	-	ID HUMAN SERVICES MEDICAID SERVICES			(FORM	APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		14G207	B. WING			10/09/2014		
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO	ODE			
EMERALD	ESTATES			1577 EAST MYRTLE, P.O. BOX 232 CANTON, IL 61520				
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		wo	000				
	ANNUAL CERTIFIC/ FUNDAMENTAL	ATION SURVEY -						
W 137	INSPECTION OF CA 483.420(a)(12) PROT RIGHTS	RE ECTION OF CLIENTS	W 1	37				
	The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that individuals who are unable to use their toothpaste appropriately are involved in a training program to learn to use it appropriately for 2 of 3 individuals who have their toothpaste kept in a closet in the facility office. (R5, R6)							
	Findings Include:							
	Evaluation" dated 8/2	nnual Interdisciplinary Team 9/14, is a 57 year old male Severe range of Intellectual						
	incident report dated out from his room to a (Direct Care Staff) wa at 11:07am. When as their toothpaste in the of them." When aske room, E1 stated R5, I	acility incident reports, an 7/31/14 states, R1 "came ask for teethcare stuff." E1 as interviewed on 10/08/14 sked if the individuals keep eir rooms, E1 stated, "Most ed who did not keep it in their R6 and R7. Regarding R5, get to it when he wants.						
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X	6) DATE	

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

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.

PRINTED: 11/14/2014

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/14/2014 I APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		14G207	B. WING		_	10/09/2014	
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
EMERALD	ESTATES			577 EAST MYRTLE, P.O. CANTON, IL 61520	BOX 232		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 137	locked. When asked in the office, E1 stated toothpaste on his fing stated that R5 is on a R5's clinical record wa "Teethcare" program y 9/15/14 which address full two minutes. The monitor R5 to ensure program does not add of toothpaste or the net the facility office. E2 (Administrator) wa at 12:20pm. When as which addresses the fis stated she was not su 2) R6, per current An Evaluation dated 11/2 female who functions Intellectual Disability. R6's Annual Interdisci contains a Teethcare date of 12/2/13, which mouthwash. It does r toothpaste in a closet E1 was interviewed o When asked why R6's facility office, E1 state walker she may accid toothpaste. The facili	I in the office and it is not why R5's toothpaste is kept d that he would put the er to brush his teeth. E1 teethcare program. as reviewed. It contains a with a "Goal Begin Date" of ses brushing his teeth for a program calls for staff to he brushes thoroughly. The dress R5's inappropriate use eed to keep it in a closet in s interviewed on 10/09/14 sked if R5 has a program toothpaste in the closet, E2 are and E1 stated no. nual Interdisciplinary Team 2/13, is a 64 year old in the Moderate range of plinary Team Evaluation program with a goal begin addresses using not address keeping her in the facility office. n 10/08/14 at 11:07am. s toothpaste was kept in the ed that when she uses the entally squeeze the ty was unable to provide a addresses keeping R6's	W 137				
W 262	toothpaste in a closet		W 262				

Facility ID: IL6011787

If continuation sheet Page 2 of 5

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/14/2014 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		14G207	B. WING			10/	09/2014
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EMERALD ESTATES					577 EAST MYRTLE, P.O. BOX 232 ANTON, IL 61520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
W 262	Continued From page CHANGE	2	w 2	262			
	monitor individual pro inappropriate behavio	d review, approve, and grams designed to manage r and other programs that, ommittee, involve risks to ights.					
	Based on record revi failed to ensure the sp committee approved t psychotropic medicati	not met as evidenced by: ew and interview the facility becially constituted the correct dosage of a tion for 1 of 2 individuals in psychotropic medications.					
	Findings include:						
	states R1 is a 56 year diagnoses which inclu						
		an order for R1 to take 150mg capsule - take 2 it 8am.					
	Notes dated 6/11/14 v identifies R1 as "7A".	Rights Committee Meeting vas reviewed. This form The Intervention Program or 7A states she takes ily.					
	Registered Nurse, wa	exor for R1. E3 stated R1					

If continuation sheet Page 3 of 5

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/14/2014 APPROVED . 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G207	B. WING			10/09/2014		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE			
EMERALD	ESTATES			577 EAST MYRTLE, P.O. B ANTON, IL 61520	OX 232			
(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 B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
W 262	Continued From page	3	W 262					
	Administrator, was as Constituted Committe	n 10/9/14 at 1150am, E2, ked if the Specially ee had signed for the R1's omg of Effexor daily. E2						
W 263	483.440(f)(3)(ii) PRO CHANGE	GRAM MONITORING &	W 263					
	are conducted only w	d insure that these programs ith the written informed parents (if the client is a an.						
	Based on record revi failed to ensure the cl the correct dosage of	not met as evidenced by: ew and interview the facility ient or guardian approved a psychotropic medication n the sample who took ions. (R1)						
	Findings include:							
	states R1 is a 56 year diagnoses which inclu							
		an order for R1 to take 150mg capsule - take 2 It 8am.						
		am Plan dated 11/22/13 is a and R1 states she takes ily.						
	During an interview of Registered Nurse, wa	n 10/9/14 at 1150am, E3, is asked to clarify the						

Facility ID: IL6011787

If continuation sheet Page 4 of 5

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/14/2014 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		14G207	B. WING			_	10/09/2014		
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, ST		-		
EMERALD) ESTATES				1577 EAST MYRTLE, P.O. E CANTON, IL 61520	3OX 232			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 263	current dosage of Effe took 150mg two tabs, During an interview o Administrator, was as	exor for R1. E3 stated R1 , or 300mg daily. n 10/9/14 at 1150am, E2, sked if R1 or her guardian 's correct dosage of 300mg	W	263					

Facility ID: IL6011787

If continuation sheet Page 5 of 5