DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	`´co∧	E SURVEY IPLETED
	14G080		B. WING _		C 03/10/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SEARLE	S GROUP HOME			3310 SEARLES AVENUE		
JEANLE				ROCKFORD, IL 61101		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMEN	rs	W 00	00		
W 149		vestigation 3-4-15 / IL 75534 FF TREATMENT OF CLIENTS	W 14	49		
	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.					
	This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure for one of four in the sample (R2) that written policies and procedures are implemented to prohibit mistreatment, neglect, or abuse of the client.					
	Findings include:					
	Per record review of the Client Roster dated 10-28-14 is written R1 is a 55 year old male who functions in the Profound Range of Intellectual Disability. R1's diagnoses includes Seizure Disorder, Autism, and Dementia. Per record review of the Client Roster dated 10-28-14 is written R2 is a 71 year old female who functions in the Profound Range of Intellectual Disability. R2's diagnoses includes Cerebral Palsy, Bilateral Cataracts and History of Subcutaneous Cysticercosis.					
	Consultation dated had self injurious be	of the Psychological 11-13-14 is written R1 has ehaviors and property re largely resolved by 2002.				
		of the Individual Service Plan itten R1 has engaged in the				

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

TITLE

(X6) DATE

PRINTED: 03/17/2015

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/17/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G080	B. WING				C 10/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SEARLES GROUP HOME				-	310 SEARLES AVENUE OCKFORD, IL 61101		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	following maladapti and objects, bite his may also poke his e often if he has the o calmed down by off keyboard. He loose Per record review o summary dated 3-4 chair back to get ou around wrapped bo started choking her head and then biting R1's grip and bough and escorted him to Per record review o Notes on 3-4-15 is He also had his mo side by her eye is re some popped blood Per record review o 3-4-15 written by E4 states that R2 was R1 and R1's fingers was moved to the n working were E5 (D (Direct Support Per report states that th and is written to che is checked. The loc is left eye with the s is red / purple width inches. The nursing the nurse checked	ve behaviors: hitting others is hands or throw objects. He eyes and will break his glasses opportunity. R1 can usually be ering him to play the piano/ ly choked a peer in the past. If the Peer to peer aggression -15 is written R2 scooted her at of her chair, R1 turned th hands around her neck, then he put his mouth to her g her. Staff immediately broke at R2 to the medication office o a chair. If the Health / Medical Status written R2 was choked by R1. uth on her head. R2 whole left ed / purple, looked like maybe d vessels in eye. If the Injury Report dated 4 (Direct Support Person) choked and bit on the head by is in the eye socket of R2. R2 nedication office. The staff birect Support Person), E6 son), and E4 (DSP). The e injury was caused by R1 eck all that apply but only bite ation of the injury on the body size being whole left eye, color 2 inches and length 2.5 g assessment is written that R2's eyes and neck with no assessment does not include	W 1	49			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/17/2015 APPROVED . 0938-0391	
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •		E CONSTRUCTION	(X3) DAT CON	(X3) DATE SURVEY COMPLETED	
		14G080	B. WING				C / 10/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SEARLE	S GROUP HOME			-	310 SEARLES AVENUE ROCKFORD, IL 61101			
(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)	LD BE	(X5) COMPLETION DATE	
W 149	Per record review of Notes are as follow hand, 2-22-15 R1 witimes, 3-2-15 R1 was out of screamed several thand, 3-4-15 R1 ch mouth on her head peer, immediately s Per record review of Training dated 3-10 progress notes and training does not into biting to self or othe Per record review of Supervision Proced R1 has a history of changes in his routi aware of outings and changed or cancele may become over of procedure is for sta only just before the chance of the outing acknowledge the co perseverate on the document for what his hand or attempt Per interview with E 11:00 A.M. acknowl updated R1's Individual biting to others and process for R1's bit for staff implementa	f the Chronological Progress s: 2-20-15 R1 yelled bit his vas biting his hand multiple t his hand several times, of it today bit his hand and imes, 3-4-15 R1 irritated bit oked R2 and also had his trying to bite. Left marks on eparated. f the Facility Developmental -15 is written R1 monitor unusual behavior. The clude documentation of R1 ers. f the Resident Assistance / lures dated 3-9-15 is written aggression. He does not like ne / plans. R1 should not be tead of time in case they get ed as he will get agitated. R1 excited or agitated. The aff to inform R1 of the outing outing is to occur due to the g being canceled. Staff will onversation but will not topic. The procedure does not the process will be if R1 bites s to bite other individuals. E1 Administrator on 3-10-15 at edged that the facility did not dual Service Plan to include that interventions and ing or choking was developed	W	149				

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		AND HUMAN SERVICES				FORM	03/17/2015 APPROVED 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G080	B. WING				C 10/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SEARLES GROUP HOME					310 SEARLES AVENUE OCKFORD, IL 61101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149 W 154	will proactively advo individuals served a in place that may be individuals are free threat to their physic and safety. The pro incidents, monitorin update individual set facility failed to mor pattern or trend whe of biting his hand 2- 3-3-15, and 3-4-15. R1's individual serv 483.420(d)(3) STAF The facility must ha violations are thorous This STANDARD is Based on record re failed to ensure for that all alleged viola investigated. Findings include: Per record review o 10-28-14 is written functions in the Pro Disability. R1's diag Disorder, Autism, a Per record review o 10-28-14 is written who functions in the	ated 1/08 is written the facility boate for the safety of the and investigate any safeguards e unsuccessful assuring from serious and immediate cal and psychological health bocedure is to regularly monitor ag for trends or patterns, and ervice plans as needed. The hitor the incidents of R1 for any en R1 had increased agitation -20-15, 2-22-15, 3-2-15, The facility failed to updated rice plan when he bit R2. F TREATMENT OF CLIENTS ave evidence that all alleged ughly investigated. s not met as evidenced by: eview and interview the facility one of four in the sample R2 ations are thoroughly of the Client Roster dated R1 is a 55 year old male who found Range of Intellectual gnoses includes Seizure and Dementia. of the Client Roster dated R2 is a 71 year old female e Profound Range of	W 1				
	10-28-14 is written who functions in the	R2 is a 71 year old female	1				

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		AND HUMAN SERVICES				FORM	03/17/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	14G080		B. WING				C 10/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SEARLES GROUP HOME					310 SEARLES AVENUE ROCKFORD, IL 61101		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 154	Cerebral Palsy, Bila Subcutaneous Cyst Per record review of Consultation dated had self injurious be destruction that wer Per record review of dated 5-14-14 is wr following maladapti and objects, bite his may also poke his e often if he has the of calmed down by off keyboard. He loose Per record review of summary dated 3-4 chair back to get ou around wrapped bo started choking her head and then bitin R1's grip and bough and escorted him to Per record review of Notes on 3-4-15 is He also had his mo side by her eye is re some popped blood Per record review of 3-4-15 written by Ea states that R2 was R1 and R1's fingers was moved to the m working were E5 (D	ateral Cataracts and History of ticercosis. of the Psychological 11-13-14 is written R1 has ehaviors and property re largely resolved by 2002. of the Individual Service Plan ritten R1 has engaged in the ve behaviors: hitting others is hands or throw objects. He eyes and will break his glasses opportunity. R1 can usually be fering him to play the piano/ ely choked a peer in the past. of the Peer to peer aggression I-15 is written R2 scooted her ut of her chair, R1 turned oth hands around her neck, r then he put his mouth to her g her. Staff immediately broke ht R2 to the medication office o a chair. of the Health / Medical Status written R2 was choked by R1. outh on her head. R2 whole left ed / purple, looked like maybe	W 1	154			

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		AND HUMAN SERVICES			FORM	03/17/2015 APPROVED 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G080	B. WING			C 10/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SEARLE	SEARLES GROUP HOME			3310 SEARLES AVENUE ROCKFORD, IL 61101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 154	report states that the and is written to che is checked. The loc is left eye with the s is red / purple width inches. The nursing the nurse checked injury noted. The as checking the head assessment does no bruise or scratch the from other docume Per record review of Notes are as follow hand, 2-22-15 R1 witimes, 3-2-15 R1 was out screamed several the hand, 3-4-15 R1 che mouth on her head peer, immediately sidentify the informat Per record review of Training dated 3-10 progress notes and training does not in biting to self or other Per record review of Supervision Proceo R1 has a history of changes in his rout aware of outings and changed or canceled may become over of procedure is for states.	in injury was caused by R1 eck all that apply but only bite sation of the injury on the body size being whole left eye, color a 2 inches and length 2.5 g assessment is written that R2's eyes and neck with no assessment does not include of R2 for the bite. The not include other injuries like at R2 might have sustained intation. of the Chronological Progress s: 2-20-15 R1 yelled bit his vas biting his hand multiple t his hand several times, of it today bit his hand and imes, 3-4-15 R1 irritated bit oked R2 and also had his trying to bite. Left marks on separated. The facility failed to tion of left marks on R2. of the Facility Developmental 0-15 is written R1 monitor unusual behavior. The clude documentation of R1	W 154			

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		AND HUMAN SERVICES				FORM	03/17/2015 APPROVED 0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		14G080	B. WING) 10/2015
NAME OF F	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
SEARLES GROUP HOME					310 SEARLES AVENUE ROCKFORD, IL 61101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 154	acknowledge the co perseverate on the document for what his hand or attempt Per interview with E 11:00 A.M. acknow have investigated a injuries of R2 better	g being canceled. Staff will onversation but will not topic. The procedure does not the process will be if R1 bites to bite other individuals. E1 Administrator on 3-10-15 at ledged that the facility could and documented the possible r. E1 acknowledged that the had more written statements of	W	154			

Facility ID: IL6008411

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