STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G236	A. BUILDING _____ B. WING _____	08/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEARDSTOWN TERRACE	310 EAST EIGHTH STREET BEARDSTOWN, IL 62618

(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	W 000		
W 120	INSPECTION OF CARE 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure that outside services meets the needs of 4 of 4 individuals in the sample (R1, R2, R3, and R4) and 1 individual outside the sample (R7) when: 1. Facility was not notified when R7 fell while attending daytraining. 2. Handwashing was not observed prior to noon meal (R1, R2, R3, R4 and R7) at daytraining. 3. Active treatment was not observed at daytraining (R1, R2, R3 and R4). Findings include: 1. R7 is identified in his ISP (Individual Service Plan) as a 31 year old male with diagnosis of Neurologic Disorder, Seizures and Psychosis who functions in the Moderate Level of Intellectual Disability.	W 120		

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

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W 120	Continued From page 1 Review of R7's ISP dated 6/24/14 in section titled, "Motor Skills," states, "R7 has difficulty with maintaining his balance and requires the use of walker, which gives him the ability to ambulate independently." During observation at daytraining on 8/4/14 at 12:55 pm, R7 was observed falling to the floor. Interview with E1 (Residential Service Director) on 8/4/14, E1 stated she was not informed R7 had fallen while attending day training. Interview with Z1 on 8/6/14 at 9:55 AM, Z1 was asked if daytraining had a policy on reporting injuries to individual homes, Z1 stated there were no written policies regarding notifying homes when injuries occurred. Z1 was asked if R7's home was notified of his fall on 8/4/14, Z1 stated, "No." Z1 stated, "We should have notified the home and I am not sure why we did not." 2. R1 is identified in his ISP dated 6/24/14 as 64 year old male who functions in the Moderate Level of Intellectual Disability. R2 is identified in his ISP dated 12/3/13 as a 61 year old male who functions in the Moderate Level of Intellectual Disability. R3 is identified in her ISP dated 7/23/14 as a 44 year old female who functions in the Severe Level of Intellectual Disability. R4 is identified in his ISP dated 4/23/14 as a 32 year old male who functions in the Profound Level of Intellectual Disability.	W 120		

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W 120	Continued From page 2 R7 is identified in his ISP dated 6/24/14 as a 31 year old male who functions in the Moderate Level of Intellectual Disability. During observation at day training for period 11:30 to 2:00 PM on 8/4/14, R1, R2, R3, R4 and R7 were found to be seated in the dining area. At 12:00 PM, Z2 shouted, "Time to eat." Z3 removed his socks and shoes and began rubbing his feet. Z3 then replaced his socks and shoes. No staff intervened. There were no observations of R1, R2, R3, R4 and R7 leaving the dining area to wash their hands and there were no observations of hand sanitizer being offered. Interview with Z2 on 8/4/14 at 1:43 PM, Z2 was asked if individuals wash their hands prior to eating lunch. Z2 stated they are told to. Z2 asked if individuals do not wash their hands if hand sanitizer or other alternative is offered. Z2 was asked if hand sanitizer was offered prior to lunch and he responded, "I don't believe so." Interview with R1 on 8/4/14, R1 was asked if he washed his hands prior to eating. R1 responded, "I will do that later." Interview with R3 on 8/4/14, R2 was asked if she washed her hands prior to eating. R3 responded, "No. I will." R2, R4 and R7 did not respond when asked if they washed their hands.	W 120		

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W 120	Continued From page 3	W 120		

Interview with Z1 on 8/6/14 at 9:55 AM, Z1 was asked if there was a policy on handwashing. Z1 stated there is no written policy.

3.

Interview with E1 on 8/4/14, E1 states all individuals residing in the home attend the same day training.

Observation at day training on 8/4/14 11:30 to 2:00 PM :

11:30-12:00 PM, R1, R2, R3, R4 and R7 were seated in dining area of day training. There were no activities observed.

12:00 PM , Z2 shouted, "Time to eat."

12:10 PM, R2 was finished with eating. at 12:15 PM, R3 had finished eating. At 12:25, R1 and R4 had finished eating and were seated in front of the television.

Observations on 8/4/14 at 12:30 PM, R1, R2, R3, R4 and R7 had all finished eating.
Observations on 8/4/14 12:30-1:00 PM, no activities occurred.

1:00 PM, R1, R2, R3, R4 and R7 were directed to go to their classrooms.

R1 and R3 were seated in front of the television.

1:07 PM R1 was observed in front of television with his head against the wall and his eyes closed.
1:25 PM R1 was observed in front of television with his head against the wall and his eyes

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W 120	Continued From page 4 closed. 1:45 PM R1 was observed in front of television with his head against the wall and his eyes closed. R3 moved into a classroom at 1:22 PM. Z3 was interviewed on 8/4/14 at 1:37 PM, Z3 was asked what type of activities R1 did while attending day training. Z3 responded R1 did his classwork in the a.m. and in the afternoon he chooses to not do any. Interview with Z1 on 8/6/14, Z1 was asked what was scheduled in the afternoon for R1, R2, R3 and R4. Z1 responded it was up to the staff what they planned. Z1 was asked what activities took place on 8/4/14 from 11:30-12:00 PM. Z1 stated, that is when programs such as handwashing are run. Z1 was not able to confirm handwashing occurred.	W 120		
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 record review and interview, the facility failed to be in compliance with State Law, Part 116 Administration of Medication in Community Settings, when they failed to: 1. Report Medication Administration errors to the Registered Nurse Trainer for 2 of 2 individuals (R1 and R3) in the sample and 2 of 2 individuals outside the sample (R5 and R6) with documented	W 370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 370	Continued From page 5	W 370		

medication errors.

2. Review medication errors within seven days after they occur for 2 of 2 individuals (R1 and R3) in the sample and 2 of 2 individuals outside the sample (R5 and R6) with documented medication errors.

Findings include:

1.

Part 116 Administration of Medication Administration in Community Settings Section 116.70 c) states, "In the event of medication error, authorized direct care staff shall immediately report the error to the registered professional nurse to receive direction on any action to be taken."

R1 is identified on his physician order sheet as a 64 year old male with diagnosis of Osteoarthrits and Hyperlipidemia who functions in the Mild Level of Intellectual Disability.

During record review, Medication Error Report for R1, dated 3/11/14, states, "Staff noticed that R1's pill was not signed off on for the day before and the pill was still in the pack."

Medication Error Report for R1, dated 3/11/14 lists medication involved as "Motrin 400 milligrams three times a day."

Medication Error Report for R1, dated 3/11/14 in section titled, "Notification: Registered Nurse Trainer," line is blank.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G236	A. BUILDING _____ B. WING _____	08/06/2014

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W 370	Continued From page 6	W 370		

R3 is identified on her physician order sheet as a 44 year old female with diagnosis of Atrial Fibrillation, Hypothyroidism and Psychosis who functions in the Moderate Level of Intellectual Disability.

During record review, Medication Error Report for R3, dated 3/11/14 states, "Staff gave R3 her 6 a.m. med and saw the pill from yesterday was still in the pack."

Medication Error Report for R3, dated 3/11/14 lists medication involved as "Metroprolol 100 milligrams one time a day."

Medication Error Report for R3, dated 3/11/14 in section titled, "Notification: Registered Nurse Trainer," line is blank.

R5 is identified on his physician order sheet as a 42 year old male with diagnosis of foot fungus and Autistic Spectrum Disorder, who functions in the Moderate Level of Intellectual Disability.

During record review, Medication Error Report for R5, dated 1/27/14 states, "Staff restocked creams on 1/26/14 p.m. and on 1/27/14 p.m. discovered that they (creams) had not been opened."

Medication Error Report of R5, dated 1/27/14, lists medications involved as "Bethamethasone and Nystatin-Triamincinolone Cream."

Medication Error Report for R5, dated 1/7/14, in section titled, "Notification: Registered Nurse Trainer," line is blank.

R6 is identified on her physician order sheets as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G236	A. BUILDING _____ B. WING _____	08/06/2014

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W 370	Continued From page 7 a 29 year old female with diagnosis of Seizure Disorder, Glaucoma and Seasonal Allergies who functions in the Moderate Level of Intellectual Disability. During record review, Medication Error Report for R6, dated 10/19/13 states, "Staff was doing 8 p.m. meds and noticed the R6's eye drops were not sent with her on home visit." Medication Error Report for R6, dated 10/19/13, lists medication involved as "Timolol and Trovatan eye drops." Medication Error Report for R6, dated 10/19/13, in section titled, ""Notification: Registered Nurse Trainer, " line is blank. Medication Error Report for R6, dated 10/21/13, states, "Waiting on pharmacy." Medication Error Report for R6, dated 10/21/13, lists medication involved as "Flucticasone-8 a.m. dose." Medication Error Report for R6, dated 10/21/13, in section titled, ""Notification: Registered Nurse Trainer, " line is blank. The facility in unable to provide evidence medication errors for R1, R3 , R5 and R6 were reported to the Registered Nurse Trainer. Interview with E1, Residential Service Director (RSD) on 8/5/14, E1 confirms there is no documentation of Registered Nurse Trainer notification for medication errors reported for R1, R3, R5 and R6.	W 370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G236	A. BUILDING _____ B. WING _____	08/06/2014

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W 370	Continued From page 8 2. Part 116 Administration of Medication Administration in Community Settings Section 116.100 c) states, "A quality assurance review of medication errors for the purpose of monitoring and recommending corrective action shall be conducted within seven days after occurrence." Medication Error Report for R1, dated 3/11/14, in section titled, Reviewed by Registered Nurse Trainer, review is undated. Medication Error Report for R3, dated 3/11/14, in section titled, Reviewed by Registered Nurse Trainer, review is undated. Medication Error Report for R5, dated 1/28/14, in section titled, Reviewed by Registered Nurse Trainer, review is undated. Medication Error Report for R6, dated 10/19/13, in section titled, Reviewed by Registered Nurse Trainer, review is dated 10/28/13. The facility was unable to provide evidence a quality assurance review of medication errors for R1, R3, R5 and R6 occurred within seven days. Interview with E1 on 8/5/14 confirms there is no documentation of medication errors were reviewed within seven days.	W 370		
W 376	483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician.	W 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G236	A. BUILDING _____ B. WING _____	08/06/2014

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W 376	Continued From page 9 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to report medication errors to the physician for 2 of 2 individuals in the sample (R1 and R3) and and 2 of 2 individuals outside the sample (R5 and R6) with documented medication errors. Findings include: R1 is identified on his physician order sheet as a 64 year old male with diagnosis of Osteoarthrits and Hyperlipidemia who functions in the Mild Level of Intellectual Disability. During record review, Medication Error Report for R1, dated 3/11/14, states, "Staff noticed that R1's pill was not signed off on for the day before and the pill was still in the pack." Medication Error Report for R1, dated 3/11/14 lists medication involved as "Motrin 400 milligrams three times a day." Medication Error Report for R1, dated 3/11/14 in section titled, "Notification: Physician, " line is blank. R3 is identified on her physician order sheet as a 44 year old female with diagnosis of Atrial Fibrillation, Hypothyroidism and Psychosis who functions in the Moderate Level of Intellectual Disability. During record review, Medication Error Report for R3, dated 3/11/14 states, "Staff gave R3 her 6 a.m. med and saw the pill from yesterday was still in the pack."	W 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G236	A. BUILDING _____ B. WING _____	08/06/2014

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W 376	Continued From page 10 Medication Error Report for R3, dated 3/11/14 lists medication involved as "Metroprolol 100 milligrams one time a day." Medication Error Report for R3, dated 3/11/14 in section titled, "Notification: Physician, " line is blank. R5 is identified on his physician order sheet as a 42 year old male with diagnosis of foot fungus and Autistic Spectrum Disorder, who functions in the Moderate Level of Intellectual Disability. During record review, Medication Error Report for R5, dated 1/27/14 states, "Staff restocked creams on 1/26/14 p.m. and on 1/27/14 p.m. discovered that they (creams) had not been opened." Medication Error Report of R5, dated 1/27/14, lists medications involved as "Bethamethasone and Nystatin-Triamincinolone Cream." Medication Error Report for R5, dated 1/7/14, in section titled, "Notification: Physician," line is blank. R6 is identified on her physician order sheets as a 29 year old female with diagnosis of Seizure Disorder, Glaucoma and Seasonal Allergies who functions in the Moderate Level of Intellectual Disability. During record review, Medication Error Report for R6, dated 10/19/13 states, "Staff was doing 8 p.m. meds and noticed the R6's eye drops were not sent with her on home visit."	W 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G236	A. BUILDING _____ B. WING _____	08/06/2014

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W 376	Continued From page 11 Medication Error Report for R6, dated 10/19/13, lists medication involved as "Timolol and Trovatan eye drops." Medication Error Report for R6, dated 10/19/13, in section titled, ""Notification: Physician, " line is blank. Medication Error Report for R6, dated 10/21/13, states, "Waiting on pharmacy." Medication Error Report for R6, dated 10/21/13, lists medication involved as "Flucticasone-8 a.m. dose." Medication Error Report for R6, dated 10/21/13, in section titled, ""Notification: Physician, " line is blank. The facility in unable to provide evidence if medication errors for R1, R3 , R5 and R6 were reported to the physician. Interview with E1, Residential Service Director (RSD) on 8/5/14, E1 states it is generally the nurse who notifies the physician. E1 confirms there is no documentation of physician notification for medication errors reported on R1, R3, R5 and R6.	W 376		