STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE	CONSTRUCTION	(X3) DATE S COMPLE	
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:		LDING			ľ
		14G169	B. WI			11/1	9/2010
	ROVIDER OR SUPPLIER			1705	ADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE RIN, IL 62948		
INDEPEN				HEK	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
W 370	Continued From pa	age 51	W	370			
	office/home address agencies that she Nurse Consultant f	ith E1 on 10/20/10 at 1:45 p.m.,		: i			
	E1 said that he wa Registered Nunce of coverage from 10/ 10/18/10 at 7:00 a.	s not aware that there been no scoverage or medication pass 15/10 at 5:00 p.m. until		İ			
	Section 116.40 Tra Non-Licensed State documentation state may delegate and	oint committee on es: Administrative Code pining and Authorization of f by Nurse-Trainers, tes "a) Only a nurse-trainer supervise the task of stration to direct care staff."		:			
W9999	Nurse is employed	o ensure that a Registered I and provides training, pervision over direct care staff ns. TIONS	√ W§	999			
	LICENSURE VIOL	ATIONS					
	350.620a) 350.3300y)						
	Section 350.620 R	Resident Care Policies		İ		•	
	procedures govern facility which shall involvement of the shall be available public. These writt	I have written policies and ning all services provided by the be formulated with the administrator. The policies to the staff, residents and the ten policies shall be followed in ity and shall be reviewed at					

		& MEDICAID SERVICES	(X2) M	IUL 1	TIPLE CONSTRUCTION	(X3) DATE S	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI			COMPL	C
		14G169	B. WIN				19/2010
	ROVIDER OR SUPPLIER			ļ	TREET ADDRESS, CITY, STATE, ZIP CO 1705 SOUTH PARK AVENUE	DE	
INDEPEN	DENCE PLACE				PROVIDER'S PLAN OF COF	RECTION	(X5)
(X4) ID PREFIX TAG	CACU DESICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION
W9999	Continued From pa	age 52	W9	99	9		
	least annually.	į					;
!	Section 350.3300	Transfer or Discharge			•		
	shall give 90 days closing a facility or prior to closing any part will require the than ten percent of shall be given to the who must be transfer resident's represent resident's family, where the proposed for closing. The faresident in securing shall advise the rewident alternate placemed guardianship, the the need for relocations until the those related to the The Department of this Section. (Sections of the shall comply with the facility as proving this Section. (Sections of the shall section of the section	racility licensed under this Act notice prior to voluntarily closing any part of a facility, or a part of a facility if closing such a transfer or discharge of more of the residents. Such notice the Department, to any resident of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and to a member of the entative, and the reason cility shall offer to assist the entative placement and sident on available alternatives. In an antifer of closing, including an ansfer or discharge of residents, may place a relocation team in entitled under subsection (u) of tion 3-423 of the Act)					
	by:	s were not met as evidenced					
	review the facility 90-day notice of or residents that the reside is closing a cictor facility, 2) fa	ation, interviews and record 1) failed to provide the required closing when they informed the home in which they currently and they would be moving to a ailed to incorporate guardians decision to transfer the residents					

(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
IDENTIFICATION NUMBER:	A. BUILDING		С	
14G169	B. WING		11/19/2010	\dashv
	170	5 SOUTH PARK AVENUE		
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	OULD BE COMPLETE	
parding the potential closure or ted that he has tried to contact ral times and left messages but	W9999			
his calls. Z1 stated that R4 was				
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 53 , and failed to involve as and families in choosing an ent when the decision was facility, and 3) failed to follow moving/discharging a resident. residents in the facility (R1 e facility's face sheet (no date), and Retardation. R4 has include: Agitation, Anger, inittent Explosive Disorder, alsive Disorder, Impulse Control chosis. Documentation states the dothis facility 04/03/02 and serves as his legal guardian. the facility on 10/19/10 at 10:50 served Z1 (R4's an) loading a mattress and box the achest of drawers, a night and personal items belonging sk the bed apart and loaded it with Z1 on 10/19/10 at 11:45 eyor that he had gotten a call training site on Friday evening ang him that there was a rumor as closing. Z1 said that neither agarding the potential closure of	A BUILDING 14G169 STREET 170 HE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) TAG TAG TAG W9999 W999 W9999 W999 W9999 W999 W9999 W999 (X2) MULTIPLE CONSTRUCTION A BUILDING 14G169 TREMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 53 and failed to involve so and families in choosing an ent when the decision was facility, and 3) failed to follow moving/discharging a resident. residents in the facility (R1 e facility's face sheet (no date), I male who functions at a intal Retardation. R4 has notube. Agitation, Anger, nittent Explosive Disorder, Impulse Control thosis. Documentation states ted to this facility 04/03/02 and terves as his legal guardian. the facility on 10/19/10 at 10:50 served Z1 (R4's). With Z1 on 10/19/10 at 11:45 eyor that he had gotten a call training site on Friday evening ing him that there was a rumor as closing. Z1 said that neither acility nor the Administrator has parding the potential closure of ted that he hast tried to contact alt times and left messages but	A BUILDING STREET ADDRESS. CITY. STATE. ZIP CODE 17/19/2010	

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		ILDING			C
	14G169	B W	NG		11/1	9/2010
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE PLACE			1705	T ADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE RRIN, IL 62948		
			I III	PROVIDER'S PLAN OF CORRE	CTION	(X5)
(CACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLÉTION DATE
W9999 Continued From page 1	age 54	W9	999			
going to live with h	is mother at this time, but that					<u> </u>
she really could no	ot handle him with his					
behaviors. Z1 said	, "We can't leave him here and					
nobody will tell us	what's going on.					!
B. Unon review of	the facility's face sheet, R1 is a		:			
34 year old female	who functions at a Mild level of [1
Mental Retardation	n. Other diagnoses include:					
Hallucinations, Imi	pulsive Behavior, Major		ļ			!
depressive Disord	er and Impulse Control		:			
Disorder, Docume	ntation states that R1 was cility 02/11/02. R1 serves as her		ĺ			
own quardian but	has family contact listed on the					
face sheet.	,		İ			
	10/45/40 -4		ı			
Per interview with	Z2 (R1's sister) on 10/15/10 at		Ì			
4:00 p.m., Z2 state	ed that R1 called her 10/15/10 3:30 p.m., and told her that she		:			
had just went to a	Halloween Party at a sister					
I facility in another t	town, Z2 reported that R1		İ			
informed her that	the facility (where R1 currently		į			
resides) was closi	ng Monday (10/18/10). R1					
continued to say t	hat all the residents that live in		į			İ
this facility were b	eing kept home from workshop being moved into the sister					
facility at that time	e.		j			
	i					 -
During continuing	interview with Z2 on 10/15/10 at					
4:00 p.m., Z2 also	stated that none of the		ļ •			!
guardians or rami	lies of the other residents living been informed of the facility		į			
closing Z2 stated	that R1 was really upset over					
the news that she	had to move. Z2 said, "Her		į į			
(R1's) family is he	ere close to her. She is her own					
guardian and doe	s not want to move out of the		l i			
area, but she was	in't given an option." Z2 stated					!
that she was goin	g to the facility to take R1 home nate placement could be found.		!			
72 continued to s	ay that this really put her in a		j			
			i			

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIPLE	CONSTRUCTION	(X3) DATE S COMPLI	
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	1	LDING			С
		14G169	B WII			11/1	9/2010
	ROVIDER OR SUPPLIER			1705	T ADDRESS, CITY, STATE, ZIP CODE		
INDEPE	NDENCE PLACE			HER	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
W9999	Continued From pa	age 55	W9	999			:
	bind because she l	nad just started a new job and to take time off work to watch anot be left by herself.		:			
	R1 told surveyor the R4 were taken to a facility in another to say, "When we can be was moving us facility is located) a facility. I didn't was where sister facility close to my mome a town where R1 curl R1 continued to say wanted to move, he moving us." R1 say residents that he was sister facility took to showed them their	ly, "(E1) didn't ask us if we e just told us that he was id that after E1 informed the was moving them, staff at the he residents inside and new rooms and introduced					
	them to their new upset me, I didn't where sister facility R1 also said that won 10/15/10, she of that they (the facility (name of town who close (current facility is located). When asked if E1 moving, R1 said, "Sunday I can't rea	roommates. R1 stated, "It really want to live at (name of town					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING		С	
		14G169	B. WII	NG	11/	19/2010	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1705 SOUTH PARK AVENUE HERRIN, IL 62948	ODE		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETION DATE	
W9999	Continued From pa	ge 56	W9	999			
	C. Upon review of to date), R2 is a 67 ye Moderate level of Madmitted to this facthis own guardian be listed on the facility. Per interview with FR2 told surveyor the (name of town whe continued to tell survive his current workshochurch here. D. Upon review of the date), R3 is a 77 ye Moderate level of Madmitted to this facthis own guardian. Chronic Anxiety. During review of R3 dated 01/20/10, R3 Per interview with FR3 said, "Want to Inow resides) - don' where sister facility (name of town where to	the facility's face sheet (no ear old male who functions at a Mental Retardation who was ility on 04/20/88. R2 serves as ut does have family contact					

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE	CONSTRUCTION	(X3) DATE S	1
AND PLAN O	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1	ILDING		COMPLE	
		14G169	B. WI	NG		1	C 9/2010
	201200000000000000000000000000000000000	140105		STREET	T ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			1705	SOUTH PARK AVENUE		
		TO DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
W9999	Continued From pa	nge 57	W9	999			
	Per interview with 2 at 2:20 p.m., Z3 sta of the facility closin when "someone from that they were closing they were closed they were closed they were closed they were closed they were closed	23 (R5's guardian) on 10/28/10 ated that she was not notified g until 10/19/10 or 10/20/10 om the home" called and saiding R5 another home because his one. Z3 said that the facility d her sooner of the potential		:			
	(IPP) dated 07/21/ who functions at a Retardation. R6 wa 07/17/98. R6 functions	R6's Individual Program Plan 10, R6 is a 33 year old male Moderate level of Mental as admitted to this facility on ions as his own guardian, but ontact listed on the facility face		:			
	R6 said, "Don't wan to be with (R7) her said I have to move uncle) and he said going to - don't like	R6 on 10/19/10 at 4:45 p.m., and to move, I like it here. Want mom came and got her. (E1) e. Called Uncle (name of I didn't have to move - Not it there (sister facility of 6 currently resides).					
	date), R7 is a 46 year a Moderate level or admitted to this fac	the facility's face sheet (no ear old female who functions at f Mental Retardation. R7 was cility 06/25/08. R7 functions as but does have family contact					
	10/29/10 at 2:10 p. member who work 10/15/10 and told t closing 10/18/10 a move R7, Z4 conti	Z4 (R7's sister-in-law) on m., Z4 stated that a family ed at the facility called her on hem that the facility was not that they (the family) need to nued to say that she and her he facility 10/17/10 and brought					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING		441	C
		14G169	B. VVII		OTATE ZIR CODE		19/2010
NAME OF PR	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH PARK AVENUE	•	
INDEPEN	DENCE PLACE			HE	RRIN, IL 62948	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION
W9999	Continued From pa	age 58	W9	999			
	R7 home with then could be found. Z4 given notice that the	n until alternative placement stated that the family was not se facility was closing other mber contacting them on		:			
	10/19/10 at 2:00 p. acting as Administ Director at this fac September 2010 w maternity leave. Et (Owner of facility) Practical Nurse) to workshop on 10/15 sister facility) for a said that the reside	dential Service Director) on .m., E2 said she has been rator and Residential Service ility since the first of while E3 (Administrator) is on 2 stated that on 10/14/10 E1 informed her and E4 (Licensed been the residents home from 510 and bring them to (name of Halloween party 10/15/10. E2 ents were kept home from 0 and taken to the Halloween					
	Halloween party) Expation area and told because he had no closing (name of cotold me to give worthey (the residents (10/18/10), that (no probably close on would be moving said that R7 starte boyfriend) console and R7 that they could be moving said that R7 starte boyfriend) console and R7 that they could be moving said that R7 starte boyfriend) console and R7 that they could be moving and R7 th						
	Per interview with	E4 (Licensed Practical Nurse)	İ	ļ			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIPLE C	CONSTRUCTION	(X3) DATE S	
ND PLAN O	F CORRECTION	IDENTIFICATION NOWIBER.	A BU	LDING			С
		14G169	B. WI	1G		11/	19/2010
	ROVIDER OR SUPPLIER			1705 S	ADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE RIN, IL 62948		
				TIE!	PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
W9999	Continued From pa		W9	999			
	(Owner of facility) I Tuesday of last we planning a Hallower Friday (10/15/10) at town. E4 said E1 towork places and ke E4 stated that she the party and he to go, that he wanted was the only reside facility on 10/15/10 E4 continued to sa sister facility, E1 to getting paid by the eyeballs and that he (name of current fasked E1 when he current facility) downers.	y that while they were at the old E2 and E4 that he was not state, that he was up to his the was going to have to shut acility) down. E4 said that she would be shutting (name of why I brought everyone up					
	intention of closing and E4, they all we where the resident residents that he he E4 said that E1 the was going to shut E4 said that E1 stand see this build here." E4 said that and began crying to crying."	r E1 had announced his (name of current facility) to E2 ent to the back of the facility is were. E4 said that E1 told the ad an announcement to make. En told the residents that he down (name of current facility). Ated, "I wanted you to come uping, I want to move you all uping at that time R7 got really upset E4 said, "It was pitiful, got me					
	the sister facility ca	ame over to R7 and said, "Let room and meet your					

	S FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY .ETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER		ILDING			C
		14G169	B. WI			11/	19/2010
	ROVIDER OR SUPPLIER			1705	FADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE RIN, IL 62948		
HADEL CIT				ــــــــــــــــــــــــــــــــــــــ	PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI	FIX	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
W9999	Continued From pa	age 60	WS	999			
	roommate." E4 sai	d she went with R7 and the					
	direct support pers	son. E4 said that the direct					· .
	support person too	k R7 into a room and identified :					:
	it as R7's new roor	m. A resident who was also in		:			i
	the room told R7,	'You're going to be my					;
	roommate."						:
	E4 sold that R7 wa	as tearful on and off all the way		:			j
	hack to the current	t facility and that R6 was almost					1
	in tears because h	ie was afraid that he and Ki					
	would be split up.	E4 continued to say that when		!			i.
	they got back to th	ie current facility. E1 gave E2, 📑		i			1
	: "\$98,00 and some	change" and told her buy food		!			<u> </u>
	to last until Monda	y (10/18/10).					
		ay that she had stopped by the		:			! '
	facility 10/17/10 to	check on the residents		İ			
[hacause they had	been so upset on Friday and					
	R6 told her. "I talk	ed to my uncle (name of uncle).					
	I don't have to mo	ve to (name of town where		!			
	Leister facility is loc	ated). I don't want to move to		İ			
	(name of town wh	ere sister facility is located)."		:			
		E4 on 10/20/10 at 1:40 n m					
	Per interview with	E4 on 10/20/10 at 1:40 p.m., came to the facility 10/18/10		i			!
	approximately 10	00 a.m. and said that he had					
	hought a few extra	a days. E4 said that E1 gave her		İ			!
	a check and told h	ner buy enough food to last	!				
	through Friday.			İ			:
ļ			!				
	During interview w	vith E3 (Administrator) on		i			1
	10/19/10 at 3:45 p	o.m., E3 said that she has been by September 2010 for maternity					
ļ	off work since ear	hat on 10/15/10 at	į				
1	approximately 2:0	00 p.m., she (E3) had called E1	i :				į !
	to let him know th	at she would be able to return to	İ	İ			į
	work 10/25/10 E3	3 said that E1 then told her that	!	ļ			i i
	he had had news.	that he had taken the residents	!	1			
	to (name of town	where sister facility is located)	1	İ			

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CONSTRUCTION		SURVEY
IND PLAN C	OF CORRECTION	14G169	A BU	ILDING	11	C /19/2010
	ROVIDER OR SUPPLIER	140103	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C 1705 SOUTH PARK AVENUE HERRIN, IL 62948		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W9999	current facility) and (name of town whe (name of	he was closing (name of was going to move them to be sister facility is located). iew, E3 said that E1 told her ag on having the residents over the weekend and would be onday (10/18/10) and that he are down later to get the rest of "He said something about but not their furniture because it ing." E3 said that when she eed to be notified he said, "No ast day of work will be y that E4 had called her the weekend letting her know is really upset regarding the that R1's sister had taken R1 said that she contacted her ined a release to return to work if, "The way I understood it weekend was their last they would be moving to be re sister facility is located). E1 also stated, "The client's on of where to go live, they were going to live at (name of acility is located)." facility's policy for "Admission, be" (no date), documentation illity plans a non-emergency int, the Administrator or resentative shall notify the days prior to the transfer in that least a tentative target	W9	999		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1	MULTIPLE CONSTRUCTION	(X3) DATE COMP	
AND PLAN C	P CORRECTION		B WI	ILDING	44	C
NAME OF P	ROVIDER OR SUPPLIER	14G169		STREET ADDRESS, CITY, STATE, ZIP (19/2010
	IDENCE PLACE			1705 SOUTH PARK AVENUE HERRIN, IL 62948		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	EACH CORRECTIVE ACTION	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W9999	Continued From pa	age 62	W9	999		
	Discharge" policy (states, "It is the poland implement discresidents. The facil residents are givento the least restrict. The facility's "Disch Discharge" policy of specific discharge maximum growth puthe residents shall. A) The specific factor be moved to and B) The specific are addressed prior to (1) Transportati (2) Orientation to (3) The actual modern (4) Planned me facility/environment facility/env	parge Planning/Actual continues to state, "The plan is a component of the potential plan and the desires of be considered and include: ility or setting the individual will eas which need to be the move, such as: on needs on the new setting moving date etings with the receiving to onment diship considerations vidual's discharge, the facility proming change with the ner family, guardian or plan shall be submitted for propriate state agency prior to ge to another facility involving care"				
	Upon review of the each individual res	facility's contract between ident and the facility (no date),		i		:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN O	FCORRECTION		A BU	ILDING NG			C 1 9/2010
	ROVIDER OR SUPPLIER	14G169	<u>.l</u>	1705	T ADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE RRIN, IL 62948	1	372010
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	and transfer or discindividual shall reconotice" During review of the policy (within each date), documentating the right to continual transferred or discing reasons, or for his patients, or for non (except as prohibits Social Security Actoreasonable notice discharge, such actor her medical reconstruction of the such transfer or discing transfer or discingular town where sister thalloween party. It closing (name of fareside), but didn't ket to close. I haven't cleaving. I guess I siguardians first." William close this facility, issues with money	tes, "If there is a termination charge by the home, the eive at least a 21 day written e facility's "Resident Rights" resident's medical record) (no on states, "Each resident has ity of care and may be harged only for medical or her welfare or that of other payment for his or her stay ed by Titles XVIII or XIX of the), and must be given to ensure orderly transfer or tions to be documented in his ord; and be given an need for and alternatives to	W9	999			
	ļ.	; i		-	-		i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IUL TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER	1	LDING		С		
		14G169	B. WI			11/19	9/2010	
	ROVIDER OR SUPPLIER			1705	T ADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE			
INDEPEN	IDENCE PLACE			HER	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE	
W9999	Continued From pa	age 64	W9	999			:	
	350.620a)	•						
	350.3750						-	
	350.3760k)	:		!				
	' 350.3760I)	:		!				
	Section 350.620 R	esident Care Policies		į				
	: -) The facility chall	have written policies and						
	a) The facility strain	ning all services provided by the						
	facility which shall	be formulated with the		ļ				
	involvement of the	administrator. The policies		:				
	shall be available to the staff, residents and the			Ì				
	public. These written	en policies shall be followed in						
	operating the facili	ty and shall be reviewed at						
	least annually.						 - -	
	0-4 250 2750	Consultation Services and					: I	
	Nursing Services	Consultation oci vices and						
	Residents needing	nursing care shall be admitted		}			: 	
	to an ICF/DD of 16	Beds or Less only if the facility		j				
	i has adequate prof	essional nursing services to					!	
	meet the resident's	s needs.Arrangements snall be 🖡					j	
	made through forn	nal contract for the services of		İ				
	a licensed nurse to	o visit as required. A						
	responsible staff n	nember shall be on duty at all					Ì	
	times who is imme	ediately accessible, and to						
	whom residents ca	an report injuries, symptoms of					!	
	Illiness, and emerg	pencies (see Section consultant nurse shall provide		:			İ	
	350.810(a)). The C	e health aspects of the		ļ				
	individual plan of c	care and shall be in the facility					ļ	
	not less than two	nours per month.		į			i	
	HOLIESS MAIN WO			į				
	Section 350.3760	Medication Policies					! 	
	k) All medications	taken by residents in this type		:			!	
	of facility must be	administered by a nurse or						
	physician licensed	I to practice in Illinois unless the		i :			<u> </u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		E CONSTRUCTION	COMPLETED	
		14G169	в wi	NG		ì	9/2010
	NAME OF PROVIDER OR SUPPLIER INDEPENDENCE PLACE			1705	T ADDRESS, CITY, STATE, ZIP CODE S SOUTH PARK AVENUE RRIN, IL 62948		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX.	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	Facility staff shall residents unless the licensed nurse or proceed in the licensed nurse or procedure in the licensed nurse or procedure in the licensed nurse of the licensed direct trained and author adm. Code 116 (A Community Setting) These Regulations by: Based on interview failed to ensure the administer medical law for 7 of 7 resides when they 1) failed Registered Nurse Support Person at 2) failed to ensure perform the duties. Findings Include: During interview with the consultant/R.N.) of stated that E1 (Ow contractual fees to that she has submonthly, and has E1 but that E1 has E5 said that she fill her R.N. coverage 5:00 p.m	administered by the resident. not administer medication to ne staff person is a properly physician. be administered by the care staff who have been rized in accordance with 59 III.	W9	999			
	Clared that our in			<u> </u>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			LUING		С	
	14G169	B. WIN	IG		11/	19/2010
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE PLACE			1705	T ADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE RIN, IL 62948		
(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
supposed to do in that nursing assess the facility. E5 said the facility or go after E1 told he E5 continued to satold me I couldn't go in to I couldn't go in to I couldn't go in to I E5 said that she cor first of September was supposed to at the facility. E5 swould get back to E5 also said that shome/office on 09 speak to E1 about facility. During review of the home/office on 09 documentation startiday and left him gotten back in tou previously on 8-25 that he would get has not" "I do not him" " I feel the getting larger with listed below" " (Direct Support Po	regards to not being paid and sments/functions were due at it that E1 told her not to go in ed that she was scheduled to no8/13/10, but that she did not ir not to. ay, "I worried a lot when (E1) go in the facility, what if need to them (the residents) and nelp them." alled E1, "At the end of August ber" and asked him what she do in regards to her R.N. duties haid that E1 told her that he her, but that he never did. she sent an e-mail to E1's /05/10 regarding the need to compliance issues at the need to che with me. I spoke with him is 10 and at that time he stated back with me, as of today he ed to discuss some issues with at the compliance issues are the facilities for nursing as (Name of facility) - no DSP erson) is "paperwork legal" to	W99	999			
pass meds (medic	cations) at this point until the ocumentation is on file. Annual assessment information for					; ;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN O	CORRECTION	}		ILDING	-	С		
		14G169	B. WI	NG	11/	/19/2010		
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE PLACE			-	STREET ADDRESS, CITY, STATE, ZIP 1705 SOUTH PARK AVENUE HERRIN, IL 62948	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
W9999	Continued From pa	nge 67	W99	999				
:	more client assess	ot in the medical records; three ments are due 9-10. New d is in need of med pass ng"				:		
:	on 09/10/10 inform temporarily suspen	y that she sent an e-mail to E1 ing him that she would be ding her Registered Nurse cility due to non-payment		;		:		
	at 7:48 p.m., docur inform you that I wi (Registered Nurse)	e-mail sent to E1 on 09/10/10 nentation states, "This is to II be temporarily lifting my RN coverage from (name of				:		
	(IDPH) (Illinois Der survey at (name of delinquent bills for	on the completion of the partment of Public Health) facility)" "When the (name of facility) are paid in the duties for providing RN icilities."						
: : : :	September 15 th, I that a survey was g to me. I sent an e-r th of September sa	nterview, E5 said, "On called (E1) again and he said poing on and he would get back nail to his office the 16 th or 17 ying that I was suspending my ties, pending payment for						
	services." E5 stated letter to E1's office suspension of her	d that she also sent a certified informing him of the licensure coverage. E5 said a response from E1.						
	she tried several tir telephone, fax, e-m him, nor did he res 10/15/10 at approx called E4 (Licensed	around the first of October, mes to contact E1 by ail and she could not reach bond to her. E5 said that on imately 2:30 - 3:30 p.m., she d Practical Nurse) at the facility at she had suspended her						

STATEMENT OF DEFICIENCIES AND BLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) N	AULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER	A BUILDING			С		
		14G169	B WI	NG		1	9/2010	
	ROVIDER OR SUPPLIER			1705	T ADDRESS, CITY, STATE, ZIP CODE S SOUTH PARK AVENUE RRIN, IL 62948			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX ·	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W9999	at 5:00 p.m E5 sa an e-mail to E1 (Ox Administrator) infor suspended her lice a certified letter to notified the state as the Registered Nur Per interview with Ep.m., E1 stated that Consultant/R.N.) his became aware that E1 said, "I think it with the day that (E4) (Linuse/L.P.N.) got to During interview with Nurse) on 10/20/10 E5 had called her cand told her that she to be effective 10/1 immediately called him about E5 suspished did not get a re E1 was aware that resigned on 10/15/work weekends, but licensed staff to part E4 continued to sathere was no one a medications excepand that they were medication unless Nurse. E4 said that passed the resider	id that she then sent a fax and wner), faxed E4 and E2 (Acting ming them all that she has nse. E5 said that she also sent E1's office/home address and gencies that she was no longer se Consultant for this facility. E1 (Owner) on 10/20/10 at 1:45 t (E5) (Registered Nurse ad quit. When asked when he the nurse consultant had quit, was Tuesday (10/19/10). It was licensed Practical he letter." th E4 (Licensed Practical of at 1:40 p.m., E4 stated that on 10/15/10 about 2:30 p.m., he was suspending her license 5/10 at 5:00 p.m., E4 said she and left E1 a voice mail telling ending her license. E4 said that the Registered Nurse had 10 and that she (E4) did not ut he (E1) did not provide ss medications. by that 10/16/10 and 10/17/10 at the facility to pass to the direct support staff, not supposed to pass the facility has a Registered tidirect support persons at's medication during the 9:00	W9	999				
	p.m. and 11:00 p.n 10/15/10. Direct su	n. medication pass on pport staff also passed						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A BUII		E CONSTRUCTION	COMPLETED	
		14G169	B WIN	G			9/2010
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE PLACE				1705	T ADDRESS, CITY, STATE, ZIP CODE SOUTH PARK AVENUE RRIN, IL 62948		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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)	ULD BE	(X5) COMPLETION DATE
W9999	10/17/10 during the a.m., 11:00 a.m., 4 p.m. medication particles and p.m. medication particles and p.m. medication particles and that he was Registered Nurse of coverage from 10/10/18/10 at 7:00 a. Per interview with the on 10/20/10 at 1:40 10/18/10 at approx letter came to the fat the envelope and thing that got faxed letter was from E5 Administrator and lighter R.N. coverage effective 10/15/10 at 2:30 documentation should be a page fax Documentation should be a p	esidents on 10/16/10 and 6:000 a.m., 7:00 a.m., 8:00 :000 p.m., 9:000 p.m. and 11:00 sses. Ith E1 on 10/20/10 at 1:45 p.m., s not aware that there been no coverage or medication pass 15/10 at 5:00 p.m. until m E4 (Licensed Practical Nurse) 0 p.m., E4 said that on imately 10:00 a.m., a certified acility. E4 said that E1 looked d said, "It's probably the same I to us." E4 stated that the and was to inform theP.N. that E5 had suspended and services to the facility at 5:00 p.m Is fax report dated 10/16/10, ows that on 10/15/10 at 2:21 was sent to the facility. Ows that the fax did arrive at 10/16/10, also shows that I p.m., a 3 page fax was sent ion shows that the fax did facility's policy regarding "R.N. of Consultant" (no date) tes, "The consultant nurse ultation in the facility not less	W99	199			

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		С	
	14G169	B WING		11/19/2010	
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE PLACE		170	ET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH PARK AVENUE ERRIN, IL 62948		
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
"Nursing Duties" (n "RN (Registered examine and compreview including br follow-up." "The in discharge plann. Consultant shall m recommendations orders and training. The facility failed to regarding Register health status reviemedication orders planning and making medication orders. Per review of 59 land Authorization Nurse-Trainers: "a) Only a nurse-trainers: "a) Only a nurse-trainers: "buring interview with 10/17/10 at 3:30 placen to the facility completed quarter assessments and training of direct simedications. The facility failed of Nurse is employed.	facility's policy regarding to date) documentation states, Nurse) Consultant shall blete quarterly health status east examination and RN consultant shall participate ing as is applicable" "RN onitor, review and make of the resident's medication programs" of follow it's own policy red Nurse Consultant coverage, w, monitoring and reviewing, participation in discharge ing recommendations for and training programs. II. Adm. Code 116.40 Training of Non-Licensed Staff by rainer may delegate and of medication administration to the since 07/27/10 and has not rely or annual nursing has not completed the yearly upport staff to legally pass to ensure that a Registered d and provides training, apervision over direct care staff ons.	W9999			
	(B)	: _			