STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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 154	Continued From page 21 window as evidenced by R1's interview on 02/23/12, Z2's interview on 02/24/12 and the local police report dated 02/03/12 stating that the local police had been called because R1 had climbed out a window of the facility, the facility failed to thoroughly investigate to determine exactly how R1 left the facility. The failure to initiate and complete a thorough investigation allowed R1 the opportunity to leave the facility a second time and put herself at possible risk for harm. The facility failed to thoroughly investigate R1's leaving the facility on 01/29/12 to ensure that appropriate actions were taken to prevent further incidents of leaving the facility without staff's knowledge.	W 154		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.1230d) 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	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

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W9999	Continued From page 22 e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. 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 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met, as evidenced by the following: A) Based on observation, interview and record review, the facility failed to implement their own policy and procedures when they failed to provide necessary supervision to prevent 1 of 1 individual (R1) in the sample with history of making inappropriate "choices in social relationships/conduct" from leaving the facility on 01/29/12 and 02/03/12 without staff's knowledge which has the potential to jeopardize R1's safety when in the community unsupervised. Findings Include:	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	301 NORTH 13TH STREET MURPHYSBORO, IL 62966

(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
W9999	Continued From page 23	W9999		

The facility failed to thoroughly investigate how R1 left the facility without staff's knowledge on 01/29/12 and again on 02/03/12. On 01/29/12 at approximately 1:00 P.M., R1 left the facility through her bedroom window and walked to the local police station without staff's knowledge. After this incident, the facility did not thoroughly investigate to determine how R1 left the facility and four days later, R1 again left the facility on 02/03/12 at approximately 12:30 A.M. R1 walked approximately one mile from the facility, got into a truck with an unknown man and was driven to a local grocery store that was closed. After these incidents, R1 was placed on continual staff observation, however staff of the facility failed to implement this level of supervision as observed on 02/23/12. On this date, R1 was observed outside, sitting in a chair, smoking on the front porch of the facility from 3:30 P.M. to 4:00 P.M. without staff monitoring and/or supervision. As based on R1's history of inappropriate conduct and lack of judgement when in the community, the facility's failure to provide necessary supervision potentially jeopardizes R1's safety when in the community, unsupervised.

The facility's Abuse and Neglect Policy (undated) states, "...The facility shall be responsible to insure that no resident is subjected to physical, verbal, sexual, neglect, exploitation or psychological abuse or punishment by an employee, staff or other agencies that service the residents, family members/guardians, volunteers, outside consultants or other individuals." "Neglect refers to any failures by facility to carry out required/appropriate services, habilitation or treatment as ordered by authorized personnel. Neglect means failure to provide goods or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

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W9999	Continued From page 24 services necessary to avoid physical or psychological harm." Upon review of R1's Physician's Order Sheet dated 02/01/12 through 02/29/12, R1 is a 44 year old female with diagnoses that include: Mild Mental Retardation, Schizoaffective Disorder, Seasonal Affective Disorder and Depression. R1's Physician's Order sheet dated 02/01/12 through 02/29/12 states that R1's medications include: Abilify 15 milligrams daily for behavioral support, Bupropion 300 milligrams daily at 7:00 a.m. for emotional support, Bupropion 150 milligrams daily at 4:00 p.m. for emotional support, Citalopram 20 milligrams daily for Depression and Valacyclovir 500 milligrams daily for Herpes. Per review of R1's Inventory for Client and Agency Planning, dated 06/20/11, R1 has an intelligence Quotient of 61 and an overall age equivalency of 9 years and 5 months. Upon review of R1's Interdisciplinary Team Report dated 07/05/11, documentation states that R1 has, "Limits in independent life skills related to impulse control such as (in)appropriate social sexual behavior...." Upon review of R1's Annual Social Assessment dated 07/05/11, documentation states that R1 is legally incompetent and has had a guardian since 08/2009. Documentation states, "This guardianship was established due to (R1's) inability to make appropriate choices in social relationships/conduct and the need to restrict her from making choices that may endanger her	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 25 well-being or life." R1's Annual Social Assessment dated 07/05/11 also says, "She (R1) cannot afford to smoke as much as she would like and in order to get more cigarettes, she will beg them from other people or offer to be someone's 'girlfriend' in exchange for cigarettes; again demonstrating her lack of judgement..." "...She demonstrates such a lack of judgement that living in a setting without 24-hour supervision would put her at great risk of being exploited and/or in danger...." R1's Annual Social Assessment dated 07/05/11 continues to say, "Some consideration should be given to whether or not (R1) should go anywhere in the community unsupervised due to her history of very poor judgement and her willingness to comply with ANY request in return for money/food/cigarettes...." During review of R1's Community Assessment dated 07/05/11 documentation states that R1 would approach a stranger without an appropriate reason, discuss private things with a stranger and hug a stranger. R1's Community Assessment also says that R1 would not ask someone to stop and move away if she were feeling uncomfortable with someone getting too close to her. Review of R1's Maladaptive Behavior Frequency Chart dated 02/03/12 states that R1 has a history of inappropriate and sexual interactions with others and while in the community. R1's program for inappropriate and sexual interactions with others includes touching others inappropriately, saying things to strangers on the street and yelling at men in the community.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	301 NORTH 13TH STREET MURPHYSBORO, IL 62966

(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
W9999	Continued From page 26	W9999		

During interview with E1 (Administrator) on 02/23/12 at 11:05 a.m., E1 stated that on 01/29/12, R1 was not happy so she just walked off. E1 said that R1 left the facility and walked approximately 1 1/2 blocks to the local police station. E1 continued to say that the local police have been known to give R1 cigarettes. E1 stated that the local police called the facility, informing them of R1's whereabouts and then returned R1 to the facility. E1 also said that in addition to R1 leaving the facility without staff's knowledge on 01/29/12 she again left the facility without staff's knowledge on 02/03/12.

As per above interview, E1 said that R1 turned off the door alarms at the main alarm station and walked out the door.

Upon review of the facility's incident report dated 01/29/12, documentation states, "As E3 (Direct Support Person) was completing his bed checks at 1:00 a.m., he observed (R1) was not in her room. He went to get the phone to call for assistance. At that time the police (department) called and reported (R1) had walked there. The police officer said he would return (R1) to the facility..."

On 02/23/12 at 11:05 a.m., when asked what interventions had been put in place after R1 left the facility on 01/29/12, E1 said that R1's supervision level had been increased to every 15 minutes at night and that staff had been trained in R1's increased supervision level.

On 02/23/12 at 11:05 a.m., E1 stated that three days after R1 walked away from the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 27	W9999		

01/29/12, she again left the facility without staff's knowledge on 02/03/12. E1 said that R1 had been in telephone contact with a man from another state and that this unknown man had promised to wire her money for cigarettes. E1 continued to say that on 02/03/12, E4 (Direct Service Person) had checked on R1 at 12:15 a.m. and that R1 was in bed. E1 said that when E4 returned 15 minutes later, R1 was no longer in her room. E1 stated that E4 checked all the rooms and determined that R1 was not in the facility. E1 said that the local police were contacted along with E1 and E2 (Resident Service Director/RSD). E1 continued to say that R1 was returned to the facility at 1:15 a.m. by the local police.

E1 stated that both times that R1 left the facility without staff's knowledge, she turned off the door alarms at the main alarm station and walked out the door.

On 02/23/12 at 11:05 a.m., when asked what systems had been put in place after the second time R1 left the facility without staff's knowledge, E1 said that the sitting room where the main alarm station for the door alarms is located now has a lock on it and that an additional staff has been hired to maintain same room supervision for R1. E1 also said that window alarms have been placed on all windows on the women's end of the facility. When asked why window alarms have been installed, E1 said that they were trying to cover all bases to prevent R1 from leaving the facility without staff's knowledge again.

During interview with E2 on 02/24/12 at 9:50 a.m., when asked why window alarms have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 28	W9999		

installed on all the windows on the women's end of the facility, E2 stated that they (facility) were trying to think of everything to prevent R1 from leaving the facility without staff's knowledge again. When asked if R1 went out of her bedroom window on 01/29/12 or 02/03/12 without staff's knowledge, E2 said that she had not heard anything about R1 climbing out of her bedroom window.

Per interview with R1 on 02/23/12 at 3:00 p.m., R1 stated that the first time that she left the facility (01/29/12) it was about midnight and that she had walked to the police station crying. R1 said, "I wanted to move to an apartment. For some reason, I didn't like it here." When asked how she left the facility without staff knowing it, R1 said, "Today, awhile ago, E5 (Direct Support Person) told me to lie. She said they would get in serious trouble if you knew I went out the window that night. I can't lie, I know that lying is wrong." R1 continued to say that on 01/29/12 she had went into her bedroom and locked the door. R1 said that she had opened her window, took the screen out and went out the window. When asked if anyone knew that she went out the window, R1 said that E3 (Direct Support Person) had found the window screen on the floor and that he had called E1 and E2 and told them that she went out the window.

On 02/23/12 at 3:00 p.m., when asked if anyone knew that she pushed the window screen out and went out her bedroom window, R1 said that on the day after she left the first time (01/29/12) she told E2 (Residential Service Director) that she had gone out the window. R1 also said that E5 (Direct Support Person), "Approached me the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 29	W9999		

next day and asked me how I left - I told her I went out the window."

On 02/24/12 at 8:55 a.m, when asked when window alarms were placed on the windows in the facility, R1 said, "After the second time I left." When asked if she knew why the window alarms had been placed on the windows R1 said, "So I won't escape again. They said it was too dangerous to run away so we're gonna put alarms on the windows."

Per interview with Z2 (R1's guardian) on 02/24/12 at 4:00 p.m., Z2 said that E2 had called her a couple of weeks ago and said that on 01/29/12 R1 had left the facility by going out her bedroom window. Z2 stated that at that time E2 asked for Z2's permission to put window alarms on R1's bedroom window.

During interview with E3 on 03/08/12 at 9:05 a.m., E3 said that on 01/29/12 he was working the midnight shift. E3 continued to say that R1 got angry with him because he had re-directed her and told her not to do his work. E3 said that R1 wanted money and a cigarette for doing his work. E3 said that he does not remember R1's bedroom door being locked and did not see the screen out of the window. E3 also said that he did not remember many details of the night of 01/29/12.

Upon review of the local police report dated 01/29/12, documentation states that R1 walked into the local police station at 1:12 a.m. and stated that she ran away because the employee was yelling at her. Documentation continues to say that the facility was called and the employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 30	W9999		

(E3) stated that he did not know she was gone. The local police report continues to say that R1 was returned to the facility at 1:15 a.m. on 01/29/12.

During interview with R1 on 02/23/12 at 3:00 p.m., R1 said that the second time that she left the facility, it was about midnight and she turned off the door alarms, got dressed and went out the back door. R1 stated, "I was heading to New Mexico, but I didn't make it." R1 continued to say that she had a new boyfriend (Z3) that she has not met, but has talked to on the telephone. R1 said that (Z3) was going to wire her some money to a bus station in (name of town approximately 7 miles from the facility). R1 said that she left the facility to go to a local grocery store to use the telephone to call (Z3)and ask him if the money was at the bus station before she went (to the bus station).

On 02/23/12 at 3:00 p.m., R1 said that after she left the facility around midnight on 02/03/12, she was walking down 7th street and it was, "A long old road." R1 continued to say that a stranger picked her up by the high-rise building and took her to the local grocery store. R1 said that when they got to the local grocery store, it was closed so she told the stranger to take her to the hospital so she could use the telephone and call (Z3) and tell him that she could not make it down there, but that the stranger called the police and the police picked her up at the local grocery store and took her home.

Upon review of the local police report dated 02/03/12 (no time), documentation states, "(Name of facility) phoned 911, but hung up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 31	W9999		

Phoned back to see if there was a problem. (E4) advised that (R1) has slipped out in the last 15 to 20 (minutes). Her gown is in the room so she changed into something else." "(12:59 a.m.) spoke with (E2). She is inroute to the office, but requested we check (local area named)." "(1:01 a.m.) 911 call from a male that stated he picked up a woman that seemed slow, wanted to go to (name of local grocery store). She was walking out by (Name of local veterinary office)." "(1:12 a.m.) Phoned (E2) back that we have located (R1) and she is being transport back to the home."

Upon review of the local police report dated 02/03/12 at 10:17 a.m., documentation states that a local policeman had been dispatched to the facility in reference to telephone harassment. Documentation states, "Upon my arrival I met with (E2) who is an employee of the facility. E2 wanted to inform me that the facility was receiving harassing phone calls from an individual only known as "(Z3)." (Z3) has started calling the facility and talking with one of their clients, (R1). (R1) has been diagnosed with several different issues but one is mild mental retardation. Last night (name of local police department) was called because (R1) had climbed out a window and was going to (name of local grocery store) to get a money order that (Z3) was suppose to have sent her to buy a train ticket in (name of neighboring town (7 miles away)) and go live with him in Deming, New Mexico. (R1) was located and returned to the facility...."

During interview with E4 (Direct Support Person) on 03/08/12 at 11:00 a.m., E4 said that when she arrived for work at 11:00 p.m. on 02/02/12, R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 32	W9999		

was up and not upset about anything. E4 stated that R1 went to bed about 12:00 a.m.. E4 continued to say that she was in R1's bedroom at approximately 12:10 a.m. because R1's roommate was getting up and needed assistance. E4 said that she went back to check on R1 approximately 15 to 30 minutes later and R1 was gone. E4 said that she checked the facility and could not find R1 and then she called the police, E2 and E1.

Per continuing interview with E4 on 03/08/12 at 11:00 a.m., E4 said that the police returned R1 to the facility about an hour later. E4 stated, "(R1) told me she had flipped off the alarms on the women's end door way and went out that door - said something about some guy was supposed to send her some money and she wanted to go get it." E4 continued to say that R1 told her that the first time she left (01/29/12), she had locked her bedroom door and went out the window because she was upset with the staff person (E3). E4 said that she did not talk to E2 about either episode. E4 stated, "I figured she (E2) already knew."

Upon review of R1's Behavior Intervention Program dated 02/03/12, documentation states that R1's problem areas are: "Irritability, Rude to peers and staff, Outbursts, Sexual Behavior, Begging for items from others, Leaving the facility without informing staff."

R1's Behavior Intervention Program states that her short term goal for leaving the facility without informing staff is: "(R1) will reduce incidents of leaving the facility without informing staff to 0 incidents per month for 6 consecutive months." Documentation continues to say that the start

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 33	W9999		

date for this goal is 02/03/12.

The method of intervention for R1's short term goal of leaving the facility without informing staff states:

"1. Often when (R1) is upset she will leave without informing staff. When she is upset staff need to talk to her and let her know she can talk to someone about what is upsetting her. She needs to be reminded that leaving is not the best option. When she is upset staff need to increase supervision.."

"2. Reassure her that we are here to help."

"3. Remind (R1) of safety concerns of leaving without notifying staff."

"4. Alarms were installed on (R1's) windows on 02/03/12. This restriction will be reviewed every 3 months for effectiveness. They will be removed when she demonstrates appropriate behavior of not leaving facility without notifying staff for 6 consecutive months."

"Intervention Hierarchy:

1. Reassure (R1) that we are here to help

2. Explain to (R1) the safety concerns of leaving the facility without notifying staff

3. Give her time to calm down

4. Encourage her to participate in an activity."

During interview with Z4 (Case Manager) at the

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	14G137	A. BUILDING _____ B. WING _____	C 03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 34	W9999		

local day training site on 02/23/12 at 1:25 p.m., Z4 stated that she had been contacted by E2 on 01/30/12 informing her that R1 had, "Taken off overnight." Z4 said that E2 did not elaborate on the circumstances of R1 leaving the facility. Z4 stated that she was informed by E2 that she (E2) would be revising R1's Behavior Program and would send Z4 a copy. Z4 said that she had received a copy of R1's revised Behavior Program on 02/15/12.

Per interview with Z1 (Qualified Mental Retardation Professional) on 02/23/12 at 1:40 p.m., at the local day training site, Z1 said that he received R1's revised Behavior Program on 02/15/12 and that the only changes that had been made had been the addition of R1 leaving the facility without informing staff. Z1 continued to say that there had been no specific plan for R1 leaving the facility without informing staff, but that the facility had added an addendum to R1's behavior of displaying socially inappropriate behavior. This addition states, "6. Often when (R1) is upset she will leave without informing staff. When she is upset staff need to talk to her and let her know she can talk to someone about what is upsetting her. When she is upset staff need to increase supervision." Z1 stated that R1's Behavior Program did not specify what type of supervision R1 is currently on or to what level to increase R1's supervision if she becomes upset.

Z1 then showed the surveyor the memo that he received from the facility on 02/23/12 at 1:15 p.m., stating, "On 1/29/12 due to (R1's) recent incident of leaving the facility without informing staff she will have increased supervision. Staff will

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W9999	Continued From page 35 remain in eye sight of (R1) at all times...." The facility's "Instructions to Staff" regarding (R1) dated 02/03/12 and after the second time that she walked away from the facility without staff's knowledge states: "(R1) is to have 24-hour, one-on-one supervision. She needs to be in staff's line of sight even when she is in bed. To make this possible, midnight shifts have been increased to 2 people. One of the midnight staff will remain within sight of (R1's) room throughout the night. There will be window alarms installed on her window. When she goes outside to smoke she is to be supervised. The only time visual contact is not necessary is when she is using the restroom. Staff should still remain outside the door..." "...The radio room will need to be locked during the midnight shift to assure the alarms do not get turned off..." On 02/23/12 R1 was to be on continual staff observation, however staff of the facility failed to implement this level of supervision. On this date, R1 was observed outside, sitting in a chair, smoking on the front porch of the facility from 3:30 P.M. to 4:00 P.M. without staff monitoring and/or supervision until brought to the attention of E1(Administrator) and E2 (RSD). As based on R1's history of inappropriate conduct and lack of	W9999		

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W9999	Continued From page 36 judgement when in the community, the facility's failure to provide necessary supervision potentially jeopardizes R1's safety when in the community, unsupervised. (A)	W9999		