306	A. BUILDING ______ B. WING ______	09/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVISION STREET HOME	317 WEST DIVISION STREET AMBOY, IL 61310

(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
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LICENSURE VIOLATION

350.620a)
350.1060a)d)f)h)
350.3000d)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 350.1060 Training and Habilitation Services
a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.
d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.
f) There shall be a functional training and habilitation record for each resident, maintained by and available to the training and habilitation staff.
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.

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Section 350.3000 General Building Requirements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident 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 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.

These REGULATIONS were not met as evidenced by:

Based on observations, record review and interviews, the facility failed to implement policies and procedures to prohibit neglect of one of one client, when R3 left the facility unsupervised and a neighbor returned her to her home after finding R3 behind her car.

Findings include:

The home's Facility Data Sheet dated 9-12-07 states that R3 is a 39 year old woman whose diagnoses include Profound Mental Retardation and Microcephaly. R3's adaptive age is 1 year and 3 months.

During observations on 9-17-07 R3 was well groomed. She would walk up to a staff person and wait for them to respond or she frequently walked in circles with no particular destination. R3 did not communicate verbally and she played

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with her necklaces while she walked.

During a review of the investigation of the incident of 8-29-07, the Investigative Report states that at approximately 8:00am, "(R3) left the group home, walked into the parking lot and across the street to a neighbor's driveway and was brought back to the (home) property by the neighbor."

During a review of the facility's Incident/Accident Report dated 8-29-07 written by Hab Tech E6, it states, "while other staff was at the other end of the house finishing clean up, I was assisting another client into a (chair. R3) walked out the front door. When I finished helping the other client (E4) I walked out front and found her at the edge of the driveway and brought her back in the house."

In an interview on 9-19-07 at 10:30am, E6 stated he turned off the alarm and went to help R4 off the floor. E6 stated R3 went out the door. When he got R4 into his chair, he went to get R3 who was in the home's driveway.

During the facility's investigation, the neighbor was interviewed. She stated she, "noticed a client in our driveway, walking around in circles. No staff were present. She got into her car and sat there a minute or so getting the dew off her windows and making sure her granddaughter was belted in."

The neighbor said she "started to back up, and her granddaughter alerted her that the 'lady was behind' their car. (She) thought she heard a noise and this may have been (R3) putting her hands onto the trunk...After the neighbor noticed (R3) behind her car, she returned (R3) to the

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group home parking lot and left to take her granddaughter to school."

In a review of the facility's Policy and Procedure Manual with a most recent review date of August of 2006, it states one of the definitions of Neglect is "failure to provide adequate supervision thereby exposing a client to potential harm."

In a review of R3's Behavior Plan dated 9-15-07, it includes; "Wandering: attempting to leave the home or work area." Under the heading "wandering" the first two items listed are; "1. At home, the door alarm should be on at all times. 2. Staff should monitor (R3's) whereabouts at all times."

In an interview at 4:30pm on 9-19-07, Supervisor E7 stated that R3 has had "wandering" as a component of her Behavior Plan for the past three years that he is aware of.

E6 was responsible for the supervision of the clients in the front of the house while his coworker was working in the back of the house. E6 did not implement R3's Behavior Plan when he turned off the alarm, and he didn't adequately supervise R3 when she went out the front door.

The facility's conclusion of their investigation states "Regardless of how this happened, the fact that (E6) did not provide adequate supervision to (R3) is obvious. This is a founded case of neglect that was able to occur due to the door alarm being turned off when it should not have been."

(A)