DEPART	IMENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLE	
						(С
		14G309	B. WIN	IG _		09/2	2/2011
NAME OF P	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
					520 SOUTH DEARBORN STREET		
DEARBO	ORN COURT			ŀ	KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS	W (000			
W 149	8/18/11 - IL54401	RT INVESTIGATION OF	W 1	149			10/17/11
	policies and proced	evelop and implement written lures that prohibit ect or abuse of the client.					
	Based on interview failed to ensure the prevent neglect of 7 R5 fell and fracture	s not met as evidenced by: v and record review the facility ir policy was implemented, to 1 of 5 individuals, R5, when d 2 bones while not being rd with identified needs.					
	Findings include:						
	"Failure to provide	per 5.24 defines Neglect: as goods and services necessary arm, mental anguish, or mental					
	notes R5 is a 61 ye diagnoses include 3 (Intelligence Quotie Undifferentiated typ Disorder, Cataracts fracture, and Osteo include "to wear pro bed" "Ambulate wit assist, may use wh						
	targets hoarding ar	Program dated 5/20/10 which ad physical aggression. Her					(X6) DATE
LABORATORY		DER/SUPPLIER REPRESENTATIVE'S SIGI	NAIURE		TITLE		(AD) 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.

PRINTED: 02/22/2012

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G309	B. WI	NG _			2/2011	
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901			
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 149	Long Term goal sta incidents of physica month for 3 consec R5's 5/7/11 Individu assessment states "this is not within the range of 98 - 108 p R5 has a Nursing C addressing problem Approaches "1. supervise closel 2. transfer with ass 3. wear helmet 4. use gait belt for 5. use rolling walk 6. use wheelchair 7. remind her to as 8. bathroom activity with assistance 9. maintain clutter 10. shoes on while 11. frequent bed ch 12. assist as soon 13. assist to bed on Short Term Goal Free of injury Fall prevention Safety committee re- incident report date incident of August 1 6:40 a.m. Direct Su E11 was assisting F this time another incident re-	ates, " (R5) will reduce al aggression to 15 or less per sutive months. ual Service Plan, dietary her weight is 175 pounds, e IBW (Ideal Body Weight) bounds." Care Plan dated 10/7/10 n "Fall risk. y sistance all transfers cer prn (when needed) sk for assistance ties (shower, toileting, etc) r free environment awake hecks as she awakens	W	149				

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		14G309	B. WI	1G			C 2/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET (ANKAKEE, IL 60901		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	staff, E4 and E11 s other individual, R4 going to address th restroom. R5 was side in front of the t appeared to be urir inch bruise on R5's help. E4 got a mor floor. E11 checked mopping E4 and E ² her wheel chair. R5 E11 dressed R5 in (Residential Service Mental Retardation training). E4 assist dressed and R5 wa E4 was instructed t room in her wheelc had xrays complete fractured left Tibia a According to hospit 8/20/11 R5 was dis 8/20/11. Hospital medical re R5 was readmitted repair of the fractur then discharged on home near her fam E1, RSD/QMRP in representative, wer 1:35 p.m. E1 was a supervision was for supposed to be witt E2 said training wa	Service Plan), screamed. Both imultaneously went to the When E11 saw that E4 was e scream, E11 returned to the lying on the floor on her right coilet. E11 noticed what he on the floor and 3-1/2 - 4 left leg. E11 called E4 for to clean the urine from the R5 for injuries. After 11 lifted R5 from the floor to 5's clothing was wet with urine. her bed while E4 called E1 es Director (RSD)/ Qualified Professional (QMRP) in ted E11 with getting R5 as placed in the wheelchair. to take R5 to the emergency hair via the facility van. R5 ed and was diagnosed with a and Fibula. and Fibula on 8/29/11 document to the hospital for surgical red Tibia and Fibula on 8/29/11 9/1/11 to a different nursing		149			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	NG _			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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	and E2 said the em disciplinary action. E1 and E2 gave su indicating a written The written warning perform job duties. resident in the bath in the bathroom una client. This residen bones. DSP had re job duties. This wa for retraining." E4 was interviewed confirmed she work said R4 screamed a E11 ran to the other scream. During tha was lying in urine. E restroom when R5 said she called E1 i the nurse and then hospital. E4 said s order to get R5 up t takes two staff to lift pick her up in the un E4 said after she ar dressed, she took E4 said R5 was not pain, if so they woul moaned. E4 said s	age 3 aployee, E11 was given urveyor an unsigned document warning was given to E11. greads, "Failure to properly On 8-18-11, DSP assisted a room. She then left a resident attended to attend to another attended to attend to another to fell resulting in broken eceived training on 6/29/11 for is discussed at time of incident I on 9/13/11 at 9:43 a.m. E4 ked on the morning R5 fell. E4 as if in pain and both E4 and r restroom to address the at time R5 fell to the floor and E4 said E11 called her to the was found on the floor. E4 immediately, who contacted instructed E4 to take R5 to the she had to mop the floor in because she is so heavy it t her. E4 said, we couldn't rine because she would slide. nd E11 got R5 up and R5 to the emergency room. t screaming or crying as if in Id have called 911. R5 just she stayed with R5 at the returned to the home from the R4 to the doctor, R4 had an ear	W	149			
	During the interview	v with E4 on 9/13/11 at 9:43 ave had in house inservices on					

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		AND HUMAN SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WING	3	(09/22	2/2011
NAME OF P	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE 520 SOUTH DEARBORN STREET		
DEARBC	DRN COURT			KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 149	R5 that she is to be times R5 will lunge lint even when staff E11 was interviewe E11 said she took F always. E11 said th night. R4 kept touc R4 didn't want to ge up. E11 said in the E11 said she gets F be in the bathroom morning staff really to get dressed. E1 get other staff to he of her night clothes walk without a walk screamed like she f happened. E4 had E11 confirmed that back restroom R5 v R5 was pointing to her lift R5 from the R5's past falls and supervision, that it f received training." me an inservice for was the first day sh On 9/14/11 at 2:05 signed copy of the given to surveyor of at that time. The si dated 8/18/11. E1	 a 1 to 1 with staff. There are for something like a piece of f is with R5. ad on 9/14/111 at 9:00 a.m. R5 to the bathroom like here was an issue with R4 that ching her ear during the night. At that morning but did get a meantime she got R5 up. R5 up last because she has to with R5. E11 said in the thas to work with R5 to get her 1 said sometimes she has to belp convince R5 to change out. E11 confirmed R5 cannot the rand gait belt. E11 said R4 fell, so E11 ran up to see what also come from the kitchen. when she returned to the was on the floor lying in urine. her leg. E11 called E4 to help floor. E11 said she knew of was aware of her level of has to be 1 to 1. "I have After the incident E1 brought m. E11 said today, 9/14/11 he got a written warning. p.m. E1 gave surveyor a written warning that had been n 9/12/11 and was not signed igned written warning was was questioned about it and the actual written warning was E1 wrote error on the written 	W 14	49		

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	NG _			C 2/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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	Prior falls and injuri incident reports, nu reports, and emerg including the follow 2/28/11 While unloa getting her wheelch busclient suddenl steps causing staff client falling down 2 (documented in day facility nursing note 3/23/11 at worksho wheel chair at day t (documented in day facility nursing note Health History date 5/25/11 Fall on left emergency room re and incident report committee report day of left hip pain, xray and left tibia and filt emergency departm 5/26/11 Staff was w a.m., she slipped fr her gait belt and fel step of the bus. (do incident report and 5/26/11 and safety 6/1/11) No complai or abrasions. 5/26/11 R5 fell from stand up at 3:05 p.r	ies are documented in irrsing notes, safety committee ency department records, ing: ading client off bus, (staff) was hair prepared outside of ly began to walk down the to lose her grip ending with 2 steps of the bus. y training incident report and es dated 2/28/11. p was found on floor in front of training, with bruising y training incident report and es dated 3/23/11 and in Annual d 5/10/11) hip. (documented in ecord, facility nursing notes dated 5/25/11 and safety ated 6/1/11) She complained ys of both hips, the left femur bula were completed. in the	W	149			

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
	14G309	B. WI	NG _			C 2/2011
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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
 6/1/11) Lab work dr 5/26/11 R5 fell at 9 was taken to the ho exam and x-rays. S by staff. (document and safety committe Committee conside training site alternat dilantin levels close care plan and use of 5/27/11 Facility inst Dilantin after R5 re department for eval (documented in fac 5/27/11 and emerge 5/27/11 and emerge 5/27/11). 6/5/11 R5 fell on he sitting on the toilet to blood in her mouth knee was bothering administered. (Doce dated 6/5/11, nursin safety committee re committee consider vision on R5 to prev In-service record da facility staff attende had dental evaluatio consultation is docu falling." 	safety committee report dated rawn for anti convulsant levels. 0:30 p.m. getting into bed. R5 ospital and released following safety protocol was reviewed ed in nursing notes of 5/27/11 ee report of 6/1/11). trations discuss with day tive transportation, monitor ly, re-train staff on nursing of gait belts. tructed to hold two doses of sturned to emergency luation due to falls on 5/26/11 ility nursing notes dated ency department report dated er back in the bathroom while pefore dinner. R5 had a little and gestured that her right	W	149			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G309	B. WI	NG _			2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	RN COURT				20 SOUTH DEARBORN STREET (ANKAKEE, IL 60901		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	day training inciden notes) In-service re regarding R5's serie former facility QMR 6/20/11 Direct Sup noise at 5:10 a.m. out of her bed and I She was in a sitting was a 1/2 inch red I Upon entering the r not properly attacke incident report and and safety committee c bed rails are in place record dated 6/20/1 signed by all staff. 6/29/11 R5 was broc chair due to an uns persons were pres out of her wheel cha ground. R5 fell onther her rear end. E7 w another individual. that she could not r facility incident repo 6/29/11, and safety 7/1/11. Nursing not abrasion to top of for considerations inclu Support Persons) p indicated and fall ris precedent over other	n forehead. (Documented in t report and 6/14/11 nursing ecord for day training staff bus fall risk presented by P on 7/14/11. port Person, E7, heard a E7 found R5 had tried to get had slid down to the floor. position on the floor. There mark in the center of her back. oom, E7 found R5's bed rails ed. (Documented in facility nursing notes dated 6/20/11 ee report dated 6/21/11.) onsiderations, ensure both ee each night. In-service 1 related to the bed rails is bught to the table in her wheel teady gait. Two direct support ent, E4 and E7. R5 tried to get air and slipped onto the o her knees and then slid onto as attending to behaviors of E7 documented in her report each R5. (Documented in ort and nursing notes dated committee report dated es dated 6/29/11 document bot. Safety committee ude discuss with DSPs (Direct iositioning closer to R5 when sk situations with R5 take	W	149			
	her rear end. E7 w another individual. that she could not r facility incident repo 6/29/11, and safety 7/1/11. Nursing not abrasion to top of fo considerations inclu Support Persons) p indicated and fall ris precedent over othe	as attending to behaviors of E7 documented in her report each R5. (Documented in ort and nursing notes dated committee report dated es dated 6/29/11 document oot. Safety committee ude discuss with DSPs (Direct iositioning closer to R5 when sk situations with R5 take er situations.					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	JRVEY TED
		14G309	B. WI	NG			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET XANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 W 154	Continued From pa bruising. An xray w follow up with her p on 7/5/11 and 7/10/ R5 was hitting her h (Documented in nu consultation notes.) 483.420(d)(3) STAF CLIENTS The facility must ha violations are thorow This STANDARD i Based on interview failed to ensure a th incident for 1 of 1 in fractures to her tibia Findings include: The September 1, 2 notes R5 is a 61 ye diagnoses include S (Intelligence Quotie Undifferentiated typ Disorder, Cataracts fracture, and Osteo include "to wear pro-	age 8 vas completed on 7/5/11, and vrimary doctor, E12 was done (11. Nursing notes document hand on the table on 7/4/11. rsing notes and physician) FF TREATMENT OF ave evidence that all alleged ughly investigated. s not met as evidenced by: v and record review the facility horough investigation of an individuals, R5, who sustained a and fibula. 2011 Physician's Orders sheet ear old female whose Severe Mental Retardation IQ ent) 33, Schizophrenia-Chronic be, Hydrocephalus, Seizure s - OS (left eye), (L) (left) hip openia. Physician Orders otective helmet when out of h walker, Gait belt, Standby	W ·	149			10/17/11
	Safety committee re incident report date incident of August 1 6:40 a.m. Direct Su	eport dated 8/22/11 and d 8/18/11 summarize an 18, 2011, which occurred at upport Persons (DSPs) E4 and E4 was in the kitchen cooking,					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G309	B. WI	NG _			C 2/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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
W 154	E11 was assisting F this time another ind ambulatory, verbal, 1/20/11 Individual S staff, E4 and E11 si other individual, R4 going to address the restroom. R5 was I side in front of the t appeared to be urin inch bruise on R5's help. E4 got a mop floor. E11 checked mopping E4 and E1 her wheel chair. R5 E11 dressed R5 in (Residential Service Mental Retardation training). E4 assist dressed and R5 wa E4 was instructed to room in her wheelc had xrays complete fractured left Tibia a Surveyor reviewed individuals, R1, R2, the time of the incid to their respective In In the investigation, regarding the use o E1 said he was not saw the helmet at the	R5 in the restroom. During dividual, R4 (a 48 year old female according to her service Plan), screamed. Both imultaneously went to the . When E11 saw that E4 was e scream. E11 returned to the ying on the floor on her right oilet. E11 noticed what ie on the floor and 3-1/2 - 4 left leg. E11 called E4 for to clean the urine from the R5 for injuries. After 1 lifted R5 from the floor to 5's clothing was wet with urine. her bed while E4 called E1 es Director (RSD)/ Qualified Professional (QMRP) in ed E11 with getting R5 s placed in the wheelchair. to take R5 to the emergency hair via the facility van. R5 ed and was diagnosed with a and Fibula. investigation. Four R3 and R4 were at home at lent. All are verbal according ndividual Service Plans. there was no information f R5's adaptive equipment. here when this happened but he emergency room. He said e gait belt and walker were	W	154			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	JRVEY TED
		14G309	B. WI	NG			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	RN COURT				20 SOUTH DEARBORN STREET (ANKAKEE, IL 60901		
(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
W 154	1.45 p.m. E1 and E committee all come for investigation. E2 said no resident the bathroom door v E11 was interviewe R5's helmet was pro- so the back end is of up from under it. If said the walker and because R5 cannot R1, R2 and R3 wer E4 was interviewed said R1 and R4 wer happened. Both E4 and E11 co was open after the 483.430(d)(1-2) DIF The facility must pro- staff to manage and accordance with the Direct care staff are on-duty staff calcula period for each defi	 interviewed on 9/12/11 at 2 stated the investigative is together and asks questions s were interviewed because was closed. d on 9/14/11 at 9:00 a.m. obably backward, she turns it over her eyes. She will look on the right way it fits. E11 gait belt were being used walk without them. E11 said e up. R1 asked if R5 was o.k. on 9/13/11 at 9:43 a.m. E4 re up and knew something onfirmed the bathroom door fall. RECT CARE STAFF ovide sufficient direct care d supervise clients in eir individual program plans. e defined as the present ated over all shifts in a 24-hour ned residential living unit. s not met as evidenced by: ion, interview and record iled to provide sufficient direct rly a.m. hours on 8/18/11 idividual R5, fell and fractured 		154			10/12/11
	when one of one in						

Facility ID: IL6013726

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WIN	IG			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBC	ORN COURT			-	20 SOUTH DEARBORN STREET CANKAKEE, IL 60901		
(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 186	Continued From pa in accord with her id Findings include:	-	W	86			
		8/18/11 at 6:40 a.m. was 5 , R3, R4 and R5.					
	notes R5 is a 61 ye diagnoses include 8 (Intelligence Quotie Undifferentiated typ Disorder, Cataracts fracture, and Ostec include "to wear pro	2011 Physician's Orders sheet ar old female whose Severe Mental Retardation IQ ent) 33, Schizophrenia-Chronic be, Hydrocephalus, Seizure 5 - OS (left eye), (L) (left) hip openia. Physician Orders btective helmet when out of h walker, Gait belt, Standby eelchair."					
	assessment states	ual Service Plan, dietary her weight is 175 pounds, e IBW (Ideal Body Weight) pounds."					
	targets hoarding ar Long Term goal sta	Program dated 5/20/10 which ad physical aggression. Her ates, " (R5) will reduce al aggression to 15 or less per sutive months.					
	addressing problem Approaches "1. supervise close 2. transfer with as 3. wear helmet 4. use gait belt for 5. use rolling wall	ly sistance all transfers					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		14G309	B. WI	IG			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(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
W 186	with assistance 9. maintain clutter 10. shoes on while 11. frequent bed cl 12. assist as soon 13. assist to bed of Short Term Goal Free of injury Fall prevention Safety committee re- incident report date incident of August 1 6:40 a.m. Direct Su E11 were working. E11 was assisting F this time another in- ambulatory, verbal, 1/20/11 Individual S staff, E4 and E11 s other individual, R4 going to address th restroom. R5 was side in front of the t appeared to be urin inch bruise on R5's help. E4 got a mop floor. E11 checked mopping E4 and E1 her wheel chair. R4 E11 dressed R5 in (Residential Service Mental Retardation training). E4 assist dressed and R5 was	sk for assistance ties (shower, toileting, etc) r free environment awake necks as she awakens	W	186			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 14G309 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 SOUTH DEARBORN STREET DEARBORN COURT** KANKAKEE, IL 60901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 186 Continued From page 13 W 186 room in her wheelchair via the facility van. R5 had xrays completed and was diagnosed with a fractured left Tibia and Fibula. E1, RSD/QMRP in training and E2 facility representative, were interviewed on 9/12/11 at 1:35 p.m. E1 was asked what the level of supervision was for R5. E1 said staff are supposed to be with R5 in the rest room. E1 and E2 said training was given to all staff prior to the fall, that R5 was not to be out of eye sight.action. E4 was interviewed on 9/13/11 at 9:43 a.m. E4 confirmed she worked on the morning R5 fell. E4 said R4 screamed as if in pain and both E4 and E11 ran to the other restroom to address the scream. During that time R5 fell to the floor and was lying in urine. E4 said E11 called her to the restroom when R5 was found on the floor. E4 said she called E1 immediately, who contacted the nurse and then instructed E4 to take R5 to the hospital. E4 said she had to mop the floor in order to get R5 up because she is so heavy it takes two staff to lift her. E4 said, we couldn't pick her up in the urine because she would slide. E4 said after she and E11 got R5 up and dressed, she took R5 to the emergency room. E4 said R5 was not screaming or crying as if in pain, if so they would have called 911, R5 just moaned. E4 said she stayed with R5 at the hospital. After E4 returned to the home from the hospital, she took R4 to the doctor, R4 had an ear infection. During the interview with E4 on 9/13/11 at 9:43 a.m., E4 said we have had in house inservices on R5 that she is to be 1 to 1 with staff. There are

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 14G309 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 SOUTH DEARBORN STREET DEARBORN COURT** KANKAKEE, IL 60901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 186 Continued From page 14 W 186 times R5 will lunge for something like a piece of lint even when staff is with R5. E11 was interviewed on 9/14/11 at 9:00 a.m. E11 said she took R5 to the bathroom like always. E11 said there was an issue with R4 that night. R4 kept touching her ear during the night. R4 didn't want to get up that morning but did get up. E11 said in the meantime she got R5 up. E11 said she gets R5 up last because she has to be in the bathroom with R5. E11 said in the morning staff really has to work with R5 to get her to get dressed. E11 said sometimes she has to get other staff to help convince R5 to change out of her night clothes. E11 confirmed R5 cannot walk without a walker and gait belt. E11 said R4 screamed like she fell, so E11 ran up to see what happened. E4 had also come from the kitchen. E11 confirmed that when she returned to the back restroom R5 was on the floor lying in urine. R5 was pointing to her leg. E11 called E4 to help her lift R5 from the floor. E11 said she knew of R5's past falls and was aware of her level of supervision, that it has to be 1 to 1. I have received training. Prior falls and injuries are documented in incident reports, nursing notes, safety committee reports, and emergency department records, including the following: 2/28/11 While unloading client off bus, (staff) was getting her wheelchair prepared outside of bus...client suddenly began to walk down the steps causing staff to lose her grip ending with client falling down 2 steps of the bus. (documented in day training incident report and facility nursing notes dated 2/28/11.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		14G309	B. WI	IG			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBC	RN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(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 186	wheel chair at day t (documented in day facility nursing note Health History date 5/25/11 Fall on left emergency room re and incident report committee report day of left hip pain, xray and left tibia and filt emergency departm 5/26/11 Staff was w a.m., she slipped fr her gait belt and fel step of the bus. (do incident report and 5/26/11 and safety 6/1/11) No complain or abrasions. 5/26/11 R5 fell from stand up at 3:05 p.r nursing notes dated dated 5/26/11 and safety 6/1/11) Lab work dr 5/26/11 R5 fell at 9 was taken to the ho exam and x-rays. S by staff. (document and safety committee consider training site alternar dilantin levels close	p was found on floor in front of rraining, with bruising y training incident report and s dated 3/23/11 and in Annual d 5/10/11) hip. (documented in ecord, facility nursing notes dated 5/25/11 and safety ated 6/1/11) She complained ys of both hips, the left femur oula were completed. in the nent. valking R5 to the bus at 7:40 om the grip the staff had on I her right hand hit the bottom cumented in day training facility nursing notes dated committee report dated ints of discomfort, no bruising wheelchair when she tried to m. (documented in facility d 5/27/11 and incident report safety committee report dated rawn for anti convulsant levels. 0:30 p.m. getting into bed. R5 ospital and released following safety protocol was reviewed ed in nursing notes of 5/27/11 ee report of 6/1/11). rations discuss with day tive transportation, monitor dy, re-train staff on nursing	W	86			
	training site alterna	tive transportation, monitor ly, re-train staff on nursing					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		14G309	B. WI	IG			2/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBC	ORN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 186	Continued From pa	ige 16	W	186			
	Dilantin after R5 red department for eva (documented in fac 5/27/11 and emerg 5/27/11).	tructed to hold two doses of eturned to emergency luation due to falls on 5/26/11 illity nursing notes dated ency department report dated					
	sitting on the toilet I blood in her mouth knee was bothering administered. (Doc dated 6/5/11, nursin safety committee re committee conside vision on R5 to prev In-service record da facility staff attende had dental evaluatio	er back in the bathroom while before dinner. R5 had a little and gestured that her right g her. First aid was umented in incident report ng notes dated 6/6/11 and eport dated 6/7/11) Safety rations to keep a line of sight vent any further falls. ated 6/6/11 documents all edFollow up with dentist. R5 on on 6/21/11, reason for umented as "check teeth after					
	day training. R5 sta floor hitting her hea small cut on side of day training inciden notes) In-service re	ted to get out of her chair at arted to slide down toward and on a table staff noticed a in forehead. (Documented in it report and 6/14/11 nursing ecord for day training staff ous fall risk presented by P on 7/14/11.					
	noise at 5:10 a.m. out of her bed and She was in a sitting was a 1/2 inch red	port Person, E7, heard a E7 found R5 had tried to get had slid down to the floor. position on the floor. There mark in the center of her back. room, E7 found R5's bed rails					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	NG			C 2/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	DRN COURT				20 SOUTH DEARBORN STREET (ANKAKEE, IL 60901		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 186	not properly attache incident report and and safety committe Safety committee of bed rails are in place record dated 6/20/1 signed by all staff. 6/29/11 R5 was bro chair due to an uns persons were press out of her wheel ch ground. R5 fell ont her rear end. E7 w another individual. that she could not r facility incident repo 6/29/11, and safety 7/1/11. Nursing not abrasion to top of fe considerations inclu Support Persons) p indicated and fall ris precedent over othe 7/5/11 R5 had an ir bruising. An xray w follow up with her p on 7/5/11 and 7/10/ R5 was hitting her H (Documented in nu consultation notes.)	ed. (Documented in facility nursing notes dated 6/20/11 ee report dated 6/21/11.) considerations, ensure both ce each night. In-service 11 related to the bed rails is ought to the table in her wheel tready gait. Two direct support eent, E4 and E7. R5 tried to get air and slipped onto the to her knees and then slid onto vas attending to behaviors of E7 documented in her report reach R5. (Documented in ort and nursing notes dated committee report dated res dated 6/29/11 document oot. Safety committee ude discuss with DSPs (Direct positioning closer to R5 when sk situations with R5 take er situations. hyury to her right hand with vas completed on 7/5/11, and orimary doctor, E12 was done (11. Nursing notes document hand on the table on 7/4/11. rsing notes and physician	W	186			

		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G309	B. WIN	IG			2/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	DRN COURT				20 SOUTH DEARBORN STREET (ANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 186	(ISP) dated 4/21/11 who functions in the Retardation. R1's d Palsy with Hydroce obesity. ISP Gener states, "(R1) ambul (R1's) limitations in mobility issues." ISI "(R1) can stand for functional skills sec prepare snacks or r not require use of th appliances" (R1) but needs assistant she has had a bow put on her pants an assistance to tie he a t-shirt or pull over it needs to be adjus inside out" "(R1) r applying toothpaste her entire body afte The 8/9/11 quarter identifies R1 as usi wheelchair, safety f R1's mobility is ider transfer swith assis on 9/12/11 at 3:45 p her wheelchair to th Person (DSP) E5. transfer required E5 including full suppo stand and support f	I, R1 is a 44 year old female e moderate level of Mental liagnoses include Cerebral phalus, Urine retention and ral Observations section lates using a wheelchair. functioning are primarily her P motor skills section states, at least 5 seconds" ISP otion states, "(R1) is unable to meals, including those that do he stove or other electrical is independent with toileting ce with cleaning herself after el movement" "(R1) can also ad shoes but needs staff er shoe laces. She can put on shirt but may not realize that sted if it is on backwards or requires assistance with e to her toothbrush, drying off er a shower or bath" y health status review ng glasses, gait belt, helmet and bilateral braces. htified as via wheelchair, tance. Surveyor observed R1 p.m. being transferred from he couch by Direct Support E5 used a gait belt. The 5 to provide total assist rt of R1. R1 was not able to	W	86			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G309	B. WIN	IG			2/2011
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(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
W 186	Moderate-High freq hearing aid (right) e Functional skills see lamine(c)tomy and coordination and ba functioning in highe Adaptive devices "(August 24, 2011 Sa R2 fell on the morn superficial abrasion fell in the morning o down on a chair wa R2 missed the chai ground. The comm doesn't have a histo missing right eye ar difficult to judge at to order reads provide observed on 9/12/1 old walker caused to the tennis balls use worn down. During rehabilitation techno 3:15 p.m., Z3 confir to be seen for a new According to the 1/2 female who function Mental Retardation cerebral palsy, bipo Compulsive Disord disorder w/ obsessi skills section identif deformity and has a Functional skills sec interruptions in her	uency hearing loss bilaterally, har. Lens implant (right) eye. ctions states "He has had a has deficits in the area of alance which limit his r lever gross motor activities. R2) has a wheeled walker." afety Committee report notes ing of 8/15/11. He received a to his left elbow. R2 also on 8/15/11 while he was sitting iting for the day training bus, r and ended up falling to the bittee findings state, "(R2) ory of falls. (R2) does have a nd can make depth perception imes." 8/16/11 Physician's e with new walker. R2 was 1 using his old walker. The him to bend forward because d to help the walker glide were	W	86			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED	
		14G309	B. WI	NG _		C 09/22/2011		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET (ANKAKEE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 186	or elbows to the gro assistance and sup many basic ADL's (as eating, dressing staff supervision" prompting in the maneeds reminders to between bites when behaviors. She occo of throwing her plat "She can use her s requires assistance knife. She cannot p cereal or a sandwice (R3) requires assist and wearing weather needs assistance to "She needs prompt grooming tasks. Sh assistance in tooth require formal prog does need assistant bathing." The beha (R3) demonstrates behaviors. Her inter is in the serious rar and hurting herself. the most concern is grinding teeth, nerv objects repeatedly, hitting elbow on flood throwing food on flood According to the Be dated 2/15/11, R3 w her protection. The 6/30/11 Behav	bund. With considerable staff ervision, (R3) can complete Activities of Daily Living) such to ileting and grooming with ((R3) requires assistance or ajority of self-help areas. She put her utensils down a she exhibits maladaptive casionally exhibits a behavior e, her food or her beverage poon and fork adequately but with cutting her food with her prepare simple snacks like th" "In the area of dressing, tance in coordinating colors er appropriate clothing. She b button and zip her clothes" ing to initiate and complete ne needs prompts and brushing and continues to ramming in this area." "She ice with washing her hair and wor section states, "overall, moderately serious problem enalized maladaptive behavior ing, including repetitive habits " The problem that causes a repetitive habits such as ous tics includes (touching kicking things repeatedly, or, hitting knees on floor and	W	186				

		I AND HUMAN SERVICES				FORM	APPROVED 0938-0391
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		14G309	B. WI	NG _			C 2/2011
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 520 SOUTH DEARBORN STREET		
DEARBO					KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 186	Continued From pa May, 24 behaviors i 2011 QMRP progra behaviors. August progress notes doc training reports doc 8/15/11 through 8/3 According to the 1/2 female who function Mental Retardation. Down's Syndrome, obesity. The function does on rare occass both urinary and bo areas of hygiene an staff prompting and to regulate a tempe She is unable to ba on-going staff prom assistance, (R4) do dry either her body assistance with tool brushing her hair, n usage." (R4) canno do not require cook Direct Support Pers E10 and E11 were is supervision required E8 (9/14/11 at 11:4 alone. R5 has to al to hold her gait belt lot that is why she h busy with other resi behaviors, it takes always tries to get ti calming you can't w	ge 21 in the the month of June. July im notes document 16 2011 QMRP program ument 7 behaviors. Day ument 9 behaviors from 31/11. 20/11 ISP, R4 is a 48 year old ns in the Severe range of . R4's diagnoses include Bilateral Hearing loss and onal skills section states," (R4) ions have accidents including wel incontinence" In the nd grooming, (R4) requires assistance She is not able erature for a shower or bath. th or wash her hair without opting and assistance. without bes not properly wash, rinse or or her hair. (R4) requires staff th brushing, shaving her legs, hail care, and deodorant of prepare simple foods that ing." Sons, E3, E4, E5, E6, E7, E8, interviewed regarding level of d for R5. 44 a.m.) said R5 can't be lways be in sight. Staff have when walking. She moves a has to be watched. "If we get dents like R3 with a lot of 2 staff to calm R3 down." R5 hings she drops. If R3 needs vatch R5. R5 needs 1 to 1.	W		DEFICIENCY)		
		own around her eyes. It is					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
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		14G309	B. WI	1G			2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET (ANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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 186	Continued From pa	ige 22	W	186			
		because she turns it around		100			
	in sight. She requir written up an incide got up and lost her She is heavier, we	p.m.), said all of us kept her red us to be with her. I had ent in the team book, when she balance and slid to the floor. struggled a lot before because old us she was the number					
	to the front bathroo take her to the back usually uses the back leave it clean for an physical limits. R5 w the floor. She then helmet was probab the back end is over from under it. If on it can be done to m the morning. One p issues do occur with has to cook. Every behaviors. R3 is pl that R5 fell, I have p getting on the bus g E10 (9/13/11 at 3:2 her and keep an ey bathroom when she need 2 staff for bat and pick up things f E7 (9/13/11 at 9:15 held on R5. She w	5 p.m.) said, I had to walk with we on her. I have to sit in the e is toileting and bathing. We hing. She would try to get up					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G309	B. WING			C 2/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	DRN COURT			520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 186	try to get up on her close calls. She wo I could be helping s the only one here s she fell there were f could catch her whe helping R3 with her when she got up another person in th another person. W to cook breakfast. had a 1 on 1 assign tried to do things o E4 (9/13/11 at 9:43 bones are brittle so take her to E.R. (en house inservices or are times when you lunge for something E5 (9/12/11 at 3:05 her at all times. E1, QMRP in trainin at 8:40 a.m E1 said staff should have be and the other individ independently, she and out of her whee crawls in the mornin uses a walker but c independent in ADL ADL's. she had an R1 fell. She has ar complains we involved	r own. There were a lot of buld try to do things by herself. someone else and when I was he fell once or twice, when no injuries. Most of the time I en she fell. Once I was plate and I had to go to R5 There may have been he kitchen and I had to help then 2 staff are here one had I almost felt she should have hed just for her because she in her own. a.m.) said we know R5's anytime she falls we have to mergency room). We've had in in her that she is 1 to 1. There is can be with her and she will	W 186			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	√G _			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBC	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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 186	maladaptive behavior the building. Both is behavior. She was get her hands on. During interview on he took over in the he started training fi training until Octobe 483.440(c)(6)(i) INE The individual prog relevant interventio toward independer This STANDARD i Based on interview failed to provide the interventions descri- for 1 of 1 individuals prevention nursing Findings include: The September 1, 2 notes R5 is a 61 ye diagnoses include S (Intelligence Quotie Undifferentiated typ Disorder, Cataracts fracture, and Osteo include "to wear pro- bed" "Ambulate witt assist, may use wh	endent. I've seen R3 exhibit for one time. She was alone in staff engaged in managing the throwing whatever she could 9/19/11 at 9:48 a.m., E1 said middle of July, 2011. E1 said for QMRP in July and will be er. DIVIDUAL PROGRAM PLAN ram plan must describe ns to support the individual nce. s not met as evidenced by: y and record review the facility e day training site with relevant ibed in a fall prevention plan s, R5, who has a fall care plan. 2011 Physician's Orders sheet ar old female whose Severe Mental Retardation IQ ent) 33, Schizophrenia-Chronic be, Hydrocephalus, Seizure 5 - OS (left eye), (L) (left) hip ppenia. Physician Orders otective helmet when out of h walker, Gait belt, Standby	W i		5		10/20/11
	notes R5 is a 61 ye diagnoses include S (Intelligence Quotie Undifferentiated typ Disorder, Cataracts fracture, and Osteo include "to wear pro bed" "Ambulate with assist, may use wh	ar old female whose Severe Mental Retardation IQ ent) 33, Schizophrenia-Chronic be, Hydrocephalus, Seizure a - OS (left eye), (L) (left) hip openia. Physician Orders otective helmet when out of h walker, Gait belt, Standby eelchair."					

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	-	AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	NG _			C 2/2011
NAME OF P	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	DRN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 240	addressing problem Approaches "1. supervise closel 2. transfer with as 3. wear helmet 4. use gait belt for 5. use rolling walk 6. use wheelchair 7. remind her to as 8. bathroom activit with assistance 9. maintain clutter 10. shoes on while 11. frequent bed cl 12. assist as soon 13. assist to bed on Short Term Goal Free of injury Fall prevention R5 has documenter training site and on 2/28/11 While unloa getting her wheelch busclient sudden steps causing staff client falling down 2 (documented in day facility nursing note Health History date	h "Fall risk. ly sistance all transfers (er prn (when needed) sk for assistance ties (shower, toileting, etc) r free environment awake hecks as she awakens nly when tired d falls occurring at the day the bus. ading client off bus, (staff) was hair prepared outside of ly began to walk down the to lose her grip ending with 2 steps of the bus. y training incident report and is dated 2/28/11. p was found on floor in front of training, with bruising y training incident report and is dated 3/23/11 and in Annual	W	240			

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
		14G309	B. WI	NG _			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	RN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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
W 240	her gait belt and fel step of the bus. (do incident report and 5/26/11 and safety 6/1/11) No complain or abrasions. 6/14/11 R5 attempt day training. R5 sta floor hitting her hea	om the grip the staff had on I her right hand hit the bottom ocumented in day training facility nursing notes dated committee report dated nts of discomfort, no bruising red to get out of her chair at arted to slide down toward d on a table staff noticed a	W 2	240			
	day training inciden notes) In-service re regarding R5's serie former facility QMR Z4, day training was 2:25 p.m. and confi was inserviced that at 10:10 a.m. Z4 sa how to transfer and protocol.	s interviewed on 9/13/11 at rmed the day training staff R5 is a fall risk. On 9/14/11 iid we had no inservicces on on her fall prevention					
W 436	The facility must fur and teach clients to choices about the u hearing and other of and other devices in interdisciplinary tea	m as needed by the client.	W	436			12/1/11
	Based on observat	s not met as evidenced by: tion, interview and record ailed to: a. teach 1 of 5					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WIN	IG			C 2/2011
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	DRN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 436	individuals on the u provide 2 of 5 indivi equipment, R1 and Findings include: a. The September sheet notes R5 is a diagnoses include S (Intelligence Quotie Undifferentiated typ Disorder, Cataracts fracture, and Osteo include "to wear pro- bed" "Ambulate with assist, may use who R5 has a Behavior targets hoarding an Long Term goal sta incidents of physica month for 3 consec R5's 5/7/11 Individu assessment states "this is not within th range of 98 - 108 p R5 has a Nursing C addressing problem Approaches "1. supervise closel 2. transfer with as 3. wear helmet 4. use gait belt for 5. use rolling walk	 Ise of her helmet, R5. b. iduals with adaptive R3. 1, 2011 Physician's Orders a 61 year old female whose Severe Mental Retardation IQ ent) 33, Schizophrenia-Chronic be, Hydrocephalus, Seizure 5 - OS (left eye), (L) (left) hip openia. Physician Orders betective helmet when out of h walker, Gait belt, Standby eelchair." Program dated 5/20/10 which he physical aggression. Her ates, " (R5) will reduce al aggression to 15 or less per cutive months. ual Service Plan, dietary her weight is 175 pounds, her weight is 175 pounds, her ated 10/7/10 n "Fall risk. ly sistance all transfers ker prn (when needed) 	W 4	436			

Facility ID: IL6013726

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	NG _			C 2/2011
NAME OF F	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	DRN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 436	 8. bathroom activi with assistance 9. maintain clutter 10. shoes on while 11. frequent bed cl 12. assist as soon 13. assist to bed of Short Term Goal Free of injury Fall prevention Facility received a construction July 20, 2011 correr sent by Z3, Rehabili reads, "In the matther helmet, this piece constructions a by our organization insurance. If a new helmet is magnitude in the patienes of the construction of the c	tities (shower, toileting, etc) r free environment a wake hecks as she awakens nly when tired citation on 6/2/11 public health ented R5 was observed at the earing helmet backwards her line of vision. espondence in R5's clinical file litation Technology Supplier, ter of (R5) and her current of equipment was measured to and the helmet was provided at no cost to the client or their hecessary according to the ase worker who viewed the ent, the cost will be \$300.00, to ht's insurance after prior t Person (DSP) was 1 at 9:00 a.m. regarding a fall ctured her tibia and fibula I said R5's helmet was , she turns it so the back end She will look up from under it.	W	436			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	NG _			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 436	E8 (9/14/11 at 11:4 down around her ey because she turns Z4, QMRP from the interviewed on 9/14 would not wear her throw the helmet ev E1, facility QMRP ir 9/14/11 at 2:30 p.m R3 take off her hel E1 or staff went bac said, "when she pur redirected her to pur would" E1 said the the proper way for F b. 1. According to the year old female who range of Mental Re include cerebral pai (Obsessive Compu- anxiety disorder w/ features" The be (R3) demonstrates behaviors. Her inter is in the serious ran and hurting herself. the most concern is grinding teeth, nerv- objects repeatedly, hitting elbow on flood throwing food on flood to the Behavior Mar	4 a.m.) said R5's helmet falls yes. It is hard for her to see it around the wrong way. day training site was k/11 at 10:10 a.m. Z4 said R3 helmet right. She would	W	436	5		

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WIN	IG			C 2/2011
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	DRN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 436	During the survey 9 was observed wear was falling below R repeatedly adjusting July 20, 2011 corre sent by Z3, Rehabil reads, " In the matt helmet, this piece of her specifications a by our organization insurance. If a new helmet is n guidelines of the ca helmet on the patie be paid by the clien approval is done." Surveyor observed Z3 came to the faci Z3 looked at the he something different E1, QMRP in trainin at 9:15 a.m. E1 sa because the materi stretched out becau manipulating it. b. 2. According to f Plan (ISP) dated 4// female who function Mental Retardation Cerebral Palsy with retention and obesi section states, "(R1	 a)/12/11 through 9/14/11 R3 b)/12/11 through 9/14/11 R3 cring her helmet. The helmet (3's line of vision. R3 was g the helmet. spondence in R3's clinical file litation Technology Supplier, er of (R3) and her current of equipment was measured to and the helmet was provided at no cost to the client or their hecessary according to the ase worker who viewed the and, the cost will be \$300.00, to it's insurance after prior R3 on 9/14/11 at 3:25 p.m. lility to evaluate R3's helmet. elmet fit and said R3 needs 	W 2	136			

Facility ID: IL6013726

If continuation sheet Page 31 of 41

		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G309	B. WIN	IG			C 2/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBC	ORN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 436	primarily her mobilit	ige 31 ty issues." ISP motor skills I) can stand for at least 5	W 4	136			
	identifies R1 as using wheelchair, safety h R1's mobility is ident transfers with assiss on 9/12/11 at 3:45 p her wheelchair to the Person (DSP) E5. transfer required E5	y health status review ng glasses, gait belt, nelmet and bilateral braces. ntified as via wheelchair, stance. Surveyor observed R1 p.m. being transferred from ne couch by Direct Support E5 used a gait belt. The 5 to provide total assist rt of R1. R1 was not able to her weight.					
	transfer. R1 said sl her new wheelchair	at 3:45 p.m. on 9/12/11 after he was missing the armrest to r. R1 also said she had her feet with existing					
		l on 9/13/11 at 3:10 p.m. Z3 wheelchair, "I didn't know air armrest.					
W9999	said, R1 will bet box footrests and a new		W99	999			
	LICENSURE VIOL	ATIONS					
	350.1210 350.3240a)						
	Section 350.1210 H	lealth Services					

Facility ID: IL6013726

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WI	NG _			C 2/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	The facility shall promaintain each resides Section 350.3240 A a) An owner, licens agent of a facility sh resident. (Section 2) These Regulations by: Based on interview failed to prevent new hen R5 fell and fra- being supervised in needs. Findings include: Facility policy numb "Failure to provide g to avoid physical ha illness." The September 1, 2 notes R5 is a 61 ye diagnoses include S (Intelligence Quotie Undifferentiated typ Disorder, Cataracts fracture, and Osteo include "to wear pro- bed" and "Ambulate Standby assist, ma R5 has a Behavior	by by by the services necessary to dent in good physical health. Abuse and Neglect ee, administrator, employee or hall not abuse or neglect a 2-107 of the Act) were not met as evidenced and record review the facility glect of 1 of 5 individuals, R5, actured 2 bones while not accordance with identified per 5.24 defines Neglect as: goods and services necessary arm, mental anguish, or mental 2011 Physician's Orders sheet ar old female whose Severe Mental Retardation IQ ent) 33, Schizophrenia-Chronic be, Hydrocephalus, Seizure s - OS (left eye), (L) (left) hip openia. Physician Orders otective helmet when out of e with walker, Gait belt,	W9	999			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		14G309	B. WI	1G			C 2/2011
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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	of physical aggress 3 consecutive mont R5's 5/7/11 Individu assessment states "this is not within the range of 98 - 108 p R5 has a Nursing C addressing problem Approaches "1. supervise closed 2. transfer with as 3. wear helmet 4. use gait belt for 5. use rolling walk 6. use wheelchair 7. remind her to at 8. bathroom activi with assistance 9. maintain clutter 10. shoes on while 11. frequent bed cl 12. assist as soon 13. assist to bed of Short Term Goal Free of injury Fall prevention" Safety committee re- incident report date incident of 8/1811, Direct Support Pers- working. E4 was in assisting R5 in the another individual, f	 ttes, "(R5) will reduce incidents ion to 15 or less per month for ths. ual Service Plan, dietary her weight is 175 pounds, e IBW (Ideal Body Weight) bounds." Care Plan dated 10/7/10 n "Fall risk." y sistance all transfers ker prn (when needed) sk for assistance ties (shower, toileting, etc) r free environment awake hecks as she awakens 	W9	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G309	B. WIN	IG			C 2/2011
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT			-	20 SOUTH DEARBORN STREET ANKAKEE, IL 60901		
(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
W9999	simultaneously wer When E11 saw that scream, E11 return lying on the floor or toilet. E11 noticed the floor and 3-1/2- E11 called E4 for h urine from the floor After mopping, E4 a floor to her wheelch with urine. E11 dre called E1 (Resident (RSD)/Qualified Me (QMRP) in training) R5 dressed and R5 E4 was instructed the room in her wheelch had xrays completed fractured left Tibia at According to hospit 8/20/11, R5 was dis on 8/20/11. Hospit 8/29/11 document if hospital for surgical and Fibula on 8/29/ to a different nursin E1, RSD/QMRP in representative, wer 1:35 p.m. E1 was at supervision was for supposed to be witt E2 said training wa fall that R5 was not	amed. Both staff, E4 and E11 at to the other individual, R4. t E4 was going to address the ned to the restroom. R5 was a her right side in front of the what appeared to be urine on - 4 inch bruise on R5's left leg. elp. E4 got a mop to clean the . E11 checked R5 for injuries. and E11 lifted R5 from the hair. R5's clothing was wet ssed R5 in her bed while E4 tial Services Director ental Retardation Professional . E4 assisted E11 with getting was placed in the wheelchair. o take R5 to the emergency hair via the facility van. R5 ed and was diagnosed with a	W99	999			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		14G309	B. WI	B. WING			2/2011	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W9999	Continued From pa	ge 35	W9	999	9			
	indicating a written The written warning perform job duties. resident in the bath in the bathroom una client. This resident bones. DSP had re job duties. This wa for retraining." E4 was interviewed confirmed she work said R4 screamed a E11 ran to the othe scream. During tha was lying in urine. E restroom when R5 said she called E1 if the nurse and then hospital. E4 said sh order to get R5 up h takes two staff to liff pick her up in the u E4 said after she and dressed, she took E4 said R5 was not pain, if so they wou moaned. E4 said sh onget infection. During the interview a.m., E4 said they h on R5 that she is to	rveyor an unsigned document warning was given to E11. g reads, "Failure to properly On 8-18-11, DSP assisted a room. She then left a resident attended to attend to another it fell resulting in broken eceived training on 6/29/11 for s discussed at time of incident at ime of incident on 9/13/11 at 9:43 a.m. E4 ed on the morning R5 fell. E4 as if in pain and both E4 and r restroom to address the at time R5 fell to the floor and E4 said E11 called her to the was found on the floor. E4 immediately, who contacted instructed E4 to take R5 to the he had to mop the floor in because she is so heavy it t her. E4 said, "we couldn't rine because she would slide." nd E11 got R5 up and R5 to the emergency room. a screaming or crying as if in ld have called 911. R5 just she stayed with R5 at the eturned to the home from the R4 to the doctor. R4 had an with E4 on 9/13/11 at 9:43 have had in house inservices ob e 1 to 1 with staff. There inge for something like a piece						

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MBER: A. B) MULTIPLE CO BUILDING WING		(X3) DATE SU COMPLE	
B. W				
			09/22	<i>,</i> 2/2011
FULL PRE	EFIX	(EACH CORRECTIVE ACTION SHOL	ILD BE	(X5) COMPLETION DATE
W	/9999			
ways. at night. ht. R4 did get up. b. E11 as to be in morning er to get to get ge out of nnot walk R4 see what kitchen. o the in urine. E4 to help knew of el of ave brought D/14/11, ng. yor a had been ot signed g was ut it and arning was e written				
	YFULL PR ATION) T	520 SOL KANKA S ID PREFIX TAG FULL ATION) PREFIX TAG W9999 a.m. E11 lways. at night. ht. R4 did get up. p. E11 as to be in morning er to get to get ge out of innot walk t R4 o see what kitchen. to the g in urine. E4 to help knew of vel of vave brought 9/14/11, ng. Yor a had been ot signed g was ut it and arning was e written	FULL ATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) W99999 ways. at night. W99999 a.m. E11 ways. at night. ways. ht. R4 did get up. p. p. E11 as to be in morning er to get to get ge out of innot walk I R4 p. see what kitchen. see what kitchen. to the j in urine. f. E4 to help knew of rel of aave brought 9/14/11, ng. yor a had been ot signed g was ut it and arning was e written	STREET ADDRESS, CITY, STATE, ZIP CODE S20 SOUTH DEARBORN STREET KANKAKEE, IL 60901 S FULL ATION) PREFIX TAG PREVIDER'S PLAN OF CORRECTION PREFIX TAG PREVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W9999 a.m. E11 lways. at night. ht. R4 did get up. p. E11 as to be in morning er to get to get to get ye out of innot walk I R4 P see what kitchen. to the jin urine. E4 to help knew of rel of iave brought 9/14/11, ng. yor a had been ot signed y was written in incident

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		14G309	B. WI	NG _			2/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	RN COURT			_	520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	following: 2/28/11 While unloa getting her wheelch busclient suddenl steps causing staff client falling down 2 (documented in day facility nursing note 3/23/11 at worksho wheel chair at day t (documented in day facility nursing note Health History date 5/25/11 Fall on left emergency room re and incident report committee report day of left hip pain, xray and left tibia and filt emergency departm 5/26/11 Staff was w a.m., she slipped fr her gait belt and fel step of the bus. (do	bartment records, including the ading client off bus, (staff) was hair prepared outside of by began to walk down the to lose her grip ending with 2 steps of the bus. y training incident report and s dated 2/28/11.) p was found on floor in front of training, with bruising y training incident report and s dated 3/23/11 and in Annual d 5/10/11) hip. (documented in ecord, facility nursing notes dated 5/25/11 and safety ated 6/1/11) She complained <i>y</i> s of both hips, the left femur bula were completed. in the	W9	999			
	5/26/11 and safety 6/1/11) No complain or abrasions. 5/26/11 R5 fell from stand up at 3:05 p.r nursing notes dated	committee report dated nts of discomfort, no bruising n wheelchair when she tried to m. (documented in facility d 5/27/11 and incident report safety committee report dated					

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DEPAR1 CENTEF	PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
14G309			B. WI	NG _		C 09/22/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	RN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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
W99999	Continued From pa 6/1/11) Lab work dr 5/26/11 R5 fell at 9 was taken to the ho exam and x-rays. S by staff. (document and safety committe Committee conside training site alternar dilantin levels close care plan and use of 5/27/11 Facility ins Dilantin after R5 re department for eval (documented in fac 5/27/11 and emerge 5/27/11 and emerge 5/27/11 not emerge 5/27/11 and emerge 5/27/11 not be sitting on the toilet to blood in her mouth knee was bothering administered. (Doc dated 6/5/11, nursin safety committee re committee consider vision on R5 to prev In-service record da facility staff attende had dental evaluatio consultation is docu falling."	ge 38 rawn for anti convulsant levels. 230 p.m. getting into bed. R5 popital and released following rafety protocol was reviewed ed in nursing notes of 5/27/11 ee report of 6/1/11). rations discuss with day tive transportation, monitor ly, re-train staff on nursing of gait belts. tructed to hold two doses of turned to emergency luation due to falls on 5/26/11 ility nursing notes dated ency department report dated ency department report dated of potes dated 6/6/11 and eport dated 6/7/11) Safety rations to keep a line of sight vent any further falls. ated 6/6/11 documents all dFollow up with dentist. R5 on on 6/21/11, reason for umented as "check teeth after	W9		DEFICIENCY)		
		n forehead. (Documented in					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G309	B. WI	NG _		C 09/22/2011	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	day training inciden notes) In-service of regarding R5's seri- former facility QMR 6/20/11 Direct Sup noise at 5:10 a.m. out of her bed and She was in a sitting was a 1/2 inch red Upon entering the r not properly attache incident report and and safety committe Safety committee of bed rails are in place record dated 6/20/1 signed by all staff. 6/29/11 R5 was brow wheelchair due to a support persons we tried to get out of he the ground. R5 fell onto her rear end. of another individua report that she coul in facility incident re 6/29/11, and safety 7/1/11.) Nursing no abrasion to top of for considerations inclu Support Persons) p indicated and fall ris precedent over othe 7/5/11 R5 had an in	at report and 6/14/11 nursing ecord for day training staff ous fall risk presented by P on 7/14/11. port Person, E7, heard a E7 found R5 had tried to get had slid down to the floor. g position on the floor. There mark in the center of her back. room, E7 found R5's bed rails ed. (Documented in facility nursing notes dated 6/20/11 ee report dated 6/21/11.) considerations, ensure both ce each night. In-service 11 related to the bed rails is pught to the table in her an unsteady gait. Two direct ere present, E4 and E7. R5 er wheelchair and slipped onto onto her knees and then slid E7 was attending to behaviors al. E7 documented in her ld not reach R5. (Documented eport and nursing notes dated committee report dated otes dated 6/29/11 document oot. Safety committee ude discuss with DSPs (Direct positioning closer to R5 when sk situations with R5 take	W9	999			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
14G309			B. WING			09/22/2011	
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
DEARBO	ORN COURT				520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	on 7/5/11 and 7/10 R5 was hitting her I	virimary doctor, E12 was done (11. Nursing notes document hand on the table on 7/4/11. Irsing notes and physician	W9	999			

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