Illinois Department of Public Health

Illinois L	epartment of Public	Health				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6013049	B. WING		05/08/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
WEBER	HOUSE		JAMES ROA	·-		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	SHOULD BE COMPLETE	
Z 000	COMMENTS		Z 000			
	ANNUAL LICENSU	RE SURVEY	UNAPPROPRIATE			
Z9999	FINDINGS		Z9999			
	Statement of Licens	sure Violations	Act to 40000 de commune management de commune de commun			
	coordinator and hou with all applicable st shall be responsible regulations are met employees are fami according to the level. This requirement is	The licensee, program use manager shall be familiar tatues and regulations. They for seeing that the applicable in the facility and that liar with those regulations el of their responsibilities.  NOT met as evidenced by:				
	Administrative Code Medication in Comm	r failed to follow Illinois Part 116, Administration of nunity Settings as required for the sample (R1, R3 and R4).				
	Findings include:					
	program coordinator familiar with all appli regulations. They shat the applicable refacility and that emples	states, "The licensee, and house manager shall be				
	Illinois Administrative Administration of Me	e Code Part 116, dications in Community				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PR5R11

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Illinois Department of Public Health

IIIINOIS L	Department of Public	Health				
AND PLAN OF CORRECTION IDEN				LE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED	
		IL6013049	B. WING		05/0	08/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY,	STATE, ZIP CODE		
WEBER	HOUSE		JAMES ROA			
			IELD, IL 62	707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z9999	Continued From page	ge 1	Z9999			
	Settings states, "Th	e purpose of this Part is to	TOTAL			
		findividuals in program	000da Endouven			
	funded by the Depa	rtment of Human Services				
	(DHS) by regulating	the storage, distribution, and				
	administration of me	edications. This applies				
	developmental disal	ograms for individuals with a bility in settings of 16 persons				
	or fewer that are fun	nded or licensed by the				
		an Services and that				
	distribute or administer medications and all intermediate care facilities for the developmentally disabled with 16 beds or fewer					
	that are licensed by Public Health."	the Illinois Department of	detroit no construinte			
			Albitrary			
	1) 2 of 4 individuals	in the sample (R1 and R3)	NAME OF THE PARTY		to service and the service and	
	had incomplete Self-Administration of Medication Assessments(SAMA):		Allowards and the second and the sec		The state of the s	
THE PERSON NAMED IN COLUMN TO THE PE	Part 116.60 a)2 state	es, "Individuals shall be				ĺ
	evaluated to determine their self-administration of medications capabilities by a Nurse-Trainer through the use of DHS required, standardized					
	screening and asses	ssment instrument.				
	R1 is identified on his	s Medication Administration				
		50 year old male with				
		nus and Allergic Rhinitis who				
	functions at the mild	level of Intellectual Disability.				
	Decision of D41 CAM	<b>A</b> 1 ( ) 1 ( ) ( ) ( )			***************************************	
Review of R1's SAM 3 is incomplete.		A dated 11/22/13, page 3 of				
	R3 is identified as his	MAP on a 40 year ald as al-	The state of the s		AAAAA IIII III III III III III III III	
4400000	with diagnosis of Dou	s MAR as a 49 year old male wn Syndrome, Heart Murmur,				
	Hypothyroidism and	Allergies who functions in the				
**************************************	Moderate level of Inte	ellectual Disability.	And the control of th			
		T ************************************				ĺ
Review of R3's SAMA dated 3/17/07, page 2 of 3 is incomplete.			THE STATE OF THE S		The state of the s	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
ANDILL	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
		IL6013049	B. WING		05/0	08/2014		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
WEDE	HOHEL	2520 ST .	JAMES ROA	D		İ		
WEDER	RHOUSE	SPRINGF	IELD, IL 62	707				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	.D BE	(X5) COMPLETE DATE		
Z9999	Continued From pa	ge 2	Z9999					
		Interview with E1 (Registered Nurse Trainer) on 5/8/14, E1 confirmed R1 and R3's SAMA were incomplete.						
		in the sample (R1) with s on the MAR were made by	Victoria de la constanta de la					
	Part 116.70 b)4) states, "All changes in medication shall be noted on the medication administration record by a licensed practical nurse, registered professional nurse, advanced practice nurse, pharmacist, physician, physician assistant, dentist, podiatrist, or certified optometrist."							
	with diagnosis of Str	is MAR as a 50 year old male rabismus and Allergic Rhiinitis mild level of Intellectual						
		R, Fluticasone Spray and the letters "PRN" (as n.						
		5/8/14, E1 states the PRN" are not written by E1.						
	3) 1 of 1 individuals Medication label that physician's order.	in the sample (R1) had a t did not match the			TO TO CONTROL TO THE TOTAL TO T			
	licensed practical nu shall review the follo medication labels an	tates, "A registered advanced practice nurse, rse, pharmacist or physician wing for all individuals: d medications listed on the ration record to ensure that			TO THE PARTY OF TH			

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they match physician orders."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED
IL6013049		IL6013049	B. WING		05/	08/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE		
			IAMES ROA			
WEBER	HOUSE		IELD, IL 62			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	REGULATORY OR L	' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
		,	1/10	DEFICIENCY)		
Z9999	Continued From pa	ae 3	Z9999			
	Continued From pa	ge 5	23333			
	D4 is identification to	NAME TO THE RESTRICT	10000000000000000000000000000000000000			
		nis MAR as a 50 year old male				
		Strabismus and Allergic ns at the mild level of	management of the control of the con			and the state of t
	Intellectual Disabilit		The state of the s			
	in tollootaal Disabilit	y.				
	Observation of Med	ications on 5/7/14, R1 had a				
	medication label on	medication which read,				
		ng (milligrams), One tablet by				
	mouth once daily)."					
Dallo Dhunining and an		r chook dated 2/05/44 DAIs				
	R1's Physician order sheet dated 3/25/14 R1's states, Loratadine tab 10 mg- one tab by mouth					
AAA	once daily as needed."					
	orioo daily do rioodo					
7000	Interview with E1 on 5/8/14, E1 confirmed R1's medication label for Loratadine 10 mg does not					
	match the physician orders.					
	1) 2 of 1 individuals	in the comple (D4, D2, and				
	4) 3 of 4 individuals in the sample (R1, R3 and R4) have PRN medications without required protocols.					
	protocolo.	PortionAdage				
		, "Authorized direct care staff				
		PRN medications unless				
	there is a written pro					
4.00		escribing practitioner for each				
200		ch mediation. A written				
		e the following information:				7
	1) the name of the	e individual				
	2) the name, route, and dosage form of the medications;					
000000		quantity to be taken;				00000
1	4) frequency or tin	nes of administration;				
		hich the medication may be				
	given;	-				
***		ns for the medications;				
	7) a maximum or					
	8) any necessary	special directions and				
	precautions for the medication's preparation and		принцина			

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IIIINOIS L	pepartment of Public	Health					
AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED 05/08/2014		
		IL6013049					
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			•
WEBER	HOUSE		IAMES ROA IELD, IL 62				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
	administration; 9) common sever interactions and the and 10) proper storage R1 is identified on h who functions in the disability R3 is identified on hi who functions in the disability. R4 is identified on hi who functions in the disability. R1's MAR has an or states, "May take up day as needed, " wit information. R3's MAR has an or (milligrams) which stevery 4 hours as needer, " which states, "1 table needed," without required information on the Maprotocol for the PRN	re side or adverse effects or action required if they occur;	Z9999				

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