STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G060	A. BUILDING _____ B. WING _____	C 08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY FARM FOUNDATION	6301 HUMBERT ROAD GODFREY, IL 62035

(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 000	INITIAL COMMENTS Complaint Investigation #1644193 IL/87284	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement their policy to prevent neglect when 1 of 1 (R1) who is identied as same room supervision left the facility unattended. Findings Include: Review of the Facility's Incident-Injury Report (7/24/16), R1 left grounds unattended. Brought back by security. Review of R1's IHP (Individual Habilitation Plan) dated 9/21/15, R1 is a 51 year old verbal ambulatory male who functions in the Moderate Range of Intellectual Disabilities with additional diagnosis of Autism Spectrum Disorder, Unspecified Impulse-Control and Generalized Convulsive Epilepsy. R1 displays maladaptive behaviors which include: verbal threats, making racially offensive statements, being noncompliant, being physically aggressive to staff or peers, and urinating inappropriately. R1's level of supervision on 7/24/16 consist of : Same -room supervision during waking hour when out of bed due to safety and behaviors.	W 149		9/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/05/2016

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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When R1 is in bed he is on a 15-minute monitor for safety. R1 does not typically spend time in his room unless he is sleeping, and he rarely gets out of bed without staff waking him first.

Interview with E3 (Direct Support Person) on 8/2/16 at 10:00am (by phone), E3 stated on 7/24/16 he was scheduled from 6:00am-2:00pm and was responsible for R1 and 4 other individuals. R1 ate breakfast around 7:30am and returned to the west activity room after breakfast. R1 seemed tired and E3 asked him if he would like to go to his bedroom. E3 walked R1 to his room and R1 covered his head with his blanket. E3 returned to the activity room. E3 did not check on R1 or hear the door alarm. E3 stated a few minutes later E5 (Supervisor) came into the activity room and informed E3 that security had just returned R1 to the building. E3 was unaware that R1 had left the building without staff.

Interview with E5 (Building Supervisor) on 8/2/16 at 7:50am, E5 (building supervisor) on 7/24/16 (6:00am-2:00pm). E5 is responsible for assigning the DSPs to their group of individuals, assigning DSP breaks/lunch and ensuring individuals are being supervised.
At approximately 7:30am breakfast started, E5 and E7 (DSP) were in the dining room assisting with breakfast. R1 ate with the first group of individuals. E7 was escorted R1 back to E3 and his group. E5 did not see R1 until E7 (security) walked into the back door with R1 around 8:40am and was informed R1 had walked to the ramp of the interstate which border the facility.
E5 contacted the nurse and E2 (AOD), a head to toe assessment was completed on R1 by the nurse and no injuries were noted. E5 was instructed by E2 to place E3 on administrative

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leave immediately.

Interview with E6 (Security) on 8/2/16, E6 stated 7/24/16 he had been in administrative office approximately 10 minutes when switchboard received a call at 8:35am, caller said a client was on the ramp of the interstate up the street. E6 responded to the scene and saw a police vehicle and 2 other cars parked on the shoulder of the ramp and talking to R1. E6 stated R1 did not appear to be agitated and showed no resistance returning back to the facility with E6.

Interview with E2 (AOD) on 8/1/16, E2 was the Administrator on Duty on 7/24/16, E2 received a call from E5 around 8:45am. E5 stated that R1 (same room supervision level) had left the building un-noticed and was brought back to the facility by security and a county deputy. E2 was informed that the nurse had already assessed R1 and no injuries were noted. E2 instructed that R1's guardian be informed and to place E3 on leave during investigation. E2 arrived at the facility around 9:15am.

Review of the Facility Internal Investigation Report of 7/27/16 and 7/29/16, The report consist of staff statements from R1's building and clients that could be interviewed. The committee determined that E3 was responsible for supervising R1 on 7/24/16 and neglectful with implementing R1's supervision level of same room supervision and 15 minute bedroom checks of R1.

Review of the Facility Policy (dated 5/16): The facility has a proactive approach to the preventive of abuse and neglect and believes in our mission to provide each individual with a dignified quality

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