STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G210	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAUNS TERRACE	**1115 EAST WASHINGTON STREET GREENVILLE, IL 62246**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY-FUNDAMENTAL LICENSURE SURVEY INSPECTION OF CARE	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to have reproducible evidence that all allegations are thoroughly investigated, for possible allegation of abuse and/or neglect for 1 of 1 individuals (R1) in the sample & 1 individual (R5) outside the sample. Findings include: 1. A- Review of letter dated 11/5/14 sent to IDPH; "Please allow this letter to serve as notification of a staff (no name stated) to resident (R1) physical contact that was reported to E1 (ADMN) at 9:10 PM by E2 (Direct Service Person-DSP) on 11/5/14. On 11/5/14 at 9:00 PM, R1 reported to a DSP (no name stated) at the residential home. That a DSP (no name stated) at Day Training shoved R1. R1 stated he was sleeping at work and the DSP said "you better get to work or you won't have any money"; R1 stated he smarted off to the DSP and the DSP shoved him. R1 stated he did not tell anyone at the Day Training. E1 reported the incident to the Day Training Coordinator (no	W 154		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/04/2015

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.

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W 154	Continued From page 1 name stated) at 9:17 PM on 11/5/14. The incident was reported to OIG. Day Training stated that OIG will conduct the investigation". Review of the facility "Safety Committee" minutes dated 11/7/14; the report noted the facility committee reviewed the letter sent to IDPH and noted the staff member from the Day Training was removed from client contact and R1 was examined by the nurse with no reports of pain or discomfort. Interview with E1(ADMN) on 2/2/14@ 2:30 PM. E1 confirmed the 11/5/14 allegation involving R1. E1 confirmed the facility obtained statements from Day Training staff members. E1 stated there was no neglect/abuse involving the incident of 11/5/14 involving R1. E1 was unable to provide reproducible evidence that the alleged incident was thoroughly investigated, appropriate actions implemented and all revenant information was obtained & considered with final outcomes stated based on the facility unable to determine that the internal & OIG investigations reviewed all staff & R1's statements and findings/recommendations & and the failure of committee review of the event of 11/5/14. B- Review of letter dated 9/17/14 sent to IDPH; "Please allow this letter to serve as notification of a Peer to Peer physical contact that occurred on 9/17/14 @ 3:55 PM, which was reported to E1 by E3 (QMRP); this physical contact involved R1 and another consumer (no name stated) at the Day Training Provider. On 9/18/14 at 3:55 PM, R1 and the other consumer were getting ready to leave for the day	W 154		

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W 154	Continued From page 2 when the consumer started hitting R1. The DT supervisor (no name stated) separated the two individuals and directed R1 towards the bus for home. R 1 was assessed by the Day Training supervisor (no name stated) & RN at home. R1 received a scratch over the left eye, lip & neck". Review of the facility "Safety Committee" minutes dated 9/20/14; the report noted the facility committee reviewed the letter sent to IDPH and nursing report. Committee findings noted "the incident occurred as documented". Interview with E1(ADMN) on 2/2/14@ 2:30 PM. E1 confirmed the 9/17/14 allegation involving R1. E1 confirmed the facility reviewed incident report from the Day Training. E1 stated there was no neglect/abuse involving the incident of 9/17/14 involving R1. E1 was unable to provide reproducible evidence that the alleged incident was thoroughly investigated, appropriate actions implemented and all revenant information was obtained & considered with final outcomes stated based on the facility unable to determine that the internal investigations reviewed all staff & R1's and unidentified individual statements and findings/recommendations & and the failure of committee review of the event of 9/17/14. 2. Review of letter dated 11/18/14 sent to IDPH; "Please allow this letter to serve as notification of a report of staff (no name stated) to resident (R5) physical contact that was reported to E1 (ADMN) at 4:18 PM by Z2 (Day Training Coordinator) on 11/18/14. On 11/18/14 at 4:30 PM, R5 reported to Z2 that at second break at the DT a one on one DSP (no name stated) hit her on the stomach. R5	W 154		

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W 154	Continued From page 3 demonstrated an open hand brushed across her stomach. The incident was reported to OIG. Day Training stated that OIG will conduct the investigation. The DSP was suspended from the Day Training". Review of the facility "Safety Committee" minutes dated 11/20/14; the report noted the facility committee reviewed the letter sent to IDPH and noted the staff member from the Day Training was removed from client contact and R1 was examined by the nurse with no reports of pain. Interview with E1(ADMN) on 2/2/14@ 2:30 PM. E1 confirmed the 11/18/14 allegation involving R5. E1 stated the facility obtained statements from Day Training staff members. E1 stated there was no neglect/abuse involving the incident of 11/18/14 involving R5. E1 was unable to provide reproducible evidence that the alleged incident was thoroughly investigated, appropriate actions implemented and all revenant information was obtained & considered with final outcomes stated based on the facility unable to determine that the internal & OIG investigations reviewed all staff & R5's statements and findings/recommendations & and the failure of committee review of the event of 11/18/14.	W 154		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated	W 242		

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W 242	Continued From page 4 that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop a formal training program for 1 of 4 individuals (R4) who has dental consultations identifying the need for assistance during tooth brushing. Findings Include: Physician's Orders (dated 1/1/15- 1/31/15) identifies R4 as a 45 year old individual who functions at the Mild level of Intellectual Disability with additional diagnoses of Non Insulin Dependant Diabetes Mellitus and Gingivitis. Review of R4's Residential Permanent Dental Records and Dental Consultation Reports states the following: 1/22/14- "Patient's gums bleed easily and heavily. Patient had lots of plaque at gum lines and food debris between teeth. Patient needs help with brushing. Patient has cavities." 2/5/14- "Puffy red gingiva around cavities. Needs thorough home care to keep from failing restorations." 2/10/14- "Needs to keep mouth very clean or fillings will fail." 7/10/14- "Very dirty mouth. Generalized and heavy plaque and food debris. I had to brush teeth before scaling to see the teeth. Gingiva red and puffy. Heavy bleeding. Patient may need help	W 242		

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W 242	Continued From page 5 brushing his teeth. Brush at least two times a day, floss daily, soft or electric (tooth brush). Peroxide rinses three times a week. Needs better home care!" 1/14/15- "Patient had heavy plaque and food debris, stressed brushing slower, longer and towards the gums." Review of formal programs, R4 has an "Orientation" program that states, " He often requires prompting to complete tasks such as bathing, brushing his teeth,a and making his bed." The tasks analysis (documentation form) has a check off list that includes a daily schedule of- ready for med pass, put on clean clothes when getting up, brush teeth after breakfast, make bed each morning, pick up all items off floor before work, clean out lunch box when return home from work, in the dining room by 5:30 PM for supper, help with at least 1 chore, participate in house activities with peers, brush teeth before lights out, complete shower before evening med pass, put on clean clothes after shower, straighten room-no items on floor and out for 9 PM med pass. There is no evidence of a formal training program related to brushing teeth. In interviews with E1/ Administrator on 2/3/15 at 1:10 PM and 1:50 PM, E1 confirmed that the dental consultations identified that R4 needed formal training related to the dental hygiene. When asked for the formal training for R4's dental, E1 stated that he has an Orientation Program. E1 confirmed that the Orientation Program was a check list of brushing teeth. E1 stated she could not provide any additional evidence that the facility was providing formal tooth brushing training as recommended by the	W 242		

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W 242	Continued From page 6 dental consultations.	W 242		
W 316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify and ensure a gradual withdraw of drugs used for behavior control at least annually for 1 of 1 clients (R1) in the sample. Findings include: 1) The 2/14/14 Individual Service Plan (ISP) states that R1 is a 29 year old male whose diagnoses is stated as Mild Intellectual Disabilities, Depression and Psychosis. The ISP further states that "R1 takes the medication Lamictal 200mg BID & Zyprexa 12.5mg daily for maladaptive behavior of verbal aggression/agitation/anxiety that disrupt his daily life/routine". According to R1's ISP and Human Rights Committee(HRC) minutes from 10/9/14; R1 began receiving Lamictal 200mg BID on 12/15/12 & Zyprexa 12.5mg on 7/15/13. In addition it was reviewed that R1's current ISP, Medication Administration Record(MAR)of 2/1/15-2/28/15 and Behavior Management Minutes of 10/9/14 do not specify any medication reduction of the behavior modifying medications. . E1(ADMN) confirmed on 2/2/14 @2:30PM that R1 did not have a medication reduction since	W 316		

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W 316	Continued From page 7 7/13 and the team has planned to reduce the medications when R1 met criteria, however there was no reproducible evidence to support the holding of an annual reduction or attempted reduction.	W 316		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation,record review and interview, the facility failed to comply with the physician's order for 1 of 6 individuals (R6) observed receiving medications. Findings Include: Physician's Orders (dated 1/1/15-1/31/15) identifies R6 as a 43 year old individual who functions at the Moderate level of Intellectual Disability with additional diagnosis of Hyperlipidemia, Hypothyroidism and Non Insulin Dependant Diabetes Mellitus. There is an hand written entry on the POS (dated 1/29/15) that states, "Lovastatin 10 mg (milligram) every night by mouth day at 4 PM." Consultation Report (dated 1/29/15) states R6 was seen for a physical and was prescribed, "Lovastatin 10 mg (every day) at hs (hour of sleep)." R6's Medication Blister Pack of Lovastatin filled on 1/29/15 states R6 is to take Lovastatin 10 mg with supper.	W 368		

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W 368	Continued From page 8 Medication Record (dated 2/1/15- 2/28/15) states, "Lovastatin 10 mg every day at 4:00 PM and has documentation that this medication was given on 2/1/15 and 2/2/15 at 4:00 PM. Observation of medication pass on 2/2/15 from 4:05 PM- 5:00 PM, E2/ Authorized Direct Support Person assisted individuals in medication administration. At 4:15 PM, R6 received her medications which included Lovastatin 10 mg. R6 was not provided with food to be taken with her medication. R6 left the facility at 5:00 PM with peers and two staff to go out to eat at a destination approximately 35 miles from the facility. The facility served their evening meat at 5:25 PM to the individuals who stayed home. In an interview with E2 on 2/3/15 at 3:15 PM, E2 confirmed that she had not provided R6 with food during the medication administration of her Lovastatin. When asked about the time the Lovastatin was to be given, E2 stated, "She was taking it at HS, I was surprised it was changed to 4 PM." In interviews with E1/ Administrator on 2/3/15 from 9:20 AM- 10:25 AM, E2 confirmed that the Physician's orders state the Lovastatin was to be given at HS. E2 confirmed that the medication blister pack states the Lovastatin was to be given with supper and that it would be expected that food be provided with the medication per pharmacy recommendations. E2 confirmed that the facility had no evidence of the Z1/ RN Trainer getting clarification of when and how the Lovastatin was to be given. E2 confirmed that the facility serves supper at 5:30 PM.	W 368		

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W 370	Continued From page 9	W 370		
W 370	483.460(k)(3) DRUG ADMINISTRATION The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow the guidelines under state law as written in Section 116 ADMINISTRATION OF MEDICATIONS by their failure to: 1. Ensure the RN Trainer gets clarifications of medications to ensure that the Medication Administration Records match the Physician's Orders for 1 of 6 individuals (R6) medication orders. 2. Ensure Authorize direct care staff received training in the change of a medication for 1 of 6 individuals (R6). These failures impacted 1 of 6 individuals (R6) observed receiving oral medications. Findings Include: 1. Physician's Orders (dated 1/1/15-1/31/15) identifies R6 as a 43 year old individual who functions at the Moderate level of Intellectual Disability with additional diagnosis of Hyperlipidemia, Hypothyroidism and Non Insulin Dependant Diabetes Mellitus. There is an hand written entry on the POS (dated 1/29/15) that states, "Lovastatin 10 mg (milligram) every night by mouth day at 4 PM."	W 370		

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W 370	Continued From page 10 Consultation Report (dated 1/29/15) states R6 was seen for a physical and was prescribed, "Lovastatin 10 mg (every day) at hs (hour of sleep)." R6's Medication Blister Pack of Lovastatin filled on 1/29/15 states R6 is to take Lovastatin 10 mg with supper. Medication Record (dated 2/1/15- 2/28/15) states, "Lovastatin 10 mg every day at 4:00 PM." Observation of medication pass on 2/2/15 from 4:05 PM- 5:00 PM, E2/ Authorized Direct Support Person assisted individuals in medication administration. At 4:15 PM, R6 received her medications which included Lovastatin 10 mg. R6 was not provided with food to be taken with her medication. R6 left the facility at 5:00 PM with peers and two staff to go out to eat at a destination approximately 35 miles from the facility. The facility served their evening meat at 5:25 PM to the individuals who stayed home. In an interview with E2 on 2/3/15 at 3:15 PM, E2 confirmed that she had not provided R6 with food during the medication administration of her Lovastatin. When asked about the time the Lovastatin was to be given, E2 stated, "She was taking it at HS, I was surprised it was changed to 4 PM." In interviews with E1/ Administrator on 2/3/15 from 9:20 AM- 10:25 AM, E2 confirmed that the Physician's orders state the Lovastatin was to be given at HS. E2 confirmed that the medication blister pack states the Lovastatin was to be given with supper and that it would be expected that	W 370		

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W 370	Continued From page 11	W 370		

food be provided with the medication per pharmacy recommendations. E2 confirmed that the Medication Administration Record does not match the Physician;s Orders. E2 confirmed that the facility had no evidence of the Z1/ RN Trainer getting clarification of when and how the Lovastatin was to be given. E2 confirmed that the facility serves supper at 5:30 PM.

2. In-Service Education / Meeting Report (dated 1/29/15) states Authorized Direct Support Staff/ ADSP were given training related to R6 receiving Lovastatin 10 mg every day at bedtime.

In an interview with E1/ Administrator on 2/3/15 at 10:25 AM, when asked if the facility had reproducible evidence that the ADSP's were given training on the change of the Lovastatin from being given at bedtime to being given at supper, E1 stated, "No."

Joint Committee on Administrative Rules: Part 116 Administration of Medication in Community Settings:

Section 116.100 Quality Assurance (no date) states:

a) A registered professional nurse, advanced practice nurse, licensed practical nurse, pharmacist or physician shall review the following for all individuals:

1) medication orders:

2) medication labels and medications listed on the medication administration record to ensure that they match physician orders;

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W 370	Continued From page 12 Section 116.20 Definitions (no date) states: "Authorized direct care staff." Non-licensed persons who have successfully completed a medication administration training program specified by the Illinois Department of Human Services (DHS) and conducted by a nurse-trainer. "Nurse-trainer." A registered professional nurse and/or advanced practice nurse who has successfully completed the DHS (Department of Human Services) nurse-trainer training program. Section 116.40 Training and Authorization on Non-licensed Staff by Nurse Trainers (no date) states the following: a) Only a nurse-trainer may delegate and supervise the task of medication administration to direct care staff. 6)receive specific additional competency-based training and assessment by a nurse-trainer as deemed necessary by the nurse-trainer whenever a change of medication or dosage occurs or a new individual that requires medication enters the program.	W 370		