PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G093	B. WING		08/	27/2014	
NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS				9	STREET ADDRESS, CITY, STATE, ZIP CODE 220 WEST FOURTH CENTRALIA, IL 62801	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	ΓS	w o	000			
	Annual Certification	n Survey-Fundamental					
	Inspection of care						
W 104	Incident Report Inve 8/14/2014/IL71586- 483.410(a)(1) GOV	No Deficiencies Cited	W 1	04			
		y must exercise general policy, ing direction over the facility.					
	Based on Interview facility's governing policy and operating complete Annual Pland Annual Occupathe physician on 4 (R2,R3,R4 and R5)	s not met as evidenced by: v and Record review the body failed to exercise general g direction when they failed to hysical Therapy Assessments ational Therapy as ordered by residents in the sample of 5 and 7 residents outside of the 0,R11,R12,R13 and R14).					
	Finding include:						
	7/2014, R2 is identi level of Individuals On this POS there	hysician Order sheet) dated fied as functioning at the Mild with Intellectual Disabilities. is an order for Physical pational Therapy Evaluation ed.					
	documented that the therapy assessment and current occupa dated 7/17/07.	ord on 8/26/2013 it is the most current physical that was conducted 10/7/2010 tional therapy evaluation is					
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		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.

Facility ID: IL6001937

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		14G093	B. WING			08/27/2014	
	NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS			9	STREET ADDRESS, CITY, STATE, ZIP CODE 120 WEST FOURTH CENTRALIA, IL 62801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 104	7/2014, R3 is identi Moderate level of Ir Disabilities. On this Physical Therapy a Evaluation yearly at Review of R2's recordocumented that the therapy assessment and the current occurrent occurrent occurrent occurrent of Ir Profound level of In Disabilities. On this Physical Therapy a Evaluation yearly at Review of R4's recording the Profound Ir	hysician order sheet) dated fied as functioning at the individuals with Intellectual POS there is an order for and Occupational Therapy and as needed. Ford on 8/26/2014 it is the most current physical at was conducted on 4/28/2011 apational therapy evaluation is the individuals with Intellectual POS there is an order for and Occupational Therapy and as needed. Ford on 7/26/2014 documents a all Therapy Assessment and Therapy Assess	W 1	104	,		
	review of R5's reco Therapy evaluation	rd documents his last Physical was on 8/12/2011 and his pational Therapy Assessment					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED	
		14G093	B. WING _		08	/27/2014
	NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS			STREET ADDRESS, CITY, STATE, ZIP CO 920 WEST FOURTH CENTRALIA, IL 62801		,
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 104	R6 is identified of full Level of Individuals On this POS is an of Occupational Theraneeded. Review of R6's Recodocumented that Review of R6's Recodocumented that Review of Romost recent Occup was completed on Physical Therapy E 10/5/2010. 6) Per the Physicia R8 is identified as full Level of Individuals On this POS is an of Occupational Theraneeded. Review of R8's recocurrent Occupation year however the massessment is date. 7) Per the Physicia R10 is identified as Level of Individuals On this POS is an of Occupational Theraneeded. Review of R10's reacurrent Physical R10's reacurrent P10's reacurren	n order sheet dated 7/2014, unctioning at the Moderate with Intellectual Disabilities. Order for Physical Therapy and apy Evaluations yearly and as cord on 8/27/2014 it is 6 had a fall dated 2/10/2014. 6's record documents his ational Therapy evaluation 10/1/2010 and his most recent evaluation completed on order sheet dated 7/2014, functioning at the Moderate with Intellectual Disabilities. Order for Physical Therapy and apy Evaluations yearly and as ord on 8/27/2014 documents a al Therapy assessment in the nost recent Physical Therapy	W 10			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G093	B. WING		 	08/:	27/2014
NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS			92	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST FOURTH ENTRALIA, IL 62801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 104	7/2014, R 11 is ider Moderate level of Ir Disabilities. On this Therapy and Occupyearly and as needed. Review of 11's recomost current Physic 10/7/2010 and mos Therapy Assessme 9) The Physician of identifies R12 as full Individuals with Interest as needed. Review of R12's recomost current Physician of Individuals with Interest current Physician of Individuals with Ir POS is an order for Occupational Therapy Evaluation 10) The Physician of identifies R13 as full of Individuals with Ir POS is an order for Occupational Therapy Evaluation Individuals with Ir POS is an order for Occupational Therapy Evaluation Individuals with Ir POS is an order for Occupational Therapy Evaluation Individuals Ir	of 11/30/2009. In Order Sheet (POS) dated atified as functioning at the adividuals with Intellectual POS is an order for Physical pational Therapy Evaluations ed. Ind on 8/27/2014 documents cal Therapy Evaluation on tourrent Occupational and on 2/15/2013. Inder sheet dated 7/2014 inctioning at the Mild Level of ellectual Disabilities. On this Physical Therapy and apy Assessments yearly and cord on 8/27/2014 documents hysical Therapy Evaluation as tourrent Occupational	W 1	04			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G093	B. WING		08	/27/2014
NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 WEST FOURTH CENTRALIA, IL 62801	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 104	Level of Individuals On this POS is an of Assessments and Chassessments and Chassessments yearly. Review of 14's record the most current Ph 6/8/2012 and current Evaluation as 3/26/2012 and Current Evaluation as	onctioning at the Profound with Intellectual Disabilities. Order for Physical Therapy Occupational Therapy y and as needed. Ord on 8/27/2014 documents on the Profound Therapy Evaluation as not Occupational Therapy 2012. With E1 RSD (Residential of 8/26/2014 at 5:30 PM when ders for yearly Physical pational Therapy onfirmed that these being done upon admission cant changes and not being ordered by the physician. SICIAN SERVICES	W 1			
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G093	B. WING		····	08/:	27/2014
NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS			920	REET ADDRESS, CITY, STATE, ZIP CODE WEST FOURTH NTRALIA, IL 62801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 322	level of Individuals on this POS there in Therapy and Occupyearly and as needs. Review of R2's recodocumented that the therapy assessment and current occupadated 7/17/07. 2) Per the POS (Pt 7/2014, R3 is identiful Moderate level of Individuals) Disabilities. On this Physical Therapy a Evaluation yearly at Evaluation yearly at the current occupated 2/7/07. 3) Per the POS (Pt 7/2014, R4 is identiful Profound level of Individuals) Disabilities. On this Physical Therapy at Evaluation yearly at Evaluation yearl	fied as functioning at the Mild with Intellectual Disabilities. Is an order for Physical pational Therapy Evaluation and on 8/26/2013 it is a most current physical at was conducted 10/7/2010 at tional therapy evaluation is the mysician order sheet) dated fied as functioning at the adividuals with Intellectual POS there is an order for and Occupational Therapy and as needed. Ford on 8/26/2014 it is a most current physical at was conducted on 4/28/2011 apational therapy evaluation is anysician order sheet) dated fied as functioning at the dividuals with Intellectual POS there is an order for and Occupational Therapy	W 3	322			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

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		14G093	B. WING		08	3/27/2014
	NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS			STREET ADDRESS, CITY, STATE, ZIP COI 920 WEST FOURTH CENTRALIA, IL 62801		
(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 CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 322	disabilities. On this Therapy and Occupyearly and as need Review of R5's receithat R5 has had the 2/26/2014,5/24/2017 review of R5's reconforce of R6's R6 is identified of force of Individuals On this POS is an office of R6's Redocumented that R5 further review of R6's Redocumented that R5 further review of R6's R6 documented on Physical Therapy E10/5/2010. 6) Per the Physicia R8 is identified as force of Individuals On this POS is an office of Individuals On this POS is an office of Individuals On this POS is an office of R8's reconforce	Individuals with Intellectual POS is an order for Physical pational Therapy Evaluations ed. ord on 7/26/2014 it is noted ree falls dated 4 and 6/13/2014. Further ord documents his last Physical was on 8/12/2011 and his pational Therapy Assessment	W 3	22		
		nost recent Physical Therapy				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS			STREET ADDRESS, CITY, STATE, ZIP COD 920 WEST FOURTH CENTRALIA, IL 62801	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
W 322	R10 is identified as Level of Individuals On this POS is an Occupational Theraneeded. Review of R10's rea current Physical the most current Oassessment is date. 8) Per the Physicia 7/2014, R 11 is ide Moderate level of Individuals in the Disabilities. On this Therapy and Occuparly and as need. Review of 11's recommost current Physical 10/7/2010 and most current Physical 10/7/2010 and most current Physical 10/7/2010 and most current Physical Sis an order for Occupational Therapy as needed. Review of R12's reasoned the most current Physical Physical Individuals with Interasoned Physical Individuals with Interasoned Physical Individuals Individu	n order sheet dated 7/2014, a functioning at the Moderate with Intellectual Disabilities. Order for Physical Therapy and apy Evaluations yearly and as cord on 7/27/2014 documents Therapy evaluation however occupational Therapy evaluation however occupational Therapy evaluation however occupational Therapy evaluation however occupational Therapy evaluation at the individuals with Intellectual size POS is an order for Physical pational Therapy Evaluations ed. Order on 8/27/2014 documents occupational ent on 2/15/2013. Order sheet dated 7/2014 inctioning at the Mild Level of ellectual Disabilities. On this or Physical Therapy and apy Assessments yearly and cord on 8/27/2014 documents thysical Therapy Evaluation as est current Occupational	W3	322		

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	` '	E SURVEY PLETED	
		14G093	B. WING			08/27/2014	
NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS				92	REET ADDRESS, CITY, STATE, ZIP CODE 20 WEST FOURTH ENTRALIA, IL 62801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 322	POS is an order for Occupational Thera as needed. Review of R13's ch current Physical The last dated Occu 6/22/2010. 11) The Physician of identifies R14 as full Level of Individuals On this POS is an of the occupant of the position of t	ntellectual Disabilities. On this Physical Therapy and apy Assessments yearly and art on 8/27/2014 documents a erapy Assessment however apational Assessment was order sheet dated 7/2014 nctioning at the Profound with Intellectual Disabilities. Order for Physical Therapy Occupational Therapy	W 3	322			
	the most current Ph	ord on 8/27/2014 documents hysical Therapy Evaluation as nt Occupational Therapy 2012.					
W 441	Service Director) o asked about the ord Therapy and Occup Assessments, E1 c assessments were and with any signific done annually as or 483.470(i)(1) EVAC	onfirmed that these being done upon admission cant changes and not being rdered by the physician.	W 4	41			
		s not met as evidenced by: or and record review the facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER COLONIAL APARTMENTS				STREET ADDRESS, CITY, STATE, ZIP 920 WEST FOURTH CENTRALIA, IL 62801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 441	times on the first sh Finding include: Upon review of the on 8/25/2014 it is n shift fire drills were 11/11/13 11:10 AM 02/17/14 11:00 AM 05/17/14 08:15 AM 08/09/14 11:00 AM During an interview Service Director) E	racuation drills under varying lift. facility's fire evacuation drills oted that the quarterly first	W 4	141		