STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013197	A. BUILDING: _____ B. WING _____	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURTISS COURT	2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703

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Z 000	COMMENTS Facility Related Incident of 6-6-23 and 7-29-23/ IL162790	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.810a) 350.810c)1)2)3) 350.1070 350.1230b)6)7) 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 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. At a minimum, there shall be at least one staff member awake dressed and on duty at all times. c) The number and categories of personnel to be provided shall be based on the following: 1) Number of residents.	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 2) Amount and kind of program content, supervision, and personal care needed to meet the particular needs of the residents at all times. 3) Size, physical condition, and the layout of the building including proximity of service areas to the resident's rooms. 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 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. (Section 2-107 of the Act) These requirements were not met as evidenced by:	Z9999		

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Z9999	Continued From page 2 Based on observation, record review and interview, the facility failed prevent (R1) with a known history of elopement, from leaving the facility without staff knowledge and failed to develop and implement safeguards to manage inappropriate behavior of leaving the facility without staff knowledge and crossing a four-lane road with heavy traffic, affecting 1 individual in the sample (R1). Findings Include: Facility roster (undated), identifies 12 individuals who reside in the facility. R6 and R10 function in the Mild Range, R5 in the Severe Range, R4, R7, R8, R9 and R11 in the Moderate Range and R1,R2, R3 and R12 in the Profound Range of Intellectual Disabilities. R1's ISP (Individual Service Plan) of 1/9/23 identifies R1 as an ambulatory, non-verbal female with Autism, Mood Disorder and Seizure Disorder. The ISP's identifies R1 does not display maladaptive behaviors including leaving the facility without staff knowledge nor does receive any psychotropic medication and typically does not participate in facility activities. In the community, needs constant supervision due to tendency to wander off and think everyone is her friend. R1's Individual Risk Tool of 12-1-22 Under the Community Safety Section, The following sections are marked NO: -plan routes and arrives at destination -navigates streets, sidewalks and parking lots safety -safety uses public transportation -respond appropriately if lost in community	Z9999		

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Z9999	Continued From page 3 -state/personal identification if hurt/ill in community Z1 (Day Training Qualified Intellectual Disabilities Professional) was interviewed by phone on 8/8/23 at 9:30am stated, R1 does like to wander at the day training site but we keep a close eye on her. R1 does not have a formal program concerning wandering away and the Day Training was unaware of any incidents of leaving the residential facility without staff knowledge. Facility Incident Report of 6/6/23, "R1 left the facility grounds without staff. R1 has not been deemed capable to have community access without supervision. R1 was noticed as she was beginning to cross the street in front of the home and staff intervene." On 8/7/23 at 3:30pm, E5 (Direct Care Staff) stated, she was in back of the building assisting an individual with a shower. Another staff (unidentified staff) was in the laundry room. E5 heard someone yell, "(R1) had left the building." E5 opened the front door and saw R1 crossing the street. E5 walked across the street and guided R1 back into the building and reported this to E2 (Residential Service Director) by phone. E2 (Residential Service Director) was asked, what prevention were implemented for R1 concerning the incident on 6/6/23. E2 stated the facility staff were re-trained on the door alarms. A staff training was completed on 6/7/23. documents, "All door alarms are to be on at all times. Every time an alarm goes off, staff need to physically go to see why and who went out or came in the door. All staff must make sure that other residents are accounted for when alarms go	Z9999		

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Z9999	Continued From page 4 off, All staff must make sure that residents are not letting other residents Facility Incident Report of 7/31/23: "On 7/29/23 individual (R1) left the facility grounds without staff. A former staff member lives close to the facility and it is believed that was her intended destination. She returned without any issues. A Safety Committee meeting has been called and her behavior plan will be reviewed and revised as needed." Interview with (E3 Direct Support Person by phone) on 8/8/23 at 10:30am, E5 stated, on the day of R1's incident (7/29) there were 11 residents in the facility (R11 was on a home visit). E3 was scheduled from 7:30am-3:30pm. E2 (RSD) was in the from 7:22am until 11:19am leaving only one staff (E3) in the building until 3:30pm. E3 was responsible for taking the individuals to the bathroom after lunch. R10 needed to be transferred to the toilet from her wheelchair. E3 had R3 sitting in the hallway outside the bathroom due to R3 is on 15 minute checks due to unstrapping his safety belt on his wheelchair and trying to slide out of the chair. E3 had seen R1 pacing in the living room before she had taken R10 and R3 down the hall. E3 did not hear the door alarms and was unaware R1 had left the building until a former staff was at the back door with R1. The following recommendations were made by the Safety Committee Notes dated 7/31/23 documents the following recommendations: -Medical alert bracelet with contact information inscribed -Implementation of a electronic monitoring device -Retrain staff on R1's ISP to ensure awareness her tendencies to wander -Create and implement a behavior program to	Z9999		

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Z9999	Continued From page 5 address and track wandering behavior. Observation of R1 on 8/7/23 at 4:00pm, was not wearing a medical alert bracelet or a electronic monitoring device. On 8/7/23 at 11:00am, E2 (RSD) confirmed a behavior program has not been developed for R1 as guardian approval has not been obtain for the electronic monitoring device and this will be part of R1's behavior program. On 8/8/23 at 1:00pm, E1 confirmed there was no behavior plan developed for R1 after the incident of 6/6/23 and stated, "I thought this was an isolated incident." E1 was unable to produce any evidence of staff training on R1's supervision after the incident of 7/29/23. The Facility Policy 5.24 revised on 12/22, defines neglect as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. - B -	Z9999		