DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			<u> </u>	MB NO. 0938-0391
-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(	X3) DATE SURVEY COMPLETED
		14G033	B. WING			R 08/30/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				114 NORTH ORCHARD DRIVE		
ELISADEI	'H LUDEMAN DEV. CTR.			PARK FOREST, IL 60466		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS		{W 00	00}		
	FOLLOW UP TO AN SURVEY OF 5/13/16	NUAL CERTIFICATION				
{W 104}	483.410(a)(1) GOVER	RNING BODY	{W 10	04}		9/21/16
		nust exercise general policy, direction over the facility.				
	This STANDARD is r REPEAT	not met as evidenced by:				
	governing body failed operating direction ov appropriate and sanit affecting 39 of 39 clie 25, 33 and 34 (R#'s 6 34, 35, 3, 22, 14, 23,	and interview, the facility's to provide general er the facility and maintain ary living environments nts residing in Homes 24, , 7, 12, 13, 21, 31, 32, 33, 24, 36, 37, 38, 39, 40, 8, 9, , 29, 30, 42, 43, 44, 45, 46,				
	Findings include:					
	8/24/16 beginning at a following was observe - Bathroom 111, as Health Technician), ha base of the toilet with were no paper towels use. - Bathroom 110, as p paper in the bathroom - Blinds in the living	per E7 (MHT - Mental ad feces smeared on the feces in the toilet. There or hands towels for client per E7, there was no toilet n for client use. room were twisted and bent. edication cart was observed				
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

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

TITLE

09/09/2016

PRINTED: 10/26/2016

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE	
			A. BUILD	ING	·		R
		14G033	B. WING				30/2016
NAME OF PI	ROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABET	H LUDEMAN DEV. CTR.				114 NORTH ORCHARD DRIVE		
					PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{W 104}	Continued From page	91	{W 1	104	1}		
	<ul> <li>8/24/16 beginning at a following was observed Residential Services a - One bathroom did client use.</li> <li>One bathroom the and had jagged edge - Two area rugs, one the back door were to presenting a trip haza - Large bedroom had and torn.</li> <li>An unused new me to be stored in the lar</li> <li>3) Observations were 8/23/16 at 4:10pm. A cart was observed to bedroom.</li> <li>4) Observations were 8/24/16 at 6:30am. A cart was observed to bedroom.</li> <li>E12 (Director of Speci interviewed on 8/25/1 asked why unused new being stored in client?</li> </ul>	not have toilet paper for two faucets were corroded s. e in the kitchen and one near orn with the edges torn ard. d blinds that were twisted edication cart was observed ge bedroom. e conducted in Home 33 on an unused new medication be stored in the large e conducted in Home 34 on an unused new medication be stored in the large e and the large cial Operations) was 6 at 2:25pm. E12 was ew medication carts are s bedrooms. E12 stated the the funds to install them in as initially planned. E12 carts were stored in the					
	E12 (Director of Speci interviewed on 8/25/1 asked why unused ne being stored in client's facility does not have the living room areas stated the medication living rooms, however in the bedrooms. E12 facility has stored the carts in the client's ho	6 at 2:25pm. E12 was ew medication carts are s bedrooms. E12 stated the the funds to install them in as initially planned. E12 carts were stored in the r, staff must have put them 2 was asked how long the unused new medication					

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PRINTED: 10/26/2016

	-	D HUMAN SERVICES				FOR	D: 10/26/2016 M APPROVED
STATEMENT O	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		14G033	B. WING				R / <b>30/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				1	114 NORTH ORCHARD DRIVE		
ELISABEI	H LUDEMAN DEV. CTR.			Р	PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{W 104}	Continued From page		{W <sup>2</sup>	04}			
{W 249}	the client's homes for approximately 2 years. 483.440(d)(1) PROGRAM IMPLEMENTATION		{W 2	249}			9/21/16
	each client must rece treatment program co interventions and serv and frequency to supp	ndividual program plan, ive a continuous active					
	This STANDARD is r REPEAT Based on observation	not met as evidenced by: ns, record review and					
	interview, the facility f identified supervision client (R46) in Home supervision level.	level needed for 1 of 1					
	Findings include:						
	in her wheelchair with area. R46 was observed three Mental Health T in the home (E18, E18 bedroom area getting the day. Surveyor observed of the living bedroom area or into through breakfast was continuous visual observed by surveyor	a, R46 was observed sitting the television in the living yed to be by herself with all echnicians (MHT) working 8 and E20) in the back the other ladies ready for served all three staff walking g area into the back the kitchen from 6:30am s served at 7:37am. No ervation from staff was . During this observation tial Services Supervisor, was					

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	-	D HUMAN SERVICES				RINTED: 10/26/2016 FORM APPROVED
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		<u>IB NO. 0938-0391</u> 3) DATE SURVEY COMPLETED
		14G033	B. WING			R 08/30/2016
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE	E, ZIP CODE	
ELISABET	'H LUDEMAN DEV. CTR.			14 NORTH ORCHARD DRIVE ARK FOREST, IL 60466	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE IICIENCY)	(X5) COMPLETION DATE
{W 249}	living area.	a 3 Iy, walking in and out of the supervision by home for	{W 249}			
	Home 34 was reviewed for In Home is listed a E21, was interviewed stated, "For R46, staff	ed. R46's supervision level is Visual Observation. on 8/24/16 at 1:19pm. E21 f has to be able to see her." on 8/24/16, "There wasn't				
{W 295}		"R46 tries to walk very unsteady that she injured, so staff has to ier."	{W 295}			9/21/16
	an integral part of an i is intended to lead to	by physical restraint only as individual program plan that less restrictive means of ating the behavior for which d.				
	Based on observation interview, the facility f Behavior Intervention	not met as evidenced by: ns, record review and ailed to ensure that the Plan for 1 of 1 client (R30) when to apply and remove nal binder).				
	Findings include:					
		ting in a wheelchair in her n 6:52am through 8:15am.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE S COMPL         R       COMPL       R	LETED
14G033     B. WING     08/3       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       114 NORTH ORCHARD DRIVE	
114 NORTH ORCHARD DRIVE	
ELISABETH LUDEMAN DEV. CTR	
PARK FOREST, IL 60466	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 295}       Continued From page 4       {W 295}         E18 was interviewed on 8/24/16 at 6:54am. E18       stated, "R30 uses a binder because of behavior.         We take it off every hour to see if she is touching the g-tube (gastrostomy tube). We take it off or 5 minutes and if she won't touch it, we leave her binder off and continue to monitor her. Once the binder is on her, it will be on her for an hour per her Behavior Plan." Surveyor asked if it is on her and she is no trying to pull her g-tube, will her gastrow asked if it is on her and she is no trying to pull her g-tube. Will her gastrow asked if it is on her an hour."         R30's Behavior Intervention Plan dated 8/1/16       was reviewed. Under Target Behavior Preventive Procedures it includes; "Pulling on g-tube: R30 will wear a binder to prevent her from tampering with and or/pulling out the g-tube. The binder will be faded as follows: It should be noted that for safety purposes, R30 does not wear the binder during showers, hygiene and / or when asleep. The binder will be increased by 5 minutes until she is no linger wearing a binder"         E4. Chief Psychologist, was interviewed on 8/25/16 at 2:37pm. E4 stated, "The binder is on 24/7 except for showers, hygiene and when asleep and during release criteria. The criteria is every hour 5 minutes of unless she begins to pull at it. If she doesn't pull at it, additional 5 minutes will be added."         (W 301)       483.450(d)(4) PHYSICAL RESTRAINTS       {W 301}       4	9/21/16

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		D HUMAN SERVICES				FOR	ED: 10/26/2016
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		14G033	B. WING				R 3/30/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABET	H LUDEMAN DEV. CTR.				114 NORTH ORCHARD DRIVE PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{W 301}	Continued From page	: 5	{VV :	301}			
	Based on record revir failed to ensure that 1 checked every 30 min abdominal binder. Findings include: R30 was observed sit home on 8/24/16 from E18 was interviewed of stated, "R30 uses a b We take it off every ho the g-tube (gastrostor minutes and if she wo binder off and continu						
	her Behavior Plan." S and she is not trying t	urveyor asked if it is on her o pull her g-tube, will the answered, "No, we wait for					
	was reviewed. Under Procedures it includes will wear a binder to p with and or/puling out be faded as follows: If safety purposes, R30 during showers, hygie The binder will be rele hourAs criterion is n	ention Plan dated 8/1/16 Target Behavior Preventive s; "Pulling on g-tube: R30 prevent her from tampering the g-tube. The binder will t should be noted that for does not wear the binder ene and / or when asleep. eased daily for 5 minutes per net, the time without the ed by 5 minutes until she is nder"					
		st, was interviewed on 4 stated, "The binder is on ers, hygiene and when					

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-		ID HUMAN SERVICES MEDICAID SERVICES					FOR	D: 10/26/2016 M APPROVED D. 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	E SURVEY PLETED
		14G033	B. WING					R / <b>30/2016</b>
NAME OF PROVIDER OR	SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZI	P CODE		
ELISABETH LUDEM	AN DEV. CTR.				14 NORTH ORCHARD DRIVE PARK FOREST, IL 60466			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BI		(X5) COMPLETION DATE
asleep a every ho at it. If sh will be ad R30's be includes behavior reinforce R30 bein abdomin E4, Chie 8/26/16 a facility's b binder. 483.450( A client p the restra This STA Based o failed to must be possible using an Findings R30 was home on E18 was stated, "f	ur 5 minutes he doesn't pu dded." havior record a start and s s, replaceme rs and staff in g checked w al binder. f Psychologis at 10:45am. F record of the d)(4) PHYSI blaced in rest aint as quickl NDARD is r n record revi ensure that a released a th is maintained abdominal b include: observed sit 8/24/16 fron interviewed R30 uses a b	ease criteria. The criteria is off unless she begins to pull ull at it, additional 5 minutes ding form was reviewed. It top record, the target ent behaviors, interventions, nitials. There is no record of then she is using her et, was interviewed on E4 verified that this is the use of R30's abdominal CAL RESTRAINTS raint must be released from y as possible. not met as evidenced by: ew and interview, the facility a record of when a client use restraint as quickly as d for 1 of 1 client (R30)	{W 3					9/21/16

Facility ID: IL6002802

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/26/2016 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		14G033	B. WING				R <b>30/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABET	TH LUDEMAN DEV. CTR.				114 NORTH ORCHARD DRIVE PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{W 302}	binder off and continue binder is on her, it will her Behavior Plan." S and she is not trying t staff take it off? E18 a an hour." R30's Behavior Interv was reviewed. Under Procedures it includes will wear a binder to p with and or/puling out be faded as follows: It safety purposes, R30 during showers, hygie The binder will be rele hourAs criterion is m binder will be increase no linger wearing a bi E4, Chief Psychologis 8/25/16 at 2:37pm. E4 24/7 except for showe asleep and during rele every hour 5 minutes at it. If she doesn't pu will be added." A behavior recording It includes a start and Psychologist, informe 10:45am, that the star binder was released a on again. The record calm criteria was met released or if the bind	e to monitor her. Once the l be on her for an hour per urveyor asked if it is on her o pull her g-tube, will the answered, "No, we wait for ention Plan dated 8/1/16 Target Behavior Preventive s; "Pulling on g-tube: R30 orevent her from tampering the g-tube. The binder will t should be noted that for does not wear the binder ene and / or when asleep. eased daily for 5 minutes per net, the time without the ed by 5 minutes until she is nder" st, was interviewed on 4 stated, "The binder is on ers, hygiene and when ease criteria. The criteria is off unless she begins to pull ull at it, additional 5 minutes form for R30 was reviewed. stop time. E4, Chief d surveyor on 8/26/16 at rt is when the abdominal and stop means it was put does not clearly show if the for the binder to be ler was released because it ase per hour was met per	{W :	302}			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/26/2016 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		14G033	B. WING					२ 30/2016
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ELISABET	TH LUDEMAN DEV. CTR.				114 NORTH ORCHARD DRIVE PARK FOREST, IL 60466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
{W 302}	abdominal binder is o	8 6 at 2:37pm that R30's n 24/7 except for showers, and during release criteria.	{w :	302}				
{W 303}	483.450(d)(4) PHYSI A record of restraint c kept.	CAL RESTRAINTS hecks and usage must be	{W 3	303}				9/21/16
	Based on record revi failed to ensure that a	not met as evidenced by: ew and interview, the facility clear record of checks and al binder for 1 of 1 client I.						
	Findings include:							
	home on 8/24/16 from E18 was interviewed stated, "R30 uses a b We take it off every ha the g-tube (gastrostor minutes and if she wo binder off and continu binder is on her, it will her Behavior Plan." S and she is not trying t	ting in a wheelchair in her a 6:52am through 8:15am. on 8/24/16 at 6:54am. E18 inder because of behavior. our to see if she is touching my tube). We take it off for 5 in't touch it, we leave her e to monitor her. Once the be on her for an hour per urveyor asked if it is on her o pull her g-tube, will the answered, "No, we wait for						
	was reviewed. Under Procedures it includes will wear a binder to p with and or/puling out be faded as follows: It	ention Plan dated 8/1/16 Target Behavior Preventive s; "Pulling on g-tube: R30 revent her from tampering the g-tube. The binder will s should be noted that for does not wear the binder						

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				F	NTED: 10/26/2016 FORM APPROVED B NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		14G033	B. WING				R 08/30/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABE	TH LUDEMAN DEV. CTR.				114 NORTH ORCHARD DRIVE PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{W 303}	during showers, hygie The binder will be rele hourAs criterion is n binder will be increase no linger wearing a bi E4, Chief Psychologis 8/25/16 at 2:37pm. E4 24/7 except for showe asleep and during rele every hour 5 minutes at it. If she doesn't pu will be added." The facility presented that includes the start replacement behavior and staff initials. The what specific behavio for the restraint to be show that she is calm removed. E4, Chief Psychologis 8/26/16 at 10:45am w the time when the res stop is the time when Every entry will have pulling g-tube so it do she did her behaviors behaviors. E22, Mental Health Te on 8/26/16 at 11:08am does not make sense except during the spe added, "Whenever we	ene and / or when asleep. eased daily for 5 minutes per net, the time without the ed by 5 minutes until she is nder" et, was interviewed on 4 stated, "The binder is on ers, hygiene and when ease criteria. The criteria is off unless she begins to pull ull at it, additional 5 minutes a Behavior Recording Form , stop, target behaviors, 's, intervention, reinforcers record does not identify rs R30 was doing in order applied and how did she when the restraint was	{W 3	803}			

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY	
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	MPLETED	
		14G033	B. WING		R 08/30/2016		
NAME OF P	ROVIDER OR SUPPLIER	140000		REET ADDRESS, CITY, STATE, ZIP CODE	0	8/30/2016	
	TH LUDEMAN DEV. CTR.		114	4 NORTH ORCHARD DRIVE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE	
{W 331}	Continued From page	e 10	{W 331}				
{W 331}	483.460(c) NURSING	SERVICES	{W 331}			9/21/16	
	The facility must prov services in accordance	ide clients with nursing e with their needs.					
	This STANDARD is not met as evidenced by: Based on observations, record reviewed and interview, the facility failed to ensure that: 1) 1 of 1 client's (R45) liquid restriction was implemented on 8/23/16; and 2) Proper nail care is provided for 1 of 1 client (R40) whose right great toenail was observed to be excessively long.						
	Findings include:						
	Home 33. Surveyor o at 5:46pm. R45 was his dinner at 6:03pm. Health Technician) we in the living room are and prompted R45 to When surveyor was le typewritten note on th It includes; "R45's die 2200ml fluid restrictio hyponatremia. To bet 2200ml fluid restrictio meals," This note is						
	and interviewed E23	o the dining/living room area at 6:14pm. E23 stated, "We this for R45." E23 then ve him water."					
		iewed. A physician's order oted. It includes; "Restrict					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/26/2016 M APPROVED D. 0938-0391
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		14G033	B. WING				R / <b>30/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABET	TH LUDEMAN DEV. CTR.				114 NORTH ORCHARD DRIVE PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 331}	fluids to 2000cc/ day juice. Discontinue ext 2) R40 was observed approximately 5:15pn on a couch in the livin wearing shoes or soc was observed to be s 3/4 inch beyond the ti great toenail was obs discolored. On 8/24/16 E9 (RSS Supervisor) was aske E9 came into Home 2 5:30pm E9 was aske R40's right great toen it was not acceptable long. R40's 5/18/16 IPP (In reviewed. R40's IPP following: "Mycotic toenails: No or pain. Keep toe nai with alcohol and apply There is no document R40's clinical record, monitored and trimme E11 (DON - Director of on 8/25/16 at 11:22ar R40's right great toen trimmed. E11 said the At 11:42am E11 state responsible to cut R4 staff attempted to cut they were unsuccessf	(total). Discontinue prune ra fluids." d on 8/24/16 in Home 25. At n R40 was observed sitting og room. R40 was not ks. R40's right great toenail ticking out approximately p of his toe. R40's right erved to be thick and - Residential Services d to observe R40's toenail. 5 and at approximately d if it was acceptable for ail to be so long. E9 stated for R40's toenail to be so dividual Program Plan) was (Medical Section) notes the sign of soft tissue infection Is trimmed Clean toenails y Vicks Vaporub at bedtime." tation, by nursing staff in that R40's toenails were	{w :	331}			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/26/2016 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		14G033	B. WING _				R / <b>30/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABETH LUDEMAN DEV. CTR.					14 NORTH ORCHARD DRIVE ARK FOREST, IL 60466		
							0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	1.0		{W 3	31}			
	stated he was not awa but was told this infor	ere unsuccessful. E11 are of any documentation mation by E10 (Nurse					
{W 369}	phone call. E10 state today. E10 stated that appointment ordered E10 stated that staff a R40's toenails. E10 v toenails were not cut. staff just let it get too E10 stated that staff a once a week or mayb stated it appears R40 toenail cut in at least E10 was asked if staff toenails and were uns he did not know if staff toenails. 483.460(k)(2) DRUG. The system for drug a that all drugs, includin self-administered, are	are responsible for cutting vas asked why R40's E10 stated, "I'm guessing long." are to monitor R40's toenails e every 2 weeks. E10 has not had his right great 1 month. If attempted to cut R40's successful. E10 stated that attempted to cut R40's ADMINISTRATION administration must assure by those that are e administered without error.	{W 3	69}			9/21/16

Event ID: CJKV12

Facility ID: IL6002802

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 10/26/2016 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	LETED
		14G033	B. WING				२ <b>30/2016</b>
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ELISABETH LUDEMAN DEV. CTR.				1'	14 NORTH ORCHARD DRIVE		
	THEODEMAN DEV. OTN.			P	ARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{W 369}	<ol> <li>R27 was observed 8/23/16 at 4:56pm fro Ferrous Sulfate 325m and mixed with yogurf Medication Administra order was noted to ha medication that states Surveyor informed E5 his medication. E5 sta out if we give it to him</li> <li>Z1, Pharmacist, was i 10:40am. Z1 stated, " gastric irritation if crus client though." If swall should make an effort</li> <li>On 8/24/16, survey Home 34 eating their through 7:51am. Surv R47 receiving their mo observed receiving he was overheard saying unavailable. I will have inform the doctor." At receiving her medicat Omeprazole 20mg an Surveyor noted on R4 Administration Record states, "GIVE 30 MIN Surveyor informed E6 they were done eating gotten here earlier an morning."</li> <li>Z1, Pharmacist, was i 10:40am. Z1 stated, "</li> </ol>	I receiving his medication on m E5, nurse. R27 received g tablet, which E5 crushed t. Surveyor reviewed the ation Record for R27. The twe a note under the s, "DO NOT CRUSH". This prior to her giving R27 ated, "He's going to spit it whole." Interviewed on 8/25/16 at Ferrous sulfate can cause shed. It's not toxic to the owing is an issue, we to change it to liquid." Yor observed clients in breakfast from 7:37am eyor then observed R9 and edications from E6. R9 was er medication at 8:04am. E6 g. R9's artificial tears is e to circle this and will 8:13am, R47 was observed ions. R47 received nong her other medications. A7's Medication d that under Omeprazole it UTES BEFORE MEALS". This, E6 stated, "I forgot g. Normally I would have d it's been a hectic	{w :	369}			
	Home 34 eating their through 7:51am. Surv R47 receiving their mo observed receiving heir was overheard saying unavailable. I will have inform the doctor." At receiving her medicat Omeprazole 20mg an Surveyor noted on R4 Administration Record states, "GIVE 30 MIN Surveyor informed E6 they were done eating gotten here earlier an morning." Z1, Pharmacist, was i	breakfast from 7:37am eyor then observed R9 and edications from E6. R9 was er medication at 8:04am. E6 g. R9's artificial tears is e to circle this and will 8:13am, R47 was observed ions. R47 received nong her other medications. 7's Medication d that under Omeprazole it UTES BEFORE MEALS". o this, E6 stated, "I forgot g. Normally I would have d it's been a hectic nterviewed on 8/25/16 at For Omeprazole to be given ainst manufacturer's					

Facility ID: IL6002802

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/26/2016 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		14G033	B. WING					२ 30/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ELISABETH LUDEMAN DEV. CTR.					14 NORTH ORCHARD DRIVE PARK FOREST, IL 60466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
{W 369}	Continued From page	e 14 t on an empty stomach.	{vv :	369}				
{W 382}	483.460(I)(2) DRUG S RECORDKEEPING		{VV 3	382}				9/21/16
	The facility must keep locked except when b administration.	all drugs and biologicals being prepared for						
	This STANDARD is r REPEAT	not met as evidenced by:						
	review the facility faile	n, interview and record ed to maintain the security of on for 1 of 1 client outside						
	Findings include:							
	Home 24 (R13's resid mostly used tube of T	imately 4:55pm, after exiting lence), surveyor found a riamcinolone Acetonide am had R13's name on a on.						
	(Physician's Order Sh POS identifies the foll	ncluding R13's current POS neet) was reviewed. R13's owing order: Triamcinolone I - Apply to soles of both						
	on 8/25/16 at 11:04an asked about the tube Home 24 on 8/24/16 i name on the label on that staff apply this m	of Nursing) was interviewed n and 11:22am. E11 was of ointment found outside of ncluding verifying R13's the tube. Initially E11 stated edication, usually after E11 stated that the tube of						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	
		14G033	B. WING				30/2016
NAME OF PF	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABET	'H LUDEMAN DEV. CTR.				14 NORTH ORCHARD DRIVE PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{W 382} {W 460}	clarified this medication nursing staff and it is R13. E11 was asked how the be disposed. E11 standisposed of in a garba E11 was asked why, fit tube, was found outsi stated that he did not outside. E11 stated that this main a locked cabinet. 483.480(a)(1) FOOD SERVICES Each client must recent well-balanced diet indo specially-prescribed of This STANDARD is main 2) Observations were Home 33. Dinner was 5:46pm. When the clied dinner, surveyor obset supplement in the mid table. Surveyor did not use the supplement of E23, Mental Health Te on 8/23/16 at 6:07pm supplement is for R26 The weekly diet upda	teroid for Athletes foot. E11 on is only applied by a prescribed medication for the medication tube was to ted the tube can be age can in the home. the mostly used medication de of R13's residence. E11 why the medication was redication should be stored AND NUTRITION tive a nourishing, duding modified and liets. not met as evidenced by: e conducted on 8/23/16 in 6 observed to be served at ents were almost done with erved a can of dietary fiber dolle of the dining room of observed any of the staff in any of the clients. echnician, was interviewed . E23 stated, "That 6 and R43." tes for home 33 was plement it lists R42 and R43	{W 3				9/21/16
	reviewed. Under supp as the clients receivin	plement it lists R42 and R43					

Facility ID: IL6002802

If continuation sheet Page 16 of 20

PRINTED: 10/26/2016

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/26/2016 // APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	TE SURVEY MPLETED	
		14G033	B. WING				२ 30/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELISABETH LUDEMAN DEV. CTR.				14 NORTH ORCHARD DRIVE ARK FOREST, IL 60466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 460}	Continued From page	e 16	{W 4	60}			
		n, record review and ailed to ensure clients well balanced diet including					

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PRINTED: 10/26/2016

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/26/2016 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		14G033	B. WING		_	۱ /08	≺ 30/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	•	
ELISABE	TH LUDEMAN DEV. CTR.			14 NORTH ORCHARD DRI PARK FOREST, IL 6046			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
{W 460}	deficiency for two indi home thirty three, one six and one individual a dietary fiber suppler dinner meal for all three Findings include: 1) Dinner meal obser home six on 8/25/16 M Mental Health Technic observed assisting ind dinner meal. At 5:00p served and R41 recei pears, milk and water 5:15pm. Record review of facil "WEEKLY DIET UPD, that R41 is to receive fiber supplement twice Interviews were held Health Technician 2 (I Residential Service S and E15; Unit 1 Direc and confirmed that the for R41 was not provi because it was not av according to E13 (MH supplement had not b 1a) Observation in ho 5:55pm in the kitchen any dietary fiber supp Record review of facil	liets to prevent a nutritional ividuals (R42) and (R43) in a individual (R41) in home I (R19) in home seven when ment was not provided at the ee homes. vations were conducted in beginning at 4:35pm. E13; cian 2 (MHT2) was dividuals to set-up for the m, the dinner meal was ved lasagne, string beans, c. R41 finished his meal at lity document titled ATES" dated 4/05/16 states : one tablespoon of a dietary e a day. on 8/25/16 with E13; Mental MHT2) at 5:15pm, E14; upervisor (RSS) at 5:50pm tor at 5:20pm in home six e dietary fiber supplement ded at the dinner meal vailable in the home and MT2), the dietary fiber been available for a week. ome seven on 8/25/16 at cabinets did not contain ilements.	{W 460}				

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OR MEDICARE & N					APPROVED
DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY 'LETED
	14G033	B. WING			२ 30/2016
IDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	00/2010
ELISABETH LUDEMAN DEV. CTR.			14 NORTH ORCHARD DRIVE		
LUDEMAN DEV. CIR.		P	ARK FOREST, IL 60466		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE
at R19 is to receive:	one tablespoon of a dietary	{W 460}			
echnician 2 (MHT2) a 17 (MHT2) stated "W e kitchen cabinets h er nursing cabinet ar per just before dinner ame because she wo uddenly started pass n interview held with upervisor on 8/26/16 ponfirmed that dietary re house and that "nu per supplements to the sponsibility of the te ve it to the residents 33.480(d)(4) DINING he facility must assur- ianner consistent wit vel. his STANDARD is n REPEAT ased on observation iled to ensure 10 of 3, 24, 36, 37, 38, 39 5 were provided appri- nife and spoon) for the indings include:	at 6:00pm in home seven. We used to keep the fiber in ere but, the nurse has it in ad provided (R19) with his r today. I do not know her orked overtime. The nurses ing it (fiber) out." E16; Unit 1 Nursing at 10:00am via telephone supplements are kept in urses, do not give dietary he individuals. It is the chnician 3 to order it and " GAREAS AND SERVICE re that each client eats in a h his or her developmental ot met as evidenced by: and interview, the facility 10 clients (R#'s 3, 14, 22, and 40) residing in Home ropriate silverware (fork, heir dinner meal.	{W 488}			9/21/16
	RRECTION IDER OR SUPPLIER JUDEMAN DEV. CTR. SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Dontinued From page at R19 is to receive: Der supplement three In interview was held echnician 2 (MHT2) at 17 (MHT2) stated "V e kitchen cabinets h er nursing cabinet ar ber just before dinne ame because she wo iddenly started pass In interview held with upervisor on 8/26/16 onfirmed that dietary e house and that "nu- ber supplements to the sponsibility of the te we it to the residents 33.480(d)(4) DINING the facility must assu anner consistent with vel. his STANDARD is n EPEAT ased on observation iled to ensure 10 of 8, 24, 36, 37, 38, 39 5 were provided app ife and spoon) for the ndings include:	RRECTION       IDENTIFICATION NUMBER:         14G033         IDER OR SUPPLIER         JUDEMAN DEV. CTR.         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Ontinued From page 18 at R19 is to receive: one tablespoon of a dietary per supplement three times a day.         In interview was held with E17; Mental Health technician 2 (MHT2) at 6:00pm in home seven.         17 (MHT2) stated "We used to keep the fiber in e kitchen cabinets here but, the nurse has it in er nursing cabinet and provided (R19) with his per just before dinner today. I do not know her ame because she worked overtime. The nurses iddenly started passing it (fiber) out."         In interview held with E16; Unit 1 Nursing upervisor on 8/26/16 at 10:00am via telephone infirmed that dietary supplements are kept in e house and that "nurses, do not give dietary per supplements to the individuals. It is the sponsibility of the technician 3 to order it and ve it to the residents."         83.480(d)(4) DINING AREAS AND SERVICE         the facility must assure that each client eats in a anner consistent with his or her developmental vel.         his STANDARD is not met as evidenced by: EPEAT         ased on observation and interview, the facility iled to ensure 10 of 10 clients (R#'s 3, 14, 22, 8, 24, 36, 37, 38, 39 and 40) residing in Home is were provided appropriate silverware (fork, ife and spoon) for their dinner meal.	IDENTIFICATION NUMBER:       A. BUILDING_         14G033       B. WING	IDENTIFICATION NUMBER:       A BUILDING         146033       B. WING         IDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE         JUDEMAN DEV. CTR.       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX         TAG       PROPERTY LAN OF CORRECTIVE ANOF CORRECTIVE ANOF (EACH DEFICIENCY MUST BE PRECEIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROPERTY         Data R19 is to receive: one tablespoon of a dietary ter supplement three times a day.       IV       460}         Interview was held with E17; Mental Health chonician 2 (MHT2) at 6:000m in home seven.       (W 460)         Interview was held with E16; Unit 1 Nursing upervisor on 8/26/16 at 10:00am via telephone infimed that dietary supplements are kept in nfime bacause she worked overtime. The nurses didenty started passing it (fiber) out."       (W 488)         Interview held with E16; Unit 1 Nursing upervisor on 8/26/16 at 10:00am via telephone infimed that dietary supplements are kept in nfimed that dietary for the technician 3 to order it and we it to the r	RRECTION     IDENTIFICATION NUMBER:     A BULDING     Identification     Identification       140033     B. WING     Identification     Identification       UDER OR SUPPLER     If NORTH ORCHARD DRIVE     If NORTH ORCHARD DRIVE       UDEMAN DEV. CTR.     If NORTH ORCHARD DRIVE     If NORTH ORCHARD DRIVE       ISUMMARY STATEMENT OF DEFICIENCIES RECORDERFICENCY WIST ER PROCEEDED BY FULL RECORDERFICENCY WIST ER PROCEDED BY FULL RECORDERFICENCY WIST ER PROFENTATE DEFICIENCY OR LSC IDENTIFICATION INFORMATION)     ID PREFIX TAG       Data Processes     PREFIX RECORDERFICENCY MIST ER PROFENTATE DEFICIENCY     ID PREFIX TAG       Data Processes     ID PREFIX TAG     PREFIX RECORDERFISE       Data Processes     ID PREFIX TAG     ID PREFIX RECORDERFISE       Data Processes     ID PREFIX RECORDERFISE     ID PREFIX RECORDERFISE       Data Processes     ID PREFIX RECORDERFISE     ID PREFIX RECORDERFISE       Data Processes     ID PREFIX RECORDERFISE     ID PREFIX RECORDERFISE       Data Processes     ID REFIX     ID REFIX       Data Processes     ID REFIX     ID REFIX       Data Processes     ID REFIX     ID REFIX       Data Processes     ID REFIX

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/26/2016 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		14G033	B. WING			R / <b>30/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
ELISABETH LUDEMAN DEV. CTR.					114 NORTH ORCHARD DRIVE PARK FOREST, IL 60466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 488}	8/24/16 beginning at a 14, 22, 23, 24, 36, 37 observed eating their These 10 clients were dinner meal with spoo had a knife or a fork. R37 was observed at meat with a spoon. E8 (MHT - Mental He interviewed on 8/24/1 E8 was asked if silver 10 clients to use for th don't need forks." Surveyor pointed out cut and eat his chicked into the kitchen and o R37. R3, R14, R22, R23, F	approximately 5pm. R#'s 3, , 38, 39 and 40 were dinner meal at this time. e observed to be eating their ons. None of the 10 clients tempting to cut a piece of	{W 4	488}			

Facility ID: IL6002802

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