		AND HUMAN SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
		14G269	B. WIN	IG			C 5/2009
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	VAY TERRACE			-	BROADWAY ICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS	W C	000			
W 122	IL41182 483.420 CLIENT P	STIGATION - #0981899 / ROTECTIONS nsure that specific client	W 1	122			7/5/09
	protections require This CONDITION	ments are met. is not met as evidenced by:					
	failed to ensure ind neglect when the fa adequate supervisi identified as attend was left unattended	eview and interview, the facility lividuals were protected from acility failed to provide on for 1 of 7 individuals (R1), ing a community outing, who d in a locked vehicle in a approximately 60 to 90					
	Findings include:						
W 149	implement written p prohibit mistreatme client.	he facility must develop and policies and procedures that ent, neglect or abuse of the FF TREATMENT OF	W 1	149			7/5/09
	policies and proced	evelop and implement written dures that prohibit ect or abuse of the client.					
	This STANDARD i STATE LICENSING	s not met as evidenced by: G FINDINGS					
	360.620a)						
LABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/03/2009

		I AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G269	B. WI	NG .			C 5/2009
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	VAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 149	350.3240a) 350.3240b) 350.3240d)	ge 1 esident Care Policies	W	149	9		
	procedures governi the facility which sh involvement of the a shall be available to public. These writte	have written policies and ing all services provided by all be formulated with the administrator. The policies to the staff, residents and the en policies shall be followed in y and shall be reviewed at					
		ee, administrator, employee v shall not abuse or neglect a					
	aware of abuse or r immediately report	ee or agent who becomes neglect of a resident shall the matter to the facility tion 3-610 of the Act)					
	who becomes awar resident shall also r	strator, employee, or agent re of abuse or neglect of a report the matter to the on 3-610 of the Act)					
	These Regulations by:	were not met ase evidenced					
	failed to ensure inc neglect when the fa 1) ensure appropria						

Facility ID: IL6012959

If continuation sheet Page 2 of 21

		AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WI	√G			C 5/2009
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	WAY TERRACE				13 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 149	missing from the fa 2) ensure that upor the home, that the incide 3) ensure that the income Findings include: In review of the face Manual, Policy 5.24 Committee dated ("Neglect: "Failure to necessary to avoid anguish, or mental "Procedure A) Any who witnesses or s rights, abuse or neg unknown source sh matter to facility ma protocol: 1. In order for the in reported the emploid directly to one of the Administrator, Exect Operations. 2. The employee of incident on a Progri to leaving the shift." In review of the Anni dated 9/25/08, R1 diagnoses that incluing Retardation, Tonic Seizures, Insertion R1 functions in the adaptive behaviors dressing and person	cility after a community outing. In realizing R1's absence from Administrator was immediately ent. Inciddent was timely reported rtment of Public Health. ility's Policy and Procedure 4 Administration Investigative D6/17/03 states the following: to provide goods and services physical harm, mental illness." 4 facility employee or agent suspects a violation of resident glect as well as injuries of hall immediately report the anagement using the following incident to be considered yee or agent must speak the following managers: cutive Director, Director of or agent will document the ress Note (Form #GP-15) prior " nual Individual Service Plan is a 42 year old female with	W	149			

If continuation sheet Page 3 of 21

		HAND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		14G269	B. WI	NG _			C 5/2009
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 43 BROADWAY		
BROAD	WAY TERRACE				CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 149	ambulate independ gait. R1 can verba but may be difficult always inform staff understand basic s She has a behavior address kicking, bit throwing objects, st excessive sleeping a Vagal Neuro Stim due to the frequence R1 wears a helmet protection due to fa activity. R1 has a b sleeping. Review of April, 2009 noted th seizure activity on 4 4/16/09, 4/17/09, 2 and 3 seizures on 4 In interview with E1 Professional(QMRF stated that the hom abuse, neglect or n month period and n occurred during the E1 stated at 5:35pr individuals of the he attended the play d taking three individ Persons (DSP) E2 individuals in the fa attended the play w head count was do who went on the tri they returned to the	lently but has an unsteady lly communicate with others, to understand. She does not when she is sick, and cannot afety signs or safety issues. r development program to ting, property destruction, tealing, non compliance and . In January, 2008, R1 had hulator surgically implanted cy and severity of her seizures. during waking hours for alling during her seizure bed rail for protection while of R1's seizure frequency for hat R1 had documented 4/13/09, 2 seizures on 4/14/09, seizures on 4/20/09, 4/21/09, 4/24/09.	W	149			

If continuation sheet Page 4 of 21

		I AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WIN	G			C 5/2009
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
BROAD	WAY TERRACE			-	BROADWAY HICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	they arrived back a way home from the called to say that the of the Attendance A 4/29/09 reflects E13 leaving at 11:04pm asleep in the van or get out of the van ti garage and found h E1 said that R1 way the van for 5 to 10 n asked who located it was E2. When as policy on checking after use, E1 said y that policy with E2 a asked if any progre written regarding the not know and would When asked if an in regarding R1 being stated no, since she minutes. When ask had been contacted she did not call E7, care staff had called In review of facility? Manual, Policy 6.13 the following: "The facility shall pol supervision in all ark key program times Purpose A) To pro care and supervisio accountability for al programming. STA Team Leader's Rol	t the home. E1 was on her outing when the house staff hey could not find R1. (Review Archive Time Card for E1 for arriving to work at 7:41pm and). E1 stated that R1 fell in the way home and did not Il staff came out to the locked her asleep in the locked van. is safe and was maybe left in minutes at the most. E1 was R1, and E1 said she thought sked if the agency had a the van for accountability res, and that she had reviewed after this incident. When is notes (P15's) had been is incident, E1 stated she did d have to look and see. investigation had occurred missing from the home, E1 e was only missing a few ked if E7, Executive Director d about this incident, E1 stated and was not sure if direct d her. is Policy and Procedure B Program, dated 6/2/88 states rovide appropriate care and reas of programming during vide residents with quality on. Purpose B) To insure staff	W 1	49			

Facility ID: IL6012959

If continuation sheet Page 5 of 21

		AND HUMAN SERVICES			FORM	: 11/03/2009 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY ETED
		14G269	B. WING			C 5/2009
NAME OF P	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	WAY TERRACE			43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 149	programmatic and a residents. The Tea responsible for the of the residents ass be responsible for of transporting progra same, daily. Team responsibility for the their working shift be with the resident is." In a follow-up interv 12:50pm when ask who attended the o to be responsible for policy, E1 stated sin together at the play particular individual R1 had no docume E1 did have a ticke confirmed that acco Archive Time Card of work at 11:04pm until E6 came into v E1 stated again sho to report that R1 wa 4/29//09. E6, Direct Service I 5/29/09 at 3:10pm. Archive Time Card to 10:58pm. E6 ren to the play, but E6 of the play or who ren E6 thought maybes home, and E6 pass those that remained	age 5 supervisory needs of the am Leaders shall be general supervision and care signed to their team, and also conducting activitiesand ms and documentation of the Leaders shall assume eir group of residents during that staff member shall either t or know where the resident view with E1 on 5/29/09 at ed if the staff (Team Leaders) buting had particular individuals or in accordance with agency nce everyone was seated v, staff were not assigned any ls to be responsible for. While ntation of attending the play, t stub for the evening. E1 ording to the Attendance for 4/29/09, E1 punched out a leaving E2 alone in the home work at 11:28pm to relieve her. e believed E2 had called her as missing from the home on Person was interviewed on According to her Attendance for 4/29/09 E6 worked 5:56pm mained home from the outing could not recall who went to nained at home that evening. 4-6 individuals remained sed the 8pm medications for d at home. When asked what urned from the trip, she stated	W 14			

Facility ID: IL6012959

If continuation sheet Page 6 of 21

	& MEDICAID SERVICES				FORM OMB NO.	11/03/2009 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COMPLE	TED
	14G269	B. WI	NG _			5 5/2009
ROVIDER OR SUPPLIER						
VAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE
she could not recall said since she was remain in the house member. In an interview with 2:40pm, she stated drove the van to the were 3 staff, 2 vehic many individuals of of the activity sheet document any indivi- evenings event, as giving them their m home from the outin "late", perhaps 10 of the van in the garag mileage but did not everyone was out of takes the individual usually would cheo E4 locked the van, garage door, while started giving medit the trip, including R pass may have take complete. E4 said 10:30pm, but since given, she left short medications. E4 sai maybe 3 to 5 minut the van and found Attendance Archive arrival to work at 2:: 10:45pm. In review of the Phy Medication Adminis	as it was a month ago. E6 working alone, she had to a till relieved by another staff E4, DSP on 5/29/09 at she worked on 4/29/09, and a play. She recalled there cles and was unsure how the home attended. In review s, E4 stated she did not riduals participating for the she was responsible for edications when they returned ng. She recalled getting home or 10:15pm. E4 said she put ge. She wrote down the check the van to insure of it. E4 stated the staff that s off the van, (DSP E2), ck to see that everyone is out. and said E2 locked the E4 came into the home and cations to those that went on 1. E4 said the medication en about 15 minutes to she usually leaves at the medications had to be thy after finishing giving the aid that "R1 was missing es tops", and E2 went out to R1 was asleep. E4's e Time Card for 4/29/09 notes 25pm and punching out at	W	149	9		
	RS FOR MEDICARE OF DEFICIENCIES PROVIDER OR SUPPLIER WAY TERRACE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pa she could not recall said since she was remain in the house member. In an interview with 2:40pm, she stated drove the van to the were 3 staff, 2 vehi many individuals of of the activity sheet document any individuals of of the van in the garag mileage but did not everyone was out of takes the individual usually would check E4 locked the van, garage door, while started giving medic the trip, including R pass may have take complete. E4 said 10:30pm, but since given, she left short medications. E4 said 10:30pm, but since given, she left short medications. E4 said 10:30pm, but since given, she left short medications. E4 said 10:45pm. In review of the Phy Medication Adminis	DF CORRECTION IDENTIFICATION NUMBER: IdENTIFICATION NUMBER: IdENTIFICATION NUMBER: IdENTIFICATION NUMBER: IdENTIFICATION NUMBER: VAY TERRACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 she could not recall as it was a month ago. E6 said since she was working alone, she had to remain in the house till relieved by another staff member. In an interview with E4, DSP on 5/29/09 at 2:40pm, she stated she worked on 4/29/09, and drove the van to the play. She recalled there were 3 staff, 2 vehicles and was unsure how many individuals of the home attended. In review of the activity sheets, E4 stated she did not document any individuals participating for the evenings event, as she was responsible for giving them their medications when they returned home from the outing. She recalled getting home "late", perhaps 10 or 10:15pm. E4 said she put the van in the garage. She wrote down the mileage but did not check the van to insure everyone was out of it. E4 stated the staff that takes the individuals off the van, (DSP E2), usually would check to see that everyone is out. E4 locked the van, and said E2 locked the garage door, while E4 came into the home and started giving medications to those that went on the trip, including R1. E4 said the medication pass may have taken about 15 minutes to complete. E4 said she usually leaves at 10:30pm, but since the medications had to be given, she left shortly after finishing giving the medications	RS FOR MEDICARE & MEDICAID SERVICES FOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) M A. BU IDENTIFICATION NUMBER: A. BU INTERACE INTERACE VAY TERRACE IDENTIFICATION NUMBER: Continued From page 6 she could not recall as it was a month ago. E6 said since she was working alone, she had to remain in the house till relieved by another staff member. W In an interview with E4, DSP on 5/29/09 at 2:40pm, she stated she worked on 4/29/09, and drove the van to the play. She recalled there were 3 staff, 2 vehicles and was unsure how many individuals of the home attended. In review of the activity sheets, E4 stated she did not document any individuals participating for the evenings event, as she was responsible for giving them their medications when they returned home from the outing. She recalled getting home "late", perhaps 10 or 10:15pm. E4 said she put the van in the garage. She wrote down the mileage but did not check the van to insure everyone was out of it. E4 stated the staff that takes the individuals off the van, (DSP E2), usually would check to see that everyone is out. E4 locked the van, and said E2 locked the garage door, while E4 came into the home and started giving medications to those that went on the trip, including R1. E4 said the medication pass may have taken about 15 minutes to complete. E4 said she usually leaves at 10:30pm, but since the medications had to be given, she left shortly after finishing giving the medications. E4 said that "R1 was missing maybe 3 to 5 minutes tops", and E2 went out to the van and found R1 was asleep. E4's Attendance Archive Time Card for 4/29/09 notes arrival to work at 2:25pm and punching out at 10:45pm.	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI B. WING. PROVIDER OR SUPPLIER 14G269 B. WING. VAY TERRACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED DY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 6 W 143 she could not recall as it was a month ago. E6 said since she was working alone, she had to remain in the house till relieved by another staff member. W 143 In an interview with E4, DSP on 5/29/09 at 2:40pm, she stated she worked on 4/29/09, and drove the van to the play. She recalled there were 3 staff, 2 vehicles and was unsure how many individuals of the home attended. In review of the activity sheets, E4 stated she did not document any individuals participating for the evenings event, as she was responsible for giving them their medications when they returned home from the outing. She recalled getting home "late", perhaps 10 or 10:15pm. E4 said she put the van in the garage. She wrote down the mileage but did not check the van to insure everyone was out of it. E4 stated the staff that takes the individuals off the van, (DSP E2), usually would check to see that everyone is out. E4 locked the van, and said E2 locked the garage door, while E4 came into the home and started giving medications to those that went on the trip, including R1. E4 said the medication pass may have taken about 15 minutes to complete. E4 said she usually leaves at 10:30pm, but since the medications had to be given, she left shortly after finishing giving the medications. E4 said that "R1 was missing maybe 3 to 5 minutes tops", and E2 went out to the van and found R	RS FOR MEDICARE & MEDICAID SERVICES COP DEFICIENCIES (M) PROVIDERSUPPLIERCLIA A BUILDING 1142269 ROVIDER OR SUPPLIER VAY TERRACE VAY TERRACE Summary Statement of DeFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYNON INFORMATION) Continued From page 6 she could not recall as it was a month ago. E6 said since she was working alone, she had to remain in the house III relieved by another staff member. In an interview with E4, DSP on 5/29/09 at 2:40pm, she stated she worked on 4/29/09, and drove the van to the play. She recalled there were 3 staff, 2 vehicles and was unsure how many individuals of the home attended. In review of the activity sheets, E4 stated she did not document any individuals participating for the evenings event, as she was responsible for giving them their medications when they returned home from the outing. She recalled getting home "late", perhaps 10 or 10:15pm. E4 stated she put the van in the garge. She wrole down the mileage but did not check the van to insure everyone was out of it. E4 stated the staff that takes the individuals of the van, (DSP E2), usually would check to see that everyone is out. E4 locked the van, and said E2 locked the givang head to 5 minutes tops", and E2 went out to the van and found R1 was asleep. E4's Attendance Archive Time Card for 4/20/90 notes arrival to work at 2:25pm and punching out at 10:45pm. In review of the Physician's Orders and Medication Administration Sheets for R1 for the	TMENT OF HEALTH AND HUMAN SERVICES FORM. SF OR MEDICARE & MEDICAID SERVICES OMB NO. TOP DEFICIENCIES (X1) PROVIDERSUPPLIER(LIA. DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 43 BRADAWY VAY TERRACE STREET ADDRESS, CITY, STATE, ZIP CODE 43 BRADAWY Continued From page 6 CROVERECTIVE AND OF CORRECTION CORRECTIVE AND OF CORRECTION REQUILATORY OR LSC IDENTIFIVING INFORMATION) D PREFIX CROVERECTIVE AND OF CORRECTION Continued From page 6 W 149 CROVERECTIVE AND OF CORRECTION (EACH CORRECTIVE AND OF CORRECTION AND AND OF CORRECTION AND

Facility ID: IL6012959

If continuation sheet Page 7 of 21

		AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SI COMPLE	JRVEY TED	
		14G269	B. WI	NG _		C 06/05/2009		
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE 43 BROADWAY			
BROAD	VAY TERRACE				CHICAGO HEIGHTS, IL 60411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 149	Carbamazepine 30 500mg. were signe on 4/29/09. The 9r 500 mg, and Hour of Lamotrigine 100 mg Divalproex Sod ER mg were signed as 4/29/09. It is doub and hour of sleep m the evening of 4/29 In an interview with E2 on 5/28/09 at 5: attended the outing attended and enjoy behaviors. She stat anyone to be lost, of E2 documented the on Form GP9 as "F each of the followin R6, R7, and R8. F attending the play of In a follow-up interva at 4:15pm, she stat E6 and QMRP, E1 (II:04pm), she was through the house when she left work she clocked out. Sh usually up on one s having seizures at saw R1 in her bed. E1 to tell her of R1 ¹ the evening of 4/29 E5 who came into y had found R1 aslee work. When asked	Omg at 4pm and Oyster Shell d as being given by DSP E4 om medications of Oyster Shell of Sleep medications of g., Clonazepam .5mg, 1000mg, and Risperidone .5 being given by DSP E6 on tful that R1 received the 9pm nedications as documented on /09. Direct Service Person (DSP), 10pm, she confirmed that she of 4/29/09, and knew R1 had red the outing without any ted she has never known or found in the van asleep. e community outing of 4/29/09 PlayEnjoyed2 hours" for ng individuals: R3, R4, R5, R1's GP9 does not reflect	W	149				

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		HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WII	NG _			C 5/2009
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	WAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 149		age 8 ome talking about it.	W	149	9		
	In observation of th 5/29/09, it is a singl windows in the buil and the door leadin The van was prese In an interview with she stated she wor into the home at 11 checked the home R1 was not in her perfectly made, and been in it at all that house calling R1's of the home withou medication log and marked as being gi then she called E1 home visit or some R1 had returned fro would call E2 and s E1 returned the phe and told E5 to go cl went outside calling calling her name th the van, calling for the last seat in the R1 was happy to se and went into the h as they exited the g person was coming home. R1 was tal vital signs and R1 s helped R1 get read had a bed check sh and located the she	he garage, at 4:30pm on le car garage, with no lding. Both the garage door, ng into the garage were locked.					

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		I AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		14G269	B. WI	NG _			C 5/2009
NAME OF F	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	•	
BROAD	VAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149 W 153	individuals of the he comment made by doing bed check, R anywhere else in th see about her when then found R1 on th 11:55." E5 was as opening up the van doubted that R1 wo assistance to dress mornings. In a phone interview at 2:20pm on 5/29/ aware anyone from any period of time i knows that staff did to the Activity Quar that reviews the ne individuals get off of not made aware that van until yesterday looking into the indi 483.420(d)(2) STAI CLIENTS The facility must er mistreatment, negle injuries of unknown immediately to the officials in accordar established proced This STANDARD i Based on interview failed to immediate to the Administrato	ome. The sheet has a E5 as follows: "at 11:40 while 1 was not in her bed or he facility. I notified RSD to reabouts. It was unknown. I he van locked in the garage at ked if R1 was capable of on her own, and E5 said she buld be able to, as she needs and undress herself in the w with E7, Executive Director 09, she was asked if she was in the home was missing for in the past. E7 stated she in ot do a van check according terly Policy 5.33 dated 11/08, ed to do a head count as of the van. E7 stated she was at R1 was found asleep in the buld be able to, as well as in source, are reported administrator or to other ince with State law through	W		9		7/5/09

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		I AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WI	IG			C 5/2009
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
BROAD	VAY TERRACE				3 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 153	one of one client (F facility after a comm	(1), found missing from the	W	153			
	dated 9/25/08 R1 i diagnoses that inclu Retardation, Tonic Seizures, Insertion R1 functions in the can ambulate indeg gait. R1 can verba but may be difficult always inform staff understand basic s Review of R1's seiz noted that R1 had of 4/13, 2 seizures on on 4/20, 4/21, 3 sei E1 stated in an inter that several individu participated in atter 4/29/09. E1 attend vehicle and taking to Staff members E2 a individuals in the fa attended the play w head count was do who went on the tri they returned to the E1 said she was or outing when the ho they could not find Archive Time Card arriving at the facilit 11:04pm). E1 state	Clonic and Partial Complex VNS Vagal Neuro Stimulator. 3 year, 5 month range. She bendently but has an unsteady lly communicate with others, to understand. She does not when she is sick, and cannot afety signs or safety issues. cure frequency for April, 2009 documented seizure activity on 4/14, 4/16, 4/17, 2 seizures					

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		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/03/2009 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WI	NG _			C 5/2009
NAME OF PROVIDER OR SUPPL	IER				REET ADDRESS, CITY, STATE, ZIP CODE		
BROADWAY TERRACE					I3 BROADWAY CHICAGO HEIGHTS, IL 60411		
PREFIX (EACH DEFICI	ENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
found her aslee R1 was safe ar minutes at the R1, and E1 sa asked if the age van for accour that she had re this incident. V (P15's) had be E1 stated she c look and see. had occurred re the home, E1 s missing a few r Executive Direc Public Health ((this incident, E was not sure if In a phone inte at 2:20pm on 5 aware anyone any period of ti knows that staff to the Activity C need to do a he the van. E7 sta R1 was found a	ne c ep ir nd m mos id sl ency tabi view Vhen did r Wh egan tate ninu ctor IDPI 1 st dire view Vhen tate ninu ctor IDPI 1 st dire view Vhen tabi view Vhen tabi view Vhen tabi view Vhen tabi view Vhen tabi tabi view Vhen tabi tabi view Vhen tabi tabi view Vhen tabi tabi view Vhen tabi tabi view Vhen tabi tabi tabi tabi tabi tabi tabi tabi	but to the locked garage and in the locked van. E1 said that haybe left in the van for 5 to 10 st. E1 was asked who located he thought it was E2. When y had a policy on checking the ility after use, E1 said yes, and wed that policy with E2 after in asked if any progress notes written regarding this incident, not know and would have to en asked if an investigation rding R1 being missing from ed no, since she was only utes. When asked if E7, or the Illinois Department of H) had been contacted about tated she did not notify E7. E1 ect care staff had called E7. w with E7, Executive Director (09, she was asked if she was in the home was missing for in the past. E7 stated she d not do a van check according rterly Policy that reviews the count as individuals get off of she was not made aware that ep in the van until yesterday, he is now looking into the port it to IDPH. TIONS		999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/03/2009 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G269	B. WII	NG	i		C 5/2009
NAME OF P	ROVIDER OR SUPPLIER			ST	STREET ADDRESS, CITY, STATE, ZIP CODE 43 BROADWAY		
BROADV	VAY TERRACE				CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa 350.3240d)	ge 12	W9	99	99		
	Section 350.620 Re	esident Care Policies					
	procedures governi the facility which sh involvement of the a shall be available to public. These writte	have written policies and ng all services provided by all be formulated with the administrator. The policies o the staff, residents and the en policies shall be followed in y and shall be reviewed at					
	Section 350.3240 A	buse and Neglect					
		ee, administrator, employee shall not abuse or neglect a -107 of the Act)					
	aware of abuse or r immediately report	ee or agent who becomes neglect of a resident shall the matter to the facility tion 3-610 of the Act)					
	who becomes awar resident shall also r	trator, employee, or agent e of abuse or neglect of a report the matter to the on 3-610 of the Act)					
	These Regulations by:	were not met as evidenced					
	failed to ensure inc neglect when the fa 1) ensure appropria maintained for one missing from the fac						

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		I AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WI	NG _			C 5/2009
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BROAD	VAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	the home, that the individual of the incide 3) ensure the incide Illinois Department Findings include: In review of the fac Manual, Policy 5.24 Committee dated ("Neglect: "Failure to necessary to avoid anguish, or mental "Procedure A) Any who witnesses or s rights, abuse or neg unknown source sh matter to facility ma protocol: 1. In order for the i reported the emplo directly to one of th Administrator, Exec Operations. 2. The employee of incident on a Progr to leaving the shift. In review of the And dated 9/25/08, R1 diagnoses that incle Retardation, Tonic Seizures, Insertion R1 functions in the adaptive behaviors dressing and perso her right hand when ambulate independ	Administrator was immediately ent. ent was timely reported to the of Public Health. ility's Policy and Procedure Administration Investigative 06/17/03 states the following: to provide goods and services physical harm, mental illness." facility employee or agent uspects a violation of resident glect as well as injuries of hall immediately report the anagement using the following ncident to be considered yee or agent must speak e following managers: cutive Director, Director of r agent will document the ess Note (Form #GP-15) prior ' hual Individual Service Plan is a 42 year old female with	W9	999			

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		HAND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WI	NG _			C 5/2009
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	WAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	but may be difficult always inform staff understand basic s She has a behavior address kicking, bit throwing objects, st excessive sleeping a Vagal Neuro Stim due to the frequence R1 wears a helmet protection due to fa activity. R1 has a b sleeping. Review of April, 2009 noted th seizure activity on 4 4/16/09, 4/17/09, 2 and 3 seizures on 4 In interview with E1 Professional(QMRF stated that the hom abuse, neglect or n month period and n occurred during the E1 stated at 5:35pr individuals of the he attending a commu attended the play of taking three individ Persons (DSP) E2 individuals in the fa attended the play w head count was do who went on the tri they returned to the E1 said she could n they arrived back a	to understand. She does not when she is sick, and cannot afety signs or safety issues. r development program to ting, property destruction, tealing, non compliance and . In January, 2008, R1 had nulator surgically implanted cy and severity of her seizures. during waking hours for alling during her seizure bed rail for protection while of R1's seizure frequency for hat R1 had documented 4/13/09, 2 seizures on 4/14/09, seizures on 4/20/09, 4/21/09, 4/24/09.	W9	999			

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		HAND HUMAN SERVICES				FORM	: 11/03/2009 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	ETED
		14G269	B. WI	NG _			C 5/2009
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	WAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	called to say that the of the Attendance A 4/29/09 reflects E13 leaving at 11:04pm asleep in the van o get out of the van ti garage and found h E1 said that R1 wa the van for 5 to 10 asked who located it was E2. When as policy on checking after use, E1 said y that policy with E2 asked if any progree written regarding the not know and would When asked if an i regarding R1 being stated no, since she minutes. When ask had been contacted she did not call E7, care staff had calle In review of facility! Manual, Policy 6.13 the following: "The facility shall policy accountability for al programming. STA Team Leader's Rol be ultimately respo- programmatic and supervision	hey could not find R1. (Review Archive Time Card for E1 for arriving to work at 7:41pm and b). E1 stated that R1 fell in the way home and did not ill staff came out to the locked her asleep in the locked van. is safe and was maybe left in minutes at the most. E1 was R1, and E1 said she thought sked if the agency had a the van for accountability ves, and that she had reviewed after this incident. When ess notes (P15's) had been his incident, E1 stated she did d have to look and see. investigation had occurred g missing from the home, E1 e was only missing a few ked if E7, Executive Director d about this incident, E1 stated , and was not sure if direct d her. is Policy and Procedure 3 Program, dated 6/2/88 states rovide appropriate care and reas of programming during s. voide residents with quality on. Purpose B) To insure staff	W9	999			

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		AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G269	B. WI	۱G			C 5/2009
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 43 BROADWAY		
BROAD	VAY TERRACE				CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	of the residents ass be responsible for of transporting progra same, daily. Team responsibility for th their working shift be with the residen is." In a follow-up interv 12:50pm when ask who attended the of to be responsible for policy, E1 stated si together at the play particular individua R1 had no docume E1 did have a ticke confirmed that acco Archive Time Card of work at 11:04pm until E6 came into v E1 stated again sho to report that R1 wa 4/29//09. E6, Direct Service I 5/29/09 at 3:10pm. Archive Time Card to 10:58pm. E6 rep to the play, but E6 the play or who rep E6 thought maybe home, and E6 pass those that remained time the others returned to the card to the card to the card to the card to the card to the card to the card to the card to the card to the card to the play or who rep E6 thought maybe	age 16 general supervision and care signed to their team, and also conducting activitiesand ms and documentation of the Leaders shall assume eir group of residents during that staff member shall either t or know where the resident view with E1 on 5/29/09 at ed if the staff (Team Leaders) uting had particular individuals or in accordance with agency nce everyone was seated v, staff were not assigned any ls to be responsible for. While ntation of attending the play, t stub for the evening. E1 ording to the Attendance for 4/29/09, E1 punched out leaving E2 alone in the home work at 11:28pm to relieve her. e believed E2 had called her as missing from the home on Person was interviewed on According to her Attendance for 4/29/09 E6 worked 5:56pm mained home from the outing could not recall who went to hained at home that evening. 4-6 individuals remained sed the 8pm medications for d at home. When asked what irned from the trip, she stated I as it was a month ago. E6 working alone, she had to	W9	999			

		AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G269	B. WI	NG .			_ 5/2009
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BROADV	VAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	member. In an interview with 2:40pm, she stated drove the van to the were 3 staff, 2 vehi many individuals of of the activity sheet document any indivi- evenings event, as giving them their m home from the outin "late", perhaps 10 of the van in the garag mileage but did not everyone was out of takes the individual usually would cheo E4 locked the van, garage door, while	E4, DSP on 5/29/09 at she worked on 4/29/09, and e play. She recalled there cles and was unsure how the home attended. In review s, E4 stated she did not riduals participating for the she was responsible for edications when they returned ng. She recalled getting home or 10:15pm. E4 said she put ge. She wrote down the check the van to insure of it. E4 stated the staff that s off the van, (DSP E2), ck to see that everyone is out. and said E2 locked the E4 came into the home and	W9	99:			
	the trip, including R pass may have take complete. E4 said 10:30pm, but since given, she left short medications. E4 sa maybe 3 to 5 minut the van and found Attendance Archive arrival to work at 2: 10:45pm. In review of the Phy Medication Adminis month of April, 2009 Carbamazepine 30	cations to those that went on 1. E4 said the medication en about 15 minutes to she usually leaves at the medications had to be thy after finishing giving the aid that "R1 was missing es tops", and E2 went out to R1 was asleep. E4's e Time Card for 4/29/09 notes 25pm and punching out at vsician's Orders and stration Sheets for R1 for the 9, R1's medications of Omg at 4pm and Oyster Shell d as being given by DSP E4					

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		I AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G269	B. WI	NG _			C 5/2009
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BROAD	VAY TERRACE				CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	500 mg, and Hour of Lamotrigine 100 mg Divalproex Sod ER mg were signed as 4/29/09. It is doubt and hour of sleep n the evening of 4/29 In an interview with E2 on 5/28/09 at 5: attended the outing attended and enjoy behaviors. She sta anyone to be lost, of E2 documented the on Form GP9 as "F each of the followin R6, R7, and R8. F attending the play of In a follow-up interva at 4:15pm, she stat E6 and QMRP, E1 (II:04pm), she was through the house a when she left work she clocked out. Sh usually up on one s having seizures at saw R1 in her bed. E1 to tell her of R1 ¹ the evening of 4/29 E5 who came into v had found R1 aslee work. When asked found in the van as	om medications of Oyster Shell of Sleep medications of g., Clonazepam .5mg, 1000mg, and Risperidone .5 being given by DSP E6 on ful that R1 received the 9pm nedications as documented on /09. Direct Service Person (DSP), 10pm, she confirmed that she of 4/29/09, and knew R1 had red the outing without any ted she has never known or found in the van asleep. e community outing of 4/29/09 PlayEnjoyed2 hours" for ng individuals: R3, R4, R5, R1's GP9 does not reflect	W9	999			

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G269	B. WI	NG	;		C 5/2009
NAME OF P	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
BROAD	WAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	In observation of th 5/29/09, it is a singl windows in the built and the door leadin The van was prese In an interview with she stated she wor into the home at 11 checked the home R1 was not in her I perfectly made, and been in it at all that house calling R1's of the home withou medication log and marked as being gi then she called E1 home visit or some R1 had returned fro would call E2 and s E1 returned the pho and told E5 to go cl went outside calling calling her name th the van, calling for the last seat in the R1 was happy to se and went into the h as they exited the g person was coming home. R1 was tal vital signs and R1 s helped R1 get read had a bed check sh and located the she Bed Check GP-83 i individuals of the home	e garage, at 4:30pm on le car garage, with no ding. Both the garage door, ig into the garage were locked.	W9	99:	29		

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		AND HUMAN SERVICES				FORM	11/03/2009 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SU COMPLE	TED
		14G269	B. WII	NG	i		C 5/2009
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BROAD	VAY TERRACE				43 BROADWAY CHICAGO HEIGHTS, IL 60411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	anywhere else in the see about her when then found R1 on the 11:55." E5 was as opening up the van doubted that R1 wo assistance to dress mornings. In a phone interview at 2:20pm on 5/29/ aware anyone from any period of time is knows that staff did to the Activity Quar that reviews the ne individuals get off of not made aware that	At was not in her bed or ne facility. I notified RSD to reabouts. It was unknown. I he van locked in the garage at ked if R1 was capable of non her own, and E5 said she buld be able to, as she needs as and undress herself in the w with E7, Executive Director 09, she was asked if she was in the home was missing for in the past. E7 stated she d not do a van check according terly Policy 5.33 dated 11/08, ed to do a head count as of the van. E7 stated she was at R1 was found asleep in the , 5/28/09, and that she is now	W9	99	29		

Facility ID: IL6012959