STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G217	A. BUILDING _____ B. WING _____	01/06/2016

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CAROLE LANE TERRACE	**1641 CAROLE LANE SAUK VILLAGE, IL 60411**

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W 000	INITIAL COMMENTS Annual Certification Survey - Fundamental Inspection Of Care	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardianship was pursued after the death of the guardian in 2011 for 1 individual outside of the sample (R5). Findings include: Per the 10/27/15 Behavior Management/Individual Rights Committee review, R5 takes Aripiprazole 5 mg one in the morning for Psychotic Disorder and Sertraline 100 mg one in the morning for Post Traumatic Syndrome Disorder. Per R5's 7/23/15 Individual Service Plan, "R5 has been determined legally incompetent and the Office of the State Guardian (OSG) has been petitioned to act as her guardian. R5's sister obtained guardianship on 9/13/1996. In 2011, R5's sister passed away. OSG has been contacted to pursue guardianship for R5." Administrator E2 validated on 1/5/16 at 1:11 PM that E2 spoke with OSG on 1/5/16 and confirmed	W 125		3/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/18/2016

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.

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W 125	Continued From page 1 that in 2011 guardianship was initiated but no lawyer was assigned to R5's case. E2 validated that R5 should have a guardian.	W 125		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure individuals who are capable of setting the table were provided the opportunity to do so at the facility, impacting 4 of 4 individuals in the sample (R1, R2, R3 and R4) and 1 individual outside of the sample (R6). Findings include: Morning observations on 1/5/16 from 6:30 AM through 9:00 AM include R1, R2, R3, R4 and R5 waiting for breakfast in the living room area. R3 and R6 ate early around 7:10 AM due to early bus pick up. R3 and R6 received their plate from Cook E7 with the french toasts and sausage patties on it. At 7:13 AM E7 was putting the glasses, napkins and utensils on the dining table. At breakfast, R1, R2 and R6 were observed independent with serving themselves by picking up the serving plates and pouring liquids from the pitchers on the table. Evening observations on 1/4/16 at 5:30 PM include R6 setting the table with napkins, utensils and plates while the other individuals waited outside of the dining room as R6 set the table with E7. Residential Services Director E4 was asked on	W 247		2/6/16

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W 247	Continued From page 2 1/5/16 at 12:55 PM about individual's capacity to engage in table setting at the facility. E4 validated that individuals like to sit in the living room in the morning and individuals including R1, R2 and R6 are capable of participating in setting the table before meals.	W 247		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that the goal steps were revised for 1 of 1 individual in the sample who made progress with the written objectives (R1). Findings include: According to the record, R1 is a 34 year old who is ambulatory, verbal and has a diagnosis of Autism. R1 functions at a broad level of 6 yrs and 4 months. His IQ is 57. R1 works and earns money daily. R1's Individual Service Plan (ISP) dated 1/13/15 includes objectives which have multiple steps to achieve the long term goal. His objectives are as follows: 1) Money: Step - [R1] will write the amount of money he needs for the week on his weekly	W 255		2/6/16

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W 255	Continued From page 3 budget sheet with verbal prompts. R1 met this unchanged step from 7/2015 to 1/2016, without progression to the next step. 2) Autobiographical - Step - [R1] will dial 758 on telephone for three consecutive months. R1 met this goal at 100% with verbal prompts from 7/1/15 to 11/2015. This step was not revised for 4 months. 3) Lunch - Step - [R1] gather needed supplies to clean the table. R1 met this at 100% independence, however this step remained unchanged from 7/2015 to 1/2016. 4) Social Skills - [R1] will identify the person's name he is talking to with 100% verbal prompts. R1 met this step at 100 % independence from 8/2015 to 1/2016. This step remains unchanged. R4 (QIDP) confirmed on 1/5/15 at 12:30 PM, that the above objective steps were not revised once R1 made progression.	W 255		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to revise objectives, for one of one resident in the sample who consistently failed to meet his objectives (R3). Findings include:	W 257		2/6/16

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W 257	Continued From page 4 According to the record R3 functions at a broad level of 3 years and has an IQ of 36. R3's progress with his priority goals were reviewed for the past 6 months. He is verbal and ambulatory. These goals were implemented in 11/2014, and have multiple steps toward the completion of each goal. The goals are as follows; 1) Autobiographical: Long term objective (LTO) Autobiographical: [R3] will complete his autobiographical Program with 90% independence by 11/30/15. His progression is as follows; Step 1= R3 will trace his name x 3 months. R3 failed to meet this Step from 6/2015 through 11/2105. This Step was continued in the R3's new annual Individual Service Plan (ISP) of 11/23/15. 2) Money: State the value of 3 quarters for 3 months. R3 failed to meet this Step from 6/2015 through 11/2015. This Step was continued in his new ISP. 3) Laundry: R3 will sort the colored clothes from white clothes. R3 failed to meet this Step from 7/1/15 through 11/2015. This Step was continued in his new ISP. The above datat was reviewed with E4 (QIDP) on 1/5/15 at 12:15 PM. She confirmed that R3 has been on the same objective steps for over 6 months.	W 257		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and	W 262		2/6/16

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W 262	Continued From page 5 monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Behavior Management/Resident Rights Committee review and monitor restrictive procedures impacting 1 of 4 individuals in the sample (R4) and 1 individual outside of the sample (R5). Findings include: Per R5's 7/23/15 Individual Service Plan, "R5 has been determined legally incompetent and the Office of the State Guardian (OSG) has been petitioned to act as her guardian. R5's sister obtained guardianship on 9/13/1996. In 2011, R5's sister passed away. OSG has been contacted to pursue guardianship for R5." Per the 10/27/15 Behavior Management/Individual Rights Committee review, R5 takes Aripiprazole 5 mg one in the morning for Psychotic Disorder and Sertraline 100 mg one in the morning for Post Traumatic Syndrome Disorder. R5 signed on 12/2/15 as the consenting individual for the Aripiprazole and Sertraline R5 takes. R5's record includes a 12/2/15 Consent For Restrictive Measures of a Bed Alarm for potential falls signed by R5. The 10/27/15 Behavior Management/Individual Rights Committee review do not mention R5's fall episodes and the use of	W 262		

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W 262	Continued From page 6 a bed alarm. Review of 3 months of facility incidents do not include any report of fall episode for R5. Residential Services Director E4 was interviewed about R5's bed alarm on 1/6/16 at 9:24 AM. E4 validated that the bed pad alarm was purchased in November 2015. R5 validated that staff applies the bed pad alarm at night when R5 sleeps in order to alert staff when R5 gets up from bed. Staff are to respond to the alarm when triggered to ensure R5 does not fall. E4 was asked on 1/6/16 at 9:30 AM about R5's roommate. E4 validated that R4 is R5's roommate and R4's records do not mention that R4 resides in a room with an individual using an alarm. There is no record of a guardian consent for R4 to share a room with an individual using a bed alarm. Administrator E2 validated on 1/5/16 at 1:11 PM that Behavior Management/Resident Rights Committee (BMC) should have identified the need pursue guardianship for R5. Residential Services Director E4 validated on 1/6/15 at 9:45 AM that there is no guardian consent and BMC review and approval for R4 to reside in a room with R5 who uses a bed alarm.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		2/6/16

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W 263	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the Human Rights Committee (HRC) failed to ensure that: 1) The psychotropic medication consents include the correct dosage, for one of three residents in the sample (R3), who take such medication. 2) There is a consent from the legal guardian for the use of a bed alarm for 1 individual outside of the sample (R5) and for 1 individual in the sample who shares a room with an individual who uses a bed alarm (R4). 3) The consent for medications used for behaviors are consented by the legal guardian for 2 of 3 individuals in the sample (R3 and R4) and for 1 individual outside of the sample (R5). Findings include: 1) According to the record, R3 has diagnoses which include Severe Mental Retardation, Obsessive Compulsive Disorder and Hyperactivity. The physician's orders, dated 12/31/15, list the following medications; Strattera 60 mg each morning. Depakote 750 mg twice daily [total of 1500mg]. Zyprexa 2.5 mg twice daily [total of 5 mg]. These medications have start dates before the HRC consents were obtained. R3's signed "Consent for Administration of Behavior Modifying Medication" for these medications were reviewed. These consents are dated 11/6/15. The consents list the Strattera dose as "25mg", the Depakote dose as 750 mg, and the Zyprexa dose as 2.5 mg.	W 263		

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W 263	Continued From page 8 E4 (OIDP) stated on 1/5/15 at 12:15 PM, that the consents do not, but should, include the total daily dosages. 2) Per R5's 7/23/15 Individual Service Plan, "R5 has been determined legally incompetent and the Office of the State Guardian (OSG) has been petitioned to act as her guardian. R5's sister obtained guardianship on 9/13/1996. In 2011, R5's sister passed away. OSG has been contacted to pursue guardianship for R5." R5's record includes a 12/2/15 Consent For Restrictive Measures of a Bed Alarm for potential falls signed by R5. Residential Services Director E4 was interviewed about R5's bed alarm on 1/6/16 at 9:24 AM. E4 validated that the bed pad alarm was purchased in November 2015. E4 was asked on 1/6/16 at 9:30 AM about R5's roommate. E4 validated that R4 is R5's roommate and R4's records do not mention that R4 shares a room with an individual using an alarm. There is no record of a consent for R4 to share a room with an individual using a bed alarm activated at night. Residential Services Director E4 validated on 1/6/15 at 9:45 AM that there is no consent for R4 sharing a room with R5 who uses a bed alarm. 3) a) Per 10/12/15 Individual Service Plan, R4's medications include Citalopram 30 mg per day and Quetiapine 500 mg per day for Depression with psychotic disorder.	W 263		

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W 263	Continued From page 9 R4's Quetiapine consent includes a verbal consent from R4's guardian on 9/25/15. R4's Citalopram 10/7/15 consent is signed by R4's guardian but there is no mark indicating whether the guardian gave consent for R4 to take this medication. R4 is taking these medications. Residential Services Director E4 validated on 1/5/16 at 1:00 PM that R4's guardian has not returned the mailed out consent for Quetiapine but a verbal consent was given on 9/25/15. E4 confirmed that the consent for the Citalopram do not indicate consent or not to this medication. b) Per the 7/3/15 Verbal Consent Form, R3 takes Diphenhydramine 50 mg before dental procedures. This Consent does not have the signature of R3's guardian and there is no mark indicating whether R3's guardian gave consent to the use of this medication. R3 had a dental procedure in December 2015 where the Diphenhydramine was used for R3. Residential Services Director E4 validated on 1/5/15 at 1:45 AM that R3's consent for Diphenhydramine is a verbal consent from 7/3/15 and the consent did not indicate consent or not to the use of the medicine. c) Per R5's 7/23/15 Individual Service Plan, "R5 has been determined legally incompetent and the Office of the State Guardian (OSG) has been petitioned to act as her guardian. R5's sister obtained guardianship on 9/13/1996. In 2011, R5's sister passed away. OSG has been contacted to pursue guardianship for R5." Per the 10/27/15 Behavior Management/Individual Rights Committee review,	W 263		

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W 263	Continued From page 10 R5 takes Aripiprazole 5 mg one in the morning for Psychotic Disorder and Sertraline 100 mg one in the morning for Post Traumatic Syndrome Disorder. R5 signed on 12/2/15 as the consenting individual for the Aripiprazole and Sertraline R5 takes. Residential Services Director E4 validated on 1/6/15 at 9:45 AM that there is no consent for R4 sharing a room with R5 who uses a bed alarm.	W 263		
W 317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure there is clinical evidence to justify the lack of an annual reduction to the medication used for behaviors impacting 1 of 3 individual in the sample who uses medications to address maladaptive behaviors (R2). Findings include: R2 is an individual with diagnoses including Schizoaffective Disorder (SA) and Obsessive Compulsive Disorder (OCD) per the January 2016 Physician's Order Sheets. R2 takes Lorazepam 1 mg two times a day and Sertraline 50 mg one time at night for the OCD. And Olanzapine 5 mg at night for the SA.	W 317		2/6/16

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W 317	Continued From page 11 R2's record do not include information of when a reduction or reduction attempt was completed in the past year. Interview with Residential Service Director E4 on 01/05/16 at 1:00 PM include "contraindication (to reduction) was written on 10/29/15." R2's behavior data shows zero display of target behaviors during the 10/27/15 Behavior Management/Resident Rights Committee meeting. E4 was asked on 1/5/16 at 1:00 PM when R2 started taking the medications, why the reduction was contraindicated for R2 in 2015 and the justification for the lack of reduction in 2015. E4 did not provide any clinical evidence to justify the contraindication to the reduction.	W 317		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to ensure medications are administered according to the doctors order, for one of four individuals observed during a medication pass (R7). Findings include: The 4 PM medication pass, conducted by E5 was observed on 1/4/15. R7's physician orders dated 12/31/15 and the Medication Administration Record dated 1/2016, states, "Chlorhexidine Gluc	W 369		2/6/16

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W 369	Continued From page 12 0.12%, swish and rinse mouth with 1/2 ounce (15 ml). If not possible then swab teeth thoroughly with toothette." Swallowing this medication may cause esophageal irritation. E5 brought R7 to the bathroom, poured 30 ml into a 30 ml medication cup. R7 took the cup, put the 30 ml of liquid medication in her mouth and swallowed it, rather than swish and rinse. At that time, E5 said, "She always swallows it, even though I say spit it out." E5 also confirmed that R7 received 30 ml of the medication, not the prescribed 15 ml.	W 369		