		I AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		14G294	B. WIN	IG		10/1	4/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			-	09 HARRIS ROAD AST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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	rs	w c	000			
	ANNUAL CERTIFI	CATION SURVEY - FULL					
W 102	INSPECTION OF 0 483.410 GOVERNI MANAGEMENT		W 1	02			11/17/11
		sure that specific governing nent requirements are met.					
	Based on interview governing body faile 1) Develop policie needs of individuals	s that address meeting the s who are in the facility for					
	overnight preadmis (R5) who was visitin pre-admission.	sion visits for 1 of 1 individual ng the facility as a					
	"Pressure Ulcer Pre	ementation of Facility Policy evention" dated March 2007 in the sample with an open					
	Findings Include:						
	Refer to deficiencie	es cited at:					
	Services	uments Signed and Dated Participation-Health Care					
W 104	483.410(a)(1) GOV		W 1	04			11/17/11
LABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/25/2012

		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WI	NG		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 104	Continued From pa	ige 1	W	104			
		y must exercise general policy, ing direction over the facility.					
	Based on interview governing body faile 1) Develop policies needs of individuals	s that address meeting the s who are in the facility for sion visits for 1 of 1 individual					
	"Pressure Ulcer Pre	ementation of Facility Policy evention" dated March 2007 in the sample with an open					
	Findings Include:						
	male. A facility con at 2:20pm states th coming this afterno- visit for screening p He previously was I some daily assistan aide. This is the inf available at this tim- as; "own guardian, ambulation, pureed limited vision, will no ADL's (bathing, hyg	lated 8/12/11 is a 54 year old nputer log entry dated 8/12/11 hat "There will be a male visitor on and staying for a 2 week prior to a possible admission. living in his own residence with nce provided by an in-home formation that we have e". The information is listed					

I

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		I AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WING _		10/14	4/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 104	this is a potential er have a short period placement will be a provide service to h was made by E2 (A A computer log ent states, "I assist (sic dry (sic)him off and clothes before I left back in and he was toilet. So I went to Director) to help me over his body to servisible at that mome side was hurting. I situation." This cor E3 (direct care). A computer log ent written by E4 (Nurs tonight while he wa told the Staff (sic) the extremely bad. Rea the (direct care staff E4 (nurse) was inter When asked what the R5's fall, E4 stated When asked if she R5 that evening, sho was in bed when E4 was laying on his left E4 stated that she we complain about his his right foot. E4 stated	nergency placement we only of time to screen if his ppropriate and if we can him." This computer log entry administrator) ry dated 9/06/11 at 8:17pm. (R5) with a shower today. I he start (sic) to put on his the bathroom. So I came between the tub and the get (E1, Resident Services to get him up. We look (sic) e if any bruise, there were no ent. He state (sic) that his call (sic) nurse about the nputer log entry was made by ry dated 9/06/11 at 7:51pm. e) states, R5 "Had a fall s in the bathroom. Resident hat his side was hurting sident was given Tylenol by f)." erviewed on 9/14/11 at 1:55pm. time she was notified about that it was around 5:00pm. had done an assessment of he stated, yes. E4 stated R5 4 arrived at the facility and he off side with his right side up. woke R5 up and he didn't right rib hurting but mentioned ated that at the time she did are was no redness, no	W 104			

Facility ID: IL6013346

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM	02/25/2012 APPROVED 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	14G294	B. WI	۱G		10/14	4/2011
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL 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 104 Continued From page	3	W	104			
 3:40pm. When asked the incident occurred, I approximately 4:30pm instructions she had reindividuals mobility and his fall regarding, E3 state shower, step out w When asked if after his the bathroom, E3 state how she knew this, E3 tells me what he is able E2 (Administrator) was 12:45pm. E2 was asked the facility had regardinat the time he came to set of documents. Incl Department of Human Rehabilitation Services dated 3/02/10. Under it states, "Needs help t pants on saying his had to put on. Not able to or shoes and socks." Un "Bathing" it states, "Is rub by himself saying hand needs help." A "Home Services Pro 1/31/11 regarding R5, Bathing it states that it is done A facility "Prescreen For the states that it is done and socks." Under it states that it is done and socks. 	. When asked what eceived regarding this d supervision needs prior to stated stay with him when in when putting clothes on. s shower does he dress in ed, "Yes." When asked b stated, "I talk to him, he e to do." s interviewed on 9/13/11 at ed for any information that ng addressing R5's needs the facility. E2 provided a duded was a form titled service-Division of s "Determination of Need" the section titled "Dressing" to put his tee shirt and ands will not grip the clothes use his hands to put on his not able to get in and out of his balance is not very good					

Facility ID: IL6013346

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G294	B. WING		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 104	Continued From pa "Physical Assist".	ge 4	W 104	4		
	When asked how s	on 9/13/11 at 12:45pm. taff were to meet R5's needs, were to assist with all ADL's.				
	written by E4 (Nurs tonight while he wa told the Staff (sic) th	ry dated 9/06/11 at 7:51pm. e) states, R5 "Had a fall s in the bathroom. Resident nat his side was hurting sident was given Tylenol by f)."				
	3:40pm. When ask she notified the nur	s interviewed on 9/15/11 at an approximately what time se of the fall, E3 stated that e about 5:00pm and the n Tylenol".				
	9/06/11 states that at 4:45pm by E3 (di interviewed on 9/14 R5 had an order for stated, "He came h home for something will not see him unt admitted. He does	histration Record dated R5 was given Acetaminophen irect care). E4 was /11 at 1:55pm. When asked if the Acetaminophen, E4 ere with Tylenol. He took it at g else. (Z1, facility physician) il he's admitted. He is not not have a routine doctor. I've administrator and she knows."				
	made by E2 (Admir there is no way to c report) on him as he be sure to documer complaints of pain i (E4) of any changes	am. a computer log entry was histrator) which stated, "as omplete a GER (general event e is not a resident yetplease ht any bruising or further n (computer log) and notify s as well." The next computer R5 was on 9/07/11 at 9:53pm				

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WI	NG _		10/14	4/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 104	 which stated, R5 "d he wasn't feeling we exactly on how he w by E5 (direct care). The next computer 3:07pm. which state be given 800mg ibu as needed he is to deep breaths." This (direct care). A form from the vis care facility dated 9 section titled "Reas of right rib pain afte Under the section ti "Fracture of rib, close E6 (direct care) was 1:00pm. E6 verified member who took F facility on 9/08/11. one or two ribs were verified that they we E2 (Administrator) was that the facility had needs at the time h provided a set of do orders were include E2 (Administrator) was 12:45pm. When as 	lidn't ate (sic) supper, he said ell, but he did not describe was feeling." This was written log entry is dated 9/09/11 at es R5 "has 2 cracked ribs is to uprofen every 6 hours for pain cough frequently and take s entry was written by E6 it to the out patient emergent //08/11 at 11:05am., under the on for Visit" states "complain er falling in his bathroom." itled "Diagnoses" it states, sed." s interviewed on 9/15/11 at d that she was the staff R5 to the emergent care When asked if she was told e broken, E6 stated two. E6 ere on the right side. was interviewed on 9/13/11 at ed that R5 came to the facility s asked for any information regarding addressing R5's ie came to the facility. E2 bouments. No physicians ed in the documents. was interviewed on 9/13/11 at sked if R5 had any physicians 'Il have to look." No order for	W	104			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WING _		10/14	4/2011
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 104	Continued From pa	ge 6	W 104	L		
	March 2007, "Admi "Visitors" dated Ma Admission Process section 1.f. states," pre-screen form to placement. An ove meeting with the po- encouraged." Unde Admissions Process issues will be discu- including but not lim funding, and the be The Visitors policy of paragraph is the on- individuals visiting to admission and only serious maladaptive E2 (Administrator) v 9:53am. When ask address what speci- address individual r visits, E2 stated, "I 2) R1, per current 6/21/11, is a 64 year wheelchair and "red transfers." R1's Ph for 9/11 lists under Retardation, Osteo Excessive Salivatio Encephalopathy, ar Disease. The POS Pureed diet. Under	er the section titled 3. s, 3. A. b. states, "Several ussed with those present, nited to, the trial period, d hold policy." dated March 2007, the last ly section that addresses he facility prior to an regarding incidents of e behavior. was interviewed on 9/14/11 at ted if the admission policies fic information is needed to needs during trial overnight				

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WI	1G		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(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 104	tip guard, seat belt, section titled "Treat Balm: Apply Topica Skin Break Down T A "Consultation For by Z1 (Personal Ca section titled "Findir states, Right Buttoo Fold. The plan liste cream antibiotic oin A computer log entr "has a sore on her I doctor and she nee side of the sore. Al 2-3 times daily until with this over the we (computer log entry how the sore is look A computer log entry how the sore is look A computer log entry states, "The sores of not too bad." A computer log entry states, "her bottom A computer log entry	and seat cushion. "Under the iment Orders" it states, "Bag ally Twice Daily To Prevent To Pressure Areas." rm" dated 1/26/11 and signed are Physician) under the ng/Recommendations" it ck superficial sore, Gluteal ed was reposition and barrier atment. ry dated 1/28/11 states, R1 buttocks. She went to the eds to sleep on the opposite lso apply (antibiotic ointment) I it heals. Please follow up reekend. When you do your /) for (R1), please comment on king and healing." ry dated 1/29/11 at 8:47am. on her butt still look fresh, but ry dated 1/29/11 at 10:41pm. is looking better". ry dated 1/30/11 at 8:37pm. ook much better."	W	104	DEFICIENCY)		
	2/12/11 under the s Diagnoses" states, tenderness." Per a review of R1's	"Coccyx area less red no s clinical record, no skin risk					
	assessment was lo	cated. Facility Policy					

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SURVEY COMPLETED	
		14G294	B. WI	NG _		10/1	4/2011
NAME OF PROVIDER OR SUPF	LIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS PLACE					209 HARRIS ROAD EAST PEORIA, IL 61611		
PREFIX (EACH DEFIC	CIENC	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 APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
 was reviewed. "Procedure" it day (sic) of ad assessment for standardized a assessments in necessary on for the develop addressed on goes on to add determined to "High Risk Re E2 was intervi asked for a Sk stated, "I'll loo stated that the the nursing qu assessed thro other than obs quarterlies is t using a standa am not aware assessment." 10:50am. Wh risk assessment o nursing quarter have." When skin risk asses per facility poli locate, no." W 111 Kasses assessment W 111 	er Pr Un state misss or pre- asses will b a qua- or pre- asses be "I sider endress be "I sider endress be "I sider erva heres for n erva here erva here cy, E CLIE ist de syst	evention" dated March 2007 der the section titled es, "1. If necessary, within 14 ion, residents will have an essure ulcer, using a ssment. 2. All resident e reviewed and revised as arterly basis. 3. Level of risk at of pressure ulcers will be nursing care plan." The policy plans for individuals Moderate Risk Residents" and	W		4		11/17/11

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G294	B. WING		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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 111	Continued From pa and protection of th	-	W 111			
	Based on interview failed to maintain a ensures that labora	s not met as evidenced by: and record review, the facility recordkeeping system that tory results are available for 2 he sample. (R1 and R2)				
	Findings Include:					
	6/21/11, is a 64 yea wheelchair and "rec transfers." R1's Ph for 9/11 lists under Retardation, Osteo Excessive Salivatio Encephalopathy, ar	Individual Service Plan of ar old female who uses a quires staff assistance for ysicians Order Sheet (POS) diagnoses, Moderate Mental porosis, Speech Disorder, n, Moderate Paraplegia, nd Degenerative Joint for 9/11 states that R1 is on a				
	Orders" it states, Pr Using Nosey Cup, Cup. Under the sec	under the section titled "Diet ureed Pudding Consistency Nectar Thick Liquids In Nosey ction titled "Laboratory Orders" y, Chem Screen yearly, and Months.				
		was reviewed. The most ests available were from 7/10.				
	under the section ti Needs/Recomment review, medications Progress Record da	sessment" dated 6/21/11, tled "Evaluation of dations" it states, "No labs to s reviewed." A Dietitian's ated 3/07/11 states, "No new Dietitian's Progress Record				

		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
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		14G294	B. WI	NG _		10/1	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				EAST PEORIA, IL 61611		
(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 APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
тад W 111	Continued From pa dated 12/07/10 stat E2 (Administrator) v 2:00pm. E2 was as done since 7/10. E uses. At 2:20pm. o she had received so May. E2 provided I 5/29/11, 5/30/11 an 2) R2, per POS fro female with diagnos Retardation, Hypert Hypercholesterolen "Laboratory Orders months, Lipid Profil 6 months, Creatinin Profile every 6 mon Fasting Blood Suga R2's clinical record recent Laboratory to and 8/10. R2's "Qu Re-Evaluation" for s "No new labs". E2 (Administrator) v	ge 10 es, "No new labs to review." was interviewed on 9/15/11 at sked if R1 has had any labs 2 called the lab the facility on 9/15/11 E2 reported that ome labs done on R1 from ab tests done on R1 for d 5/31/11. m 9/11, is a 68 year old ses of Moderate Mental tension, Hypothyroidism, and hia. Under the section titled " it states, Electrolytes every 3 e every 6 months, CBC every be every 6 months, Liver ths, Thyroid Profile yearly, ar yearly, and A1c yearly. was reviewed. The most ests available were from 7/10	W		DEFICIENCY)	ROPRIATE	DATE
W 114	recent labs availabl 7/2010 and 8/2010. would see if there v provided copies of	e in R2's chart, E2 stated E2 also stated that she vere newer ones. E2 later labs done on 9/06/11.	W	114			11/17/11
		makes an entry in a client's it legibly, date it, and sign it.					

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WI	1G		10/1	4/2011
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(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 114	This STANDARD i Based on interview failed to ensure that in the clinical record individuals in the sa Findings Include: R2, per POS from 9 with diagnoses of N Depression, and Ag R2's clinical record use of Abilify 10mg Prozac 20mg as an consent for R2 to re Pneumonia" vaccin R2's guardian (Z2), dated as to when the guardian. Both the consent for the Pro "This consent is va signed" but did not the guardian signed E2 was interviewed When asked about Prozac, E2 stated, were updated with Plan) in February." had "no date". 483.420(d)(3) STAI CLIENTS	s not met as evidenced by: and record review, the facility t guardian consents contained ds were dated for 1 of 4 ample. (R2) 9/11, is a 68 year old female Moderate Mental Retardation, ggressive Behavior . contained consents for the as an "Antidepressant", and a eceived the "Pneumococcal e. All three were signed by None of the consents were hey were signed by the consent for the Abilify and the zac contained the statement, id for one year from day have a date listed as to when d the consents. I on 9/15/11 at 10:05am. the consents for Abilify and "My assumption is that they the ISP (Individual Service E2 verified that the consents F TREATMENT OF we evidence that all alleged		114			11/17/11

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		AND HUMAN SERVICES			FORM	: 02/25/2012 APPROVED : 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		14G294	B. WING	3	10/1	4/2011	
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP C	DDE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 154	This STANDARD i Based on interview failed to have evide investigation of an i fractured ribs for 1 visiting the facility a Findings Include: 1) R5, per "Authori Information" form d male. A facility con at 2:20pm states th coming this afterno visit for screening p He previously was some daily assistar aide. This is the int available at this tim as; "own guardian, ambulation, pureed limited vision, will n ADL's (bathing, hyg of Daily Living]. Th this is a potential en have a short period placement will be a provide service to h was made by E2 (A A computer log ent states, "I assist (sic dry (sic)him off and clothes before I left back in and he was toilet. So I went to Director) to help me	s not met as evidenced by: v and record review, the facility ence of a thorough incident which resulted in of 1 individual (R5) who was as a pre-admission. ization to Exchange lated 8/12/11 is a 54 year old nputer log entry dated 8/12/11 the start of the start of the start on and staying for a 2 week prior to a possible admission. Iving in his own residence with noce provided by an in-home formation that we have e." The information is listed utilized a walker for I diet, no current medications, eed physical assistance in giene, etc)" [ADL's, Activities the computer log continues "As mergency placement we only I of time to screen if his ppropriate and if we can him." This computer log entry	W 15				

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G294	B. WI	NG _		- 10/14/2011		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611			
(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	visible at that mome side was hurting. I situation." This con E3 (direct care). A computer log entri- written by E4 (Nurs- tonight while he was told the Staff (sic) the extremely bad. Res- the (direct care staff E4 (nurse) was inter When asked what the R5's fall, E4 stated When asked if she R5 that evening, sh- was in bed when E4 was laying on his le E4 stated that she w complain about his his right foot. E4 st the assessment the swelling and no ede E2 (Administrator) w 12:45pm. When as R5's needs, E2 stat with all ADL's. A computer log entri- written by E4 (Nurs- tonight while he was told the Staff (sic) the extremely bad. Res- the (direct care staff	ent. He state (sic) that his call (sic) nurse about the nputer log entry was made by ry dated 9/06/11 at 7:51pm. e) states, R5 "Had a fall s in the bathroom. Resident hat his side was hurting sident was given Tylenol by ff)." erviewed on 9/14/11 at 1:55pm. time she was notified about that it was around 5:00pm. had done an assessment of he stated, yes. E4 stated R5 4 arrived at the facility and he eff side with his right side up. woke R5 up and he didn't right rib hurting but mentioned tated that at the time she did ere was no redness, no ema. was interviewed on 9/13/11 at sked how staff were to meet ted that they were to assist ry dated 9/06/11 at 7:51pm. e) states, R5 "Had a fall s in the bathroom. Resident hat his side was hurting sident was given Tylenol by	W	154				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G294	B. WI	۱G		- 10/14/2011		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611			
(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	there is no way to c report) on him as he be sure to documer complaints of pain i (E4) of any changes log entry regarding which stated, R5 "d he wasn't feeling we exactly on how he w by E5 (direct care). The next computer 3:07pm. which state be given 800mg Ibu as needed he is to of deep breaths." This (direct care). An untitled form from emergent care facil under the section til "complain of right ri bathroom". Under to it states, "Fracture of E6 (direct care) was 1:00pm. E6 verified member who took F facility on 9/08/11. one or two ribs were verified that they we E2 was interviewed	histrator) which stated, "as omplete a GER (general event e is not a resident yetplease ht any bruising or further n (computer log) and notify is as well." The next computer R5 was on 9/07/11 at 9:53pm idn't ate (sic) supper, he said ell, but he did not describe vas feeling." This was written log entry is dated 9/09/11 at es R5 "has 2 cracked ribs is to profen every 6 hours for pain cough frequently and take is entry was written by E6 m the visit to the out patient ity dated 9/08/11 at 11:05am., tled "Reason for Visit" states b pain after falling in his the section titled "Diagnoses" of rib, closed." is interviewed on 9/15/11 at d that she was the staff R5 to the emergent care When asked if she was told e broken, E6 stated two. E6 ere on the right side. on 9/13/11 at 12:45pm. fall was investigated, E2	W	154				
W 159		IED MENTAL	W	159			11/17/11	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build	LTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		14G294	B. WING	;	10/1	4/2011
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	=	
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	ge 15	W 15	59		
	integrated, coordina	treatment program must be ated and monitored by a ardation professional.				
	Based on interview Qualified Mental Re (QMRP) failed to er outside day training the day training site Plans (ISP) and Be	s not met as evidenced by: y and record review, the facility etardation Professional neure consistency with the site by failing to ensure that had current Individual Service havior Management Programs lividuals in the sample. (R2,				
	Findings Include:					
	female with diagnos	m 9/11, is a 68 year old ses of Moderate Mental ssion, and Aggressive				
	9/14/11 at 11:47am most recent ISP th Z3 checked the file have the facility's IS she had been reque	MRP) was interviewed on . Z3 was asked what was the e day training site had for R2, and stated that they did not SP for this year. Z3 stated that esting it from the facility since ted that the staffing for Z3				
	states, "We have be our upcomingsurv following paperwork case files. If you co	8/11 from Z3 to the facility een reviewing case files for vey and have found the c missing from the workshop buld review the list below, end them to me as soon as				

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	14G294	B. WING _		10/14	4/2011
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
items requested for programs and moni- to present." R2's clinical record dated 2/15/11. E2 10:05am. When as did not have R2's co- stated that ISP's and stated, "They didn't 2) R3, per current I (ISP) of 6/21/11, is under the section til states, Profound Me Z3 (Day Training Q 9/14/11 at 11:47am most recent ISP th Z3 checked the file have the facility's IS what the most recen- stated that they did were not monitoring R3's clinical record dated 6/21/11. Unc Reaction To Situation what he wants to do respond in appropri- been working on a His aggression is do staff. He has some his short term goal aggression per mor-	ally appreciate it." Among the R2 are "Residential ISP with thly progress reports for 9/09 at the facility contained an ISP was interviewed on 9/15/11 at sked why the day training site urrent ISP of 2/15/11, E2 e sent to day training and then have a copy of it?" Individualized Service Plan a 63 year old male. The ISP tled "Current Diagnosis" it	W 159			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G294	B. WIN	G		- 10/14/2011		
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 159	Continued From pa	ge 17	W 1	59				
	•	is of schizophrenia and is						
	which addresses ag	contained a BMP dated 3/10 ggression. Hand written under d date of 3/10 is "6/11 ISP).						
	2:55pm. When ask ensuring that day tr	was interviewed on 9/15/11 at ked who was responsible for raining had copies of R3's ISP d that the facility would be.						
	year old male with or Retardation, Organ	ans Order Sheet of 9/11 is a 74 diagnoses of Severe Mental ic Brain Syndrome with or, and Intermittent Explosive						
	9/14/11 at 11:47am most recent ISP th Z3 checked the file have the facility's IS what is the most re- stated that they did	MRP) was interviewed on a. Z3 was asked what was the e day training site had for R4, and stated that they did not SP for this year. When asked cent BMP they had for R4, Z3 not have a BMP for R3. and any methodologies to on, Z3 stated no.						
	7/21/11. Under the Situations" it states with having intermit currently takes Zyp (R4) gets upset he call others names a	acility contained an ISP dated section titled "My Reaction To , R4 is currently diagnosed ttent explosive disorder. He rexa" It also states, "When likes to yell and curse. He will and it takes quite a bit for him 's facility record also contained						

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		I AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G294	B. WING		- 10/14/2011		
NAME OF P	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 248	483.440(c)(7) INDI	VIDUAL PROGRAM PLAN	W 24	8		11/17/11	
	made available to a of other agencies w	nt's individual plan must be all relevant staff, including staff /ho work with the client, and to if the client is a minor) or legal					
	Based on interview failed to ensure tha current Individual S	s not met as evidenced by: and record review, the facility t the day training site had ervice Plans (ISP) for 3 of 4 ample. (R2, R3, and R4)					
	Findings Include:						
	9/11, is a 68 year o	ans Order Sheet (POS) from ld female with diagnoses of etardation, Depression, and or .					
	9/14/11 at 11:47am most recent ISP th Z3 checked the file have the facility's IS she had been reque	MRP) was interviewed on a. Z3 was asked what was the e day training site had for R2, and stated that they did not SP for this year. Z3 stated that esting it from the facility since ited that the staffing for Z3					
	states, "We have be our upcomingsur following paperworl case files. If you co make copies and so	8/11 from Z3 to the facility een reviewing case files for vey and have found the k missing from the workshop buld review the list below, end them to me as soon as ally appreciate it." Among the					

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G294	B. WIN	G		- 10/14/2011		
NAME OF P	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	PLACE				99 HARRIS ROAD AST PEORIA, IL 61611			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 248	Continued From pa items requested for programs and mont to present." R2's clinical record contained an ISP da interviewed on 9/15 why the day training ISP of 2/15/11, E2 s day training and the copy of it?" 2) R3, per current I (ISP) of 6/21/11, is under the section the states, Profound Me Z3 (Day Training Q 9/14/11 at 11:47am most recent ISP th Z3 checked the file have the facility's IS R3's record at the fa 6/21/11. E2 (Admir 9/15/11 at 2:55pm. responsible for ensi- copies of R3's ISP, would be. 3) R4, per Physicial year old male with o	nge 19 r R2 are "Residential ISP with thly progress reports for 9/09 at the facility was reviewed. It ated 2/15/11. E2 was 5/11 at 10:05am. When asked g site did not have R2's current stated that ISP's are sent to en stated, "They didn't have a Individualized Service Plan a 63 year old male. The ISP tled "Current Diagnosis" it ental Retardation. MRP) was interviewed on n. Z3 was asked what was the re day training site had for R3, and stated that they did not	W 2	48				
		MRP) was interviewed on . Z3 was asked what was the						

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WIN	1G		10/1/	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(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 248	most recent ISP th Z3 checked the file have the facility's iS R4's clinical record	e day training site had for R4, and stated that they did not	W 2	248			
W 318	dated 7/21/11. 483.460 HEALTH C The facility must en services requireme	sure that specific health care	WS	318			11/17/11
	Based on interview failed to provide add care for 1 of 1 indiv facility as a pre-adn fractured ribs due to	is not met as evidenced by: and record review, nursing equate and prompt medical idual (R5) who was visiting the nission and who had two o a fall while unsupervised shower and fell, when they					
	bathing and dressin	ate supervision while providing ng for 1 of 1 individual (R5) e facility as a pre-admission.					
	individual (R5) after	up assessment of 1 of 1 r a fall in the bathroom for obtaining an X-ray which bs.					
	prompt health care physicians orders for was visiting the faci	alth care needs, provide services and obtain or 1 of 1 individuals (R5) who ility as a pre-admission, falling resulting in two fractured ribs.					
	This resulted in an	Immediate Jeopardy.					

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WING _		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 318	Continued From pa	ige 21	W 318	3		
	failed to provide ad	and record review, nursing equate and prompt medical riduals in the sample (R1 and d to:				
	Follow up with n potential head injur	euro checks for R1 after ies.	L			
		riate skin care including an ssessment for R1 who en area.	L			
	4) Provide bowel m has a diagnosis of a	novement tracking for R3 who constipation.	l			
	Findings Include:		I			
	was identified to ha fell in the facility bat and the facility faile Physicians visit unti diagnosed with two safety measures ha regarding R5's pers The facility failed to facility policy does r how to meet the nu visitors. E2 (Admin	om, an Immediate Jeopardy two begun on 9/06/11 when R5 throom while unsupervised d to follow-up with a il 9/08/11 when R5 was fractured ribs. No additional ave been implemented sonal care or retraining of staff. o investigate this incident. The not address overnight visits or rising needs of overnight histrator) was notified of the by on 9/14/11 at 3:00pm.				
	E2 was notified that removed on 9/23/17	t the Immediate Jeopardy was 1 at 2:30pm.				
	Refer to deficiencie	s cited at:	l			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WI	NG _		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 318	Continued From pa W322-Physicians S	-	W	318	}		
	W331-Nursing Serv	vices					
W 322	W368-Medication A With Physicians Or 483.460(a)(3) PHYS		W	322	2		11/17/11
	The facility must pro general medical car	ovide or obtain preventive and re.					
	Based on interview failed to ensure that	s not met as evidenced by: and record review, the facility t referrals to specialists were of 4 individuals in the					
	Findings Include:						
	is a 64 year old fem and "requires staff a Physicians Order S diagnoses, Modera Osteoporosis, Spee Salivation, Moderat and Degenerative J	vidual Service Plan of 6/21/11, nale who uses a wheelchair assistance for transfers." R1's heet (POS) for 9/11 lists under te Mental Retardation, ech Disorder, Excessive e Paraplegia, Encephalopathy, loint Disease. The POS for is on a Pureed diet.					
	dated 7/25/11 signe Physician) states "F study Dx (diagnosi	ord contained a prescription ed by Z1 (Personal Care Pt (patient) needs swallow s) Pureed Diet". No swallow n the clinical record.					
	E2 (Administrator)	was interviewed on 9/15/11 at					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		14G294	B. WI	NG .		10/1	4/2011
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	۶IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 322 W 331	 11:50am. When as ordered 7/25/11 wa have to look." On S reported that R1's s 9/19/11. 2) R1's current Phy the section titled "La R1 is to have a marmost recent mammis from 7/26/10. E2 was interviewed When asked for R1 E2 stated that she was current. On 9/15/1 R1's mammogram 483.460(c) NURSIN The facility must proservices in accorda This STANDARD i Based on interview failed to provide ad care for 1 of 1 indiv facility as a pre-adm fractured ribs due to after completing a s failed to: 1a) Provide adequibathing and dressir who was visiting the pre-admission. 	sked if R1's swallow study s completed, E2 stated, "I'll 0/15/11 at 1:34pm., E2 swallow study is scheduled for vsicians Order Sheet, under aboratory Orders" states that mmogram done yearly. The logram in R1's clinical record on 9/15/11 at 11:50am. 's most recent mammogram, would see if there is one more 1 at 1:34pm, E2 reported that is scheduled for 9/20/11.	W				11/17/11

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		I AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WING _		10/14	4/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	resulting in a delay showed fractured ri 1c) Identify the he prompt health care physicians orders for was visiting the fact while unsupervised This resulted in an Based on interview failed to provide ad care for 2 of 4 indiv R3) when they faile 2) Follow up with m potential head injur 3) Provide appropri updated skin risk as experienced an ope 4) Provide bowel m has a diagnosis of of Findings Include: On 9/14/11 at 3:00p was identified to ha fell in the facility bai and the facility faile Physicians visit unt diagnosed with two safety measures ha regarding R5's persi-	er a fall in the bathroom for obtaining an X-ray which bs. alth care needs, provide services and obtain or 1 of 1 individuals (R5) who ility as a pre-admission, falling resulting in two fractured ribs. Immediate Jeopardy. and record review, nursing equate and prompt medical iduals in the sample (R1 and d to: neuro checks for R1 after ies. riate skin care including an ssessment for R1 who en area.	W 331			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WI	NG _		10/1	4/2011
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 331	how to meet the nu visitors. E2 (Admin Immediate Jeopard 1a) The facility faile supervision while p for 1 of 1 individuals facility as a pre-adm R5, per "Authorizati form dated 8/12/11 facility computer log 2:20pm states that coming this afterno visit for screening p He previously was I some daily assistan aide. This is the int available at this tim as; "own guardian, ambulation, pureed limited vision, will n ADL's (bathing, hyg of Daily Living]. Th this is a potential en have a short period placement will be a provide service to h was made by E2 (A A computer log ent states, "I assist (sic dry (sic)him off and clothes before I left back in and he was toilet. So I went to	not address overnight visits or rsing needs of overnight histrator) was notified of the ly on 9/14/11 at 3:00pm. The d to provide adequate roviding bathing and dressing s (R5) who was visiting the nission. The evill be a male visitor on and staying for a 2 week prior to a possible admission. There will be a male visitor on and staying for a 2 week prior to a possible admission. The information is listed utilized a walker for diet, no current medications, eed physical assistance in piene, etc)" [ADL's, Activities the computer log continues "As mergency placement we only of time to screen if his ppropriate and if we can him." This computer log entry	W	331			

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		I AND HUMAN SERVICES			FORM	: 02/25/2012 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	ILTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	
		14G294	B. WING	3	10/1	4/2011
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 331	visible at that mom side was hurting. I situation." This cor E3 (direct care). E3 was interviewed asked approximate occurred, E3 stated 4:30pm. When ask received prior to his stated stay with him when putting clothe shower does he dre "Yes." When aske stated, "I talk to him to do." E2 (Administrator) 12:45pm. E2 verifi on 8/12/11. E2 was that the facility had care needs at the ti provided a set of de form titled Departm of Rehabilitation Se Need" dated 3/02/1 "Dressing" it states shirt and pants on s the clothes to put o to put on his shoes Under the section t able to get in and o balance is not very A "Home Services	e if any bruise, there were no ent. He state (sic) that his call (sic) nurse about the mputer log entry was made by I on 9/15/11 at 3:40pm. When ly what time the incident d that it was approximately ked what instructions she had s fall regarding ADLs, E3 n when in the shower, step out es on. When asked if after his ess in the bathroom, E3 stated, d how she knew this, E3 n, he tells me what he is able was interviewed on 9/13/11 at ed that R5 came to the facility s asked for any information which addresses R5's health me he came to the facility. E2 ocuments. Included was a ient of Human Service-Division ervices "Determination of 0. Under the section titled , "Needs help to put his tee saying his hands will not grip n. Not able to use his hands and socks." itled "Bathing" it states, "Is not ut of tub by himself saying his good and needs help."	W 33	31		

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G294	B. WIN	IG		10/14	4/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(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 331	"Homemaker." Und it states that it is do A facility "Prescreen R5 under the sectio "Physical Assist." E2 was interviewed When asked how s E2 stated that they 1b) The facility faile follow-up assessme after a fall in the ba obtaining an X-ray w A computer log ent written by E4 (Nurs tonight while he wa told the Staff (sic) the extremely bad. Rea the (direct care staff E3 was interviewed asked approximate nurse of the fall, E3 nurse about 5:00pm Tylenol." E4 (nurse) was inter When asked what the R5's fall, E4 stated When asked if she R5 that evening, shi was in bed when E4 was laying on his left E4 stated that she w	der the task listed as Dressing one by a "Homemaker." In Form" (undated) regarding on titled "Dressing" it states If on 9/13/11 at 12:45pm. Staff were to meet R5's needs, were to assist with all ADL's. ed to provide a nursing ent of 1 of 1 individuals (R5) of throom resulting in a delay for which showed fractured ribs. ry dated 9/06/11 at 7:51pm. (e) states, R5 "Had a fall s in the bathroom. Resident hat his side was hurting sident was given Tylenol by	Wa	331			

I

Facility ID: IL6013346

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WING	G		10/14	4/2011
NAME OF F	PROVIDER OR SUPPLIER		S		FADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				T PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (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)	JLD BE	(X5) COMPLETION DATE
W 331	his right foot. E4 st the assessment the swelling and no edd The computer log e states, "Will continu- change of condition On 9/07/11 at 8:33a made by E2 (Admir there is no way to c report) on him as he be sure to documer complaints of pain i (E4) of any changes log entry regarding which stated, R5 "d he wasn't feeling we exactly on how he we by E5 (direct care). The next computer 3:07pm. which state be given 800mg ibut as needed he is to deep breaths." This (direct care). A form from the vis care facility dated 9 section titled "Reas of right rib pain afte Under the section ti "Fracture of rib, close E6 (direct care) was 1:00pm. E6 verified	ated that at the time she did ere was no redness, no ema. entry of 9/06/11 at 7:51pm. ue to assess Resident for n." am. a computer log entry was histrator) which stated, "as complete a GER (general event e is not a resident yetplease int any bruising or further in (computer log) and notify s as well." The next computer R5 was on 9/07/11 at 9:53pm lidn't ate (sic) supper, he said ell, but he did not describe was feeling." This was written log entry is dated 9/09/11 at es R5 "has 2 cracked ribs is to uprofen every 6 hours for pain cough frequently and take s entry was written by E6 it to the out patient emergent u/08/11 at 11:05am., under the on for Visit" states "complain er falling in his bathroom." itled "Diagnoses" it states,	W 33	31			

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WI	NG _		10/14	4/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 331	facility on 9/08/11. one or two ribs were verified that they we interviewed on 9/14 there have been an R5 since the fall, E6 heal itself in 2 week and Ibuprofen every E2 (Administrator) of 12:45pm. When as investigation into R9 9/06/11, E2 stated, interviewed on 9/13 there has been any R5's needs regardin dressing, E2 stated asked if staff were to R5, E2 stated, "Ass and assist." 1c) Identify the hea prompt health care physicians orders for was visiting the faci while unsupervised E2 (Administrator) of 12:45pm. E2 verified on 8/12/11. E2 was that the facility had health care needs a facility. E2 provided physicians orders we documents. A computer log entiti	When asked if she was told e broken, E6 stated two. E6 ere on the right side. E6 was l/11 at 9:20am. When asked if by new instructions regarding 6 stated that she was told it will ks, to give him a pillow for it y 4 hours as needed. was interviewed on 9/13/11 at sked if there was an 5's fall in the bathroom on "I don't believe so." E2 was 8/11 at 2:42pm. When asked if retraining of staff to address ng being in the bathroom and I, "I'll have to look." When to do anything different with sist with all ADL's, supervise alth care needs, provide services and obtain or 1 of 1 individuals (R5) who ility as a pre-admission, falling resulting in two fractured ribs. was interviewed on 9/13/11 at ed that R5 came to the facility s asked for any information regarding addressing R5's at the time he came to the d a set of documents. No	W	331			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G294	B. WII	NG _		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 331	Continued From pa	ge 30	W	331			
	tonight while he was told the Staff (sic) th	s in the bathroom. Resident nat his side was hurting sident was given Tylenol by					
	asked approximate nurse of the fall, E3	on 9/15/11 at 3:40pm. When ly what time she notified the stated that she called the n and the "nurse said give him					
	9/06/11 states that at 4:45pm by E3 (di interviewed on 9/14 R5 had an order for stated, "He came h home for something will not see him unt admitted. He does	nistration Record dated R5 was given Acetaminophen irect care). E4 was /11 at 1:55pm. When asked if r the Acetaminophen, E4 ere with Tylenol. He took it at g else. (Z1, facility physician) il he's admitted. He is not not have a routine doctor. I've administrator and she knows."					
	12:45pm. When as	was interviewed on 9/13/11 at sked if R5 had any physicians 'll have to look." No order for vided.					
	Rehabilitation Servi form dated 3/02/10 "Eating" states, "Sa ground up saying he Says he has trouble	Human Services-Division of ces "Determination of Need" under the section titled ys he has to have his food e is not able to eat whole food. e chewing his food mostly s stuck to his teeth."					
	11/08/08 states, "H	rt from a local hospital dated e is also having difficulty with is being evaluated by the					

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WIN	IG		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(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 331	on a modified diet. However, he denies A facility "Social His under the section ti diet." E2 was interv When asked if ther the pureed diet, E2 he came with." The diet provided. E2 w 2:42pm. When ask information for the p believe that's on the from the PAS (prea Facility Policies "Ad March 2007, "Admi "Visitors" dated Mar Admission Process section 1.f. states, ' pre-screen form to placement. An ove meeting with the po- encouraged." Unde Admissions Process issues will be discu- including but not lim funding, and the be The Visitors policy of paragraph is the on individuals visiting t admission and only serious maladaptive E2 (Administrator) w	w evaluation group and he is He has swallowing difficulty. s any aspiration or choking." story" form dated 9/13/11 tled "Health" it states "Pureed viewed on 9/13/11 at 12:45pm. e was a physicians order for stated, "Not other than what ere was no order for a pureed vas interviewed on 9/13/11 at ked where the facility got the pureed diet from, E2 stated, "I e pre-screen form, information admission screening) agent." dmission Process" dated ssions" dated 12/1/08, and rch 2007 were reviewed. a dated March 2007, under the "The team will complete a determine suitability for ernight visit or face-to-face otential resident is er the section titled 3. is, 3. A. b. states, "Several ussed with those present, nited to, the trial period, ed hold policy." dated March 2007, the last hy section that addresses the facility prior to an or regarding incidents of e behavior. was interviewed on 9/14/11 at	W 3	331	DEFICIENCY)		
	9:53am. When ask	ked if the admission policies					

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G294	B. WIN	IG		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 331	 address individual r visits, E2 stated, "I E2 (Administrator) v 12:45pm. E2 verifie on 8/12/11. E2 was notified that removed on 9/23/1⁻ surveyor confirmed of the facility plan th following actions to Jeopardy. A proceed visits has been developed for (RSD) to ensure that all staff so individual visits needs are ide passed without a cu will be retrained on policy. The RSD wit investigations. All se Registered Nurse (I is notified if there is While the Immediate 9/23/11, the facility the facility has not h implement and eval plan. 2) The facility failed checks for R1 after R1, per current Indi is a 64 year old fem 	fic information is needed to needs during trial overnight	W 3	331			
	is a 64 year old fem	nale who uses a wheelchair					

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	
		14G294	B. WING _		10/14	4/2011
NAME OF P	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 331	Continued From pa	ige 33	W 331			
	"was being assisted her stand as she pu began to wiggle. S slipped and bumpe the fall, staff contro hair, checked vitals for observation. (R puzzle books and b finally did go back t monitor her through E4 (Nurse) was inte 1:50pm. E4 was as head injury of 9/11/ asked if she had do head injury, E4 stat checks had been do 9/11/11, E4 stated thave done them if t if Neuro checks are staff have a sheet f should staff initiate "Right away, anytim When asked if dired Neuro checks, E4 s No documentation done were provided The facility policy tit dated March 2007 of section titled "Policy this facility that neu completed when on Additionally, neurole	erviewed on 9/14/11 at sked if she was notified of R1's 11. E4 stated, no. When one an assessment of R1's ted, no. When asked if Neuro one due to R1 head injury of that the direct care staff would they were done." When asked e documented, E4 stated that for that. When asked when Neuro checks, E4 stated ne a person hits their head." ct care are trained to perform stated, yes. of Neuro checks having been d for the incident of 9/11/11. tled "Neurological Checks" was reviewed. Under the y" it states, "It is the policy of rological checks may be initiated ure when there is reason to				

Facility ID: IL6013346

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G294	B. WIN	IG		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			-	AST PEORIA, IL 61611		
(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 331	Continued From pa neurological event l	-	W 3	331			
	section titled "Injury (sic) and fell in the s off. She hit her hea was interviewed on asked if Neuro chea R1's head injury on check. E4 stated th be in the chart. No	eport dated 8/04/11,under the / Summary" states, R1 "slip shower while I was drying her ad on the shower head." E4 9/14/11 at 1:50pm. When cks were done as a result of 8/04/11, E4 stated she would hat the Neuro checks should documentation of Neuro n done were provided for the					
		d to provide appropriate skin pdated skin risk assessment nced an open area.					
	is a 64 year old fem and "requires staff a Physicians Order S diagnoses, Modera Osteoporosis, Spee Salivation, Moderat and Degenerative J section titled "Treat Balm: Apply Topica	ividual Service Plan of 6/21/11, nale who uses a wheelchair assistance for transfers." R1's theet (POS) for 9/11 lists under te Mental Retardation, ech Disorder, Excessive te Paraplegia, Encephalopathy, Joint Disease. "Under the tment Orders" it states, "Bag ally Twice Daily To Prevent To Pressure Areas".					
	by Z1 (Personal Ca section titled "Findir states, Right Buttoc Fold. The plan liste cream antibiotic oin						
	A computer log enti	ry dated 1/28/11 states, R1					

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WING _		10/14	4/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	"has a sore on her doctor and she nee side of the sore. Al 2-3 times daily until with this over the w (computer log entry how the sore is loof A computer log ent states, "The sores of not too bad." A computer log ent states, "her bottom A computer log ent states, "her bottom A computer log ent states, "Her sores l A "Monthly Nursing 2/12/11 under the s Diagnoses" states, tenderness." R1's Medication Ad were reviewed. R1 Balm Apply Topical Break Down To Pre as having been use times). R1's MAR to documented as hav opportunities (61 tir the Bag Balm had r been used at all in 2/11 for the Bag Bal been used on all op E2 (Administrator)	buttocks. She went to the eds to sleep on the opposite lso apply (antibiotic ointment) l it heals. Please follow up eekend. When you do your /) for (R1), please comment on king and healing." ry dated 1/29/11 at 8:47am. on her butt still look fresh, but ry dated 1/29/11 at 10:41pm. is looking better." ry dated 1/30/11 at 8:37pm.	W 331			

Facility ID: IL6013346

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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 B. WING 14G294 10/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 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 331 Continued From page 36 W 331 not documented as used in January 2011, E2 stated, "I'll look into it, but that's the only documentation we have." On 9/15/11 at 1:10pm, regarding the Bag Balm documentation for 1/11, E2 stated, "I guess it (the documentation sheet) was never put in." There was no documentation to determine if or how frequently the Bag Balm was applied during 1/11, the month R1 developed sores on her Gluteal Fold area. Per a review of R1's clinical record, no skin risk assessment was located. Facility Policy "Pressure Ulcer Prevention" dated March 2007 was reviewed. Under the section titled "Procedure" it states, "1. If necessary, within 14 day (sic) of admission, residents will have an assessment for pressure ulcer, using a standardized assessment. 2. All resident assessments will be reviewed and revised as necessary on a quarterly basis. 3. Level of risk for the development of pressure ulcers will be addressed on the nursing care plan." The policy goes on to address plans for individuals determined to be "Moderate Risk Residents" and "High Risk Residents." E2 was interviewed on 9/15/11 at 1:34pm. When asked for a Skin Risk Assessment on R1, E2 stated, "I'll look for it." On 9/15/11 at 2:00pm, E2 stated that the skin risk is completed as part of the nursing guarterly. E2 stated the skin is assessed through observation. When asked if, other than observations done on the nursing quarterlies is there a current skin risk assessment using a standardized assessment, E2 stated, "I am not aware of any other than the admit assessment." E2 was interviewed on 9/16/11 at 10:50am. When asked for a standardized skin

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	02/25/2012 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
		14G294	B. WI	NG _		10/14	4/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD		
HARRIS	PLACE				EAST PEORIA, IL 61611		
(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 APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 331	risk assessment of urr nursing quarterly, E have." When askes skin risk assessme per facility policy, E locate, no." 4) The facility failed tracking for R3 who constipation. R3, per current Indi of 6/21/11, is a 63 y the section titled "T constipation and the basis." Under the s Diagnosis" it states and History of Cons A Consultation Forr and signed by Z1 (F under the section ti "Findings/Recomm mark and states co bloating. A monthly month of 8/11 and o titled "Appointments" with Z1. Under "Dia of water and give m bowel movements" by E4 (Nurse). R3's as needed MA given Milk of Magne	her than the visual ent skin status done on the 2 stated, "That's what we d if there was a standardized nt done during admission as 2 stated, "Not that we can d to provide bowel movement o has a diagnosis of vidualized Service Plan (ISP) year old male. The ISP under oileting" states, "He has en diarrhea on a regular section titled "Current , Profound Mental Retardation stipation. m regarding R3 dated 8/02/11 Personal Care Physician), tled endations" it has a question nstipation mild abdominal y "Health Care Report" for the dated 9/1/11 under the section s" states, 8/2/11 at 1:30pm agnosis" it states, "give plenty nilk of magnesis and monitor . This report was generated NR for 8/11 states that R3 was esia one time for the month of at 3:25pm. for constipation.	W	331			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G294	B. WIN	IG		10/14	4/2011
NAME OF PF	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS F	PLACE				AST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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)	JLD BE	(X5) COMPLETION DATE
W 368	2:25pm. When ask to give plenty of was stated that because to give water, Milk of When asked how R monitored, E2 state facility's computer of was asked if there w monitoring of bowel E2 stated that she w 9/15/11 at 2:50pm., a system for monito "during that time the properly." When as documentation of bo during 8/11 for R3, 9/16/11 at 10:50am facility has a system that time period it w 483.460(k)(1) DRU The system for drug that all drugs are ac the physician's order This STANDARD is Based on interview failed to ensure that ordered by the physi individuals in the fac Findings Include: 1) R6, per Physicia	erviewed on 9/15/11 at sed about the recommendation ter and milk of magnesis, E2 e of the constipation (Z1) said of Magnesium, and monitor. R3's bowel movements are ed that it is recorded on the documentation system. E2 was any documentation of the I movements for R3 for 8/11? would have to check. On E2 stated that the facility has oring bowel movements but e system was not utilized sked if the facility had any owel movement tracking E2 stated, "We do not." On L, E2 again verified that the n in place but for R3 during ras "not utilized." G ADMINISTRATION g administration must assure dministered in compliance with ers. s not met as evidenced by: and record review, the facility t medications were passed as sician without error for 3 of 14 cility. (R6, R7, and R8)	W 3				11/17/11

DEPARTMENT OF HEALT CENTERS FOR MEDICAR					FORM	02/25/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	14G294	B. WI	NG		- 10/14/2011		
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS PLACE				09 HARRIS ROAD AST PEORIA, IL 61611			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 368 Continued From p	age 39	W	368				
 the facility regardin 7/14/11 and stated to (a local hospital dizziness. Lab wo currently awaiting may be due to a ma	sent to the Department by the 11 stated, "After an a determined per staff member 6) received an additional 200mg the AM med pass on July 9-12. The hospital are still pending. It at after a (outpatient emergent n 7/08/11 that an incorrect med pharmacy which resulted in an back of a medication that had as delivered on July 8th, 2011. Dose (150mg) and the additional histered on July 9th, 10th, 11th, erviewed on 9/15/11 at d that R6 went to the (outpatient ility) and an order was sent to stated that the pharmacy sent ad 200mg pills. When asked if y retraining since the incident, f can no longer put medications hat if a nurse is not in the n not dispose of or put any new						

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G294	B. WIN	NG		10/1	4/2011
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS I	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(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 368	Continued From pa	ige 40	W 3	368			
W 440	the facility regarding 7/25/11 and was in which occurred on 7 R8's "4:00 medicati The medications lis Colestipol, Metform 3) R7, per POS of who functions in the Retardation. An incident was rep the facility regarding 8/05/11 and was in which occurred on 8 R7's "AM nebulizer Pulmicort) was omi 483.470(i)(1) EVAC The facility must ho quarterly for each s This STANDARD is Based on interview failed to ensure tha completed quarter f individuals in the fac Findings Include: The facility evacuat	CUATION DRILLS old evacuation drills at least shift of personnel. s not met as evidenced by: v and record review the facility t evacuations drills were for all three shifts for 14 of 14 cility. (R1-R4, R6-R15) tion drills were reviewed. were no evacuation drills	W 4	440			11/17/11

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G294	B. WI	NG _		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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 440	Continued From par For second shift, the available between 7 For third shift, there available since 3/13 E2 (Administrator) when asked if there since 2/01/11, E2 stated, asked if there were 3/31/11, E2 stated 7 FINAL OBSERVAT LICENSURE VIOL 350.620a) 350.620a) 350.620a) 350.1210 350.1220j) 350.1230d)2) 350.3240a) Section 350.620 Ref a) The facility shall procedures governif facility which shall to involvement of the a shall be available to	ge 41 ere were no evacuation drills 1/18/11 and 7/19/11. e were no evacuation drills 8/11. was interviewed on 9/16/11. e were any first shift drills tated no. When asked if there hift drills between 1/18/11 and "It doesn't appear so." When any third shift drills since "None since March."	W99	440	DEFICIENCY)		
	least annually.	y and shall be reviewed at Imission, Retention and					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G294	B. WI	NG _		10/14/2011		
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611			
(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	
W9999	 b) Residents shall of a comprehensive e emotional, social ar by an appropriately team. Section 350.1210 F The facility shall pro- maintain each reside Section 350.1220 F j) The facility shall r of any accident, inju- condition that threa welfare of a resider the presence of inc- ulcers or a weight lo- more within a perior Section 350.1230 N d) Direct care personare not limited to, the 2) Basic skills require and problems of the Section 350.3240 A a) An owner, licens agent of a facility sh resident. (Section 2) These Regulations by: 	Analysis admitted who have had valuation covering physical, and cognitive factors, conducted constituted interdisciplinary Health Services ovide all services necessary to lent in good physical health. Physician Services notify the resident's physician ury, or change in a resident's tens the health, safety or at, including, but not limited to, ipient or manifest decubitus oss or gain of five percent or d of 30 days. Jursing Services onnel shall be trained in, but ne following: red to meet the health needs e residents. Abuse and Neglect ee, administrator, employee or nall not abuse or neglect a	W9	999				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY	
		14G294	B. WING	;	- 10/14/2011		
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W9999	 care for 1 of 1 indiv facility as a pre-adm fractured ribs due to after completing a s a) Provide adequate bathing and dressing who was visiting the pre-admission. b) Provide follow-ut individuals (R5) after resulting in a delay showed fractured ritical c) Identify the heaten health care services for 1 of 1 individuals facility as a pre-adm unsupervised result Findings Include: a) The facility failer supervision while p for 1 of 1 individuals facility as a pre-adm R5, per "Authorizattiform dated 8/12/11 facility computer log 2:20pm states that coming this afterno visit for screening p He previously was b some daily assistant 	equate and prompt medical idual (R5) who was visiting the hission and who had two o a fall while unsupervised shower, when they failed to: te supervision while providing hg for 1 of 1 individuals (R5) e facility as an overnight p assessment of 1 of 1 er a fall in the bathroom in obtaining an X-ray which bs. Ith care needs, provide prompt s and obtain physicians orders s (R5) who was visiting the hission, and fell while ting in two fractured ribs.	W999				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WI	3. WING		10/14/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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
W9999	available at this tim as, "own guardian, ambulation, pureed limited vision, will n ADL's (bathing, hyg Daily Living]." The this is a potential er have a short period placement will be a provide service to h was made by E2 (A A computer log entr states, "I assist (sic dry (sic) him off and clothes before I left back in and he was toilet. So I went to Director) to help me over his body to see visible at that mome side was hurting. I situation." This con E3 (direct care). E3 was interviewed asked approximate occurred, E3 stateo 4:30pm. When ask received prior to his stated stay with him when putting clothe shower does he dre "Yes." When asked stated, "I talk to him to do."	e." The information is listed utilized a walker for diet, no current medications, eed physical assistance in iene, etc) [ADL's, Activities of computer log continues, "As nergency placement we only of time to screen if his ppropriate and if we can im." This computer log entry	W9	999			

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G294	(X2) M A. BU B. WII	ILDIN	PLE CONSTRUCTION G	FORM OMB NO (X3) DATE S COMPLE	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		7/2011
HARRIS	PLACE			20	09 HARRIS ROAD AST PEORIA, IL 61611	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W9999	12:45pm. E2 verifie on 8/12/11. E2 was that the facility had care needs at the ti provided a set of do form titled Departm of Rehabilitation Se Need" dated 3/02/1 "Dressing" it states shirt and pants on s the clothes to put o to put on his shoes section titled "Bathi in and out of tub by not very good and r A "Home Services I 1/31/11 regarding F "Bathing," states th "Homemaker." Une states that it is done A facility "Prescreen R5 under the sectio "Physical Assist." E2 was interviewed When asked how s E2 stated that they b) The facility failed follow-up assessme after a fall in the ba obtaining an X-ray of A computer log ent written by E4 (Nurs	ed that R5 came to the facility s asked for any information which addresses R5's health me he came to the facility. E2 ocuments. Included was a ent of Human Service-Division ervices "Determination of 0. Under the section titled , "Needs help to put his tee saying his hands will not grip n. Not able to use his hands and socks." Under the ng" it states, "Is not able to get himself saying his balance is needs help." Program Service Plan" dated R5, under the task listed as	W9	999			

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		I AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WING	i	10/14	4/2011
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE			209 HARRIS ROAD EAST PEORIA, IL 61611		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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
W9999	told the Staff (sic) the extremely bad. Rest the (direct care staff E3 was interviewed asked approximate nurse of the fall, E3 nurse about 5:00pm Tylenol." E4 (nurse) was inter When asked what the R5's fall, E4 stated When asked if she R5 that evening, she was in bed when E4 was laying on his le E4 stated that she complain about his his right foot. E4 st the assessment the swelling and no ede The computer log ef states, "Will continue change of condition On 9/07/11 at 8:33a made by E2 (Admin there is no way to cor report) on him as he be sure to documer complaints of pain i (E4) of any changes log entry regarding which stated, R5 "d he wasn't feeling wo	hat his side was hurting sident was given Tylenol by ff)." I on 9/15/11 at 3:40pm. When ly what time she notified the stated that she called the n and the "nurse said give him erviewed on 9/14/11 at 1:55pm. time she was notified about that it was around 5:00pm. had done an assessment of the stated, yes. E4 stated R5 4 arrived at the facility and he efft side with his right side up. woke R5 up and he did not right rib hurting but mentioned tated that at the time she did ere was no redness, no ema.	W999			

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SL COMPLE	JRVEY
		14G294	B. WI	IG		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				09 HARRIS ROAD AST PEORIA, IL 61611		
(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	Continued From pa by E5 (direct care).	-	W99	999			
	3:07pm. which state be given 800mg ibu as needed he is to	log entry is dated 9/09/11 at es R5 "has 2 cracked ribs is to uprofen every 6 hours for pain cough frequently and take s entry was written by E6					
	care facility dated 9 section titled "Reas of right rib pain afte	it to the outpatient emergent 0/08/11 at 11:05am., under the on for Visit" states "complain er falling in his bathroom." itled "Diagnoses" it states, sed."					
	1:00pm. E6 verified member who took F facility on 9/08/11. one or two ribs were verified that they we interviewed on 9/14 there have been an R5 since the fall, E6 heal itself in 2 week	s interviewed on 9/15/11 at d that she was the staff R5 to the emergent care When asked if she was told e broken, E6 stated two. E6 ere on the right side. E6 was 1/11 at 9:20am. When asked if by new instructions regarding 6 stated that she was told it will ks, to give him a pillow for it y 4 hours as needed.					
	12:45pm. When as investigation into R 9/06/11, E2 stated, interviewed on 9/13 there has been any R5's needs regardin dressing, E2 stated asked if staff were	was interviewed on 9/13/11 at sked if there was an 5's fall in the bathroom on "I don't believe so." E2 was 8/11 at 2:42pm. When asked if retraining of staff to address ng being in the bathroom and I, "I'll have to look." When to do anything different with sist with all ADL's, supervise					

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G294	B. WI	NG		10/14	4/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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
W9999	Continued From pa and assist."	ıge 48	W9	999			
	needs, provide pror obtain physicians o (R5) who was visitir	fell while unsupervised					
	12:45pm. E2 verifie on 8/12/11. E2 was that the facility had health care needs a	was interviewed on 9/13/11 at ed that R5 came to the facility s asked for any information regarding addressing R5's at the time he came to the d a set of documents. No vere included in the	1				
	written by E4 (Nurs tonight while he wa told the Staff (sic) th	ry dated 9/06/11 at 7:51pm. e) states R5, "Had a fall s in the bathroom. Resident hat his side was hurting sident was given Tylenol by ff)."					
	asked approximate nurse of the fall, E3	I on 9/15/11 at 3:40pm. When Ily what time she notified the 3 stated that she called the n and the "nurse said give him					
	9/06/11 states that at 4:45pm by E3 (di interviewed on 9/14 R5 had an order for stated, "He came h	nistration Record dated R5 was given Acetaminophen irect care). E4 was 1/11 at 1:55pm. When asked if r the Acetaminophen, E4 here with Tylenol. He took it at g else. (Z1, facility physician)					

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		HAND HUMAN SERVICES				FORM	02/25/2012 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	
14G294		14G294	B. WI	NG		10/14/2011	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HARRIS	PLACE				209 HARRIS ROAD EAST PEORIA, IL 61611		
(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
W9999	will not see him unt admitted. He does referred that to the E2 (Administrator) of 12:45pm. When as orders, E2 stated "I the Tylenol was pro- The Department of Rehabilitation Servit form dated 3/02/10 "Eating" states, "Sa ground up saying h Says he has trouble saying the food gets A consultation repo 11/08/08 states, "H swallowing, and he speech and swallow on a modified diet. However, he denies A facility "Social His under the section ti diet." E2 was interv When asked if there the pureed diet, E2 he came with." The diet provided. E2 w 2:42pm. When ask information for the p believe that's on the from the PAS (prea	il he's admitted. He is not not have a routine doctor. I've administrator and she knows." was interviewed on 9/13/11 at sked if R5 had any physicians I'll have to look." No order for	W9	999			

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DEPAR CENTER	FORM	PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
14G294		B. WI	NG _		10/14/2011			
NAME OF PROVIDER OR SUPPLIER HARRIS PLACE					TREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD EAST PEORIA, IL 61611			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
W9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 "Visitors" dated March 2007 were reviewed. Admission Process dated March 2007, under the section 1.f. states, "The team will complete a pre-screen form to determine suitability for placement. An overnight visit or face-to-face meeting with the potential resident is encouraged." Under the section titled 3. Admissions Process, 3. A. b. states, "Several issues will be discussed with those present, including but not limited to, the trial period, funding, and the bed hold policy." The Visitors policy dated March 2007, the last paragraph is the only section that addresses individuals visiting the facility prior to an admission and only regarding incidents of serious maladaptive behavior. E2 (Administrator) was interviewed on 9/14/11 at 9:53am. When asked if the admission policies address what specific information is needed to address individual needs during trial overnight visits, E2 stated, "I do not believe so." E2 (Administrator) was interviewed on 9/13/11 at 12:45pm. E2 verified that R5 came to the facility on 8/12/11. (A)		W9	999	Э			

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