DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G236	B. WING		08	3/06/2014	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BEARDST	OWN TERRACE			310 EAST EIGHTH STREET			
				BEARDSTOWN, IL 62618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		W 00	00			
	ANNUAL CERTIFICA FUNDAMENTAL	ATION SURVEY -					
W 120	INSPECTION OF CA 483.410(d)(3) SERVI OUTSIDE SOURCES	CES PROVIDED WITH	W 12	20			
	The facility must assumet the needs of ea	re that outside services ch client.					
	Based on observatio interview, the facility f services meets the ne	ailed to assure that outside eeds of 4 of 4 individuals in R3, and R4) and 1 individual					
	1. Facility was not no attending daytraining.	tified when R7 fell while					
	-	not observed prior to noon and R7) at daytraining.					
	3. Active treatment w daytraining (R1, R2, F						
	Findings include:						
	as a 31 year old male Neurologic Disorder,	ISP (Individual Service Plan) with diagnosis of Seizures and Psychosis who rate Level of Intellectual					

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

TITLE

(X6) DATE

PRINTED: 08/29/2014

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/29/2014 M APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY PLETED
		14G236	B. WING		30	8/06/2014
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DE	
BEARDST	OWN TERRACE		_	0 EAST EIGHTH STREET EARDSTOWN, IL 62618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 120	Continued From page	21	W 120			
	"Motor Skills," states, maintaining his baland walker, which gives h independently." During observation at 12:55 pm, R7 was ob- Interview with E1 (Re- on 8/4/14, E1 stated s had fallen while attend Interview with Z1 on 8 asked if daytraining h injuries to individual h no written policies reg when injuries occurre- home was notified of "No." Z1 stated, "We s home and I am not su 2. R1 is identified in his year old male who fur Level of Intellectual D R2 is identified in his year old male who fur Level of Intellectual D R3 is identified in her	 B/6/14 at 9:55 AM, Z1 was ad a policy on reporting omes, Z1 stated there were yarding notifying homes d. Z1 was asked if R7's his fall on 8/4/14, Z1 stated, should have notified the ure why we did not." ISP dated 6/24/14 as 64 notions in the Moderate isability. ISP dated 12/3/13 as a 61 notions in the Moderate isability. ISP dated 7/23/14 as a 44 unctions in the Severe Level 				
		ISP dated 4/23/14 as a 32 nctions in the Profound Level ty.				

Facility ID: IL6012363

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/29/2014 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		14G236	B. WING			08/	06/2014
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BEARDST	OWN TERRACE				10 EAST EIGHTH STREET BEARDSTOWN, IL 62618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 120	Continued From page	2	w	120			
		ISP dated 6/24/14 as a 31 nctions in the Moderate isability.					
	11:30 to 2:00 PM on 8	day training for period 3/4/14, R1, R2, R3, R4 and seated in the dining area.					
	At 12:00 PM, Z2 shou	ited, "Time to eat."					
		s and shoes and began hen replaced his socks and /ened.					
	and R7 leaving the dir	vations of R1, R2, R3, R4 ning area to wash their e no observations of hand d.					
	asked if individuals wa eating lunch. Z2 stat asked if individuals do hand sanitizer or othe was asked if hand sar	8/4/14 at 1:43 PM, Z2 was ash their hands prior to ted they are told to. Z2 to not wash their hands if er alternative is offered. Z2 nitizer was offered prior to led, "I don't believe so."					
		8/4/14, R1 was asked if he or to eating. R1 responded,					
		8/4/14, R2 was asked if she ior to eating. R3 responded,					
	R2, R4 and R7 did no they washed their har	ot respond when asked if nds.					

If continuation sheet Page 3 of 12

							0.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		14G236	B. WING			08/	06/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BEARDS	TOWN TERRACE				10 EAST EIGHTH STREET EARDSTOWN, IL 62618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
W 120	Interview with Z1 on a sked if there was a stated there is no wri 3. Interview with E1 on individuals residing in day training. Observation at day tr 2:00 PM : 11:30-12:00 PM, R1, seated in dining area no activities observed 12:00 PM , Z2 shoute 12:10 PM, R2 was fir PM, R3 had finished had finished eating a the television. Observations on 8/4/ R4 and R7 had all fin Observations on 8/4/ activities occurred.	8/6/14 at 9:55 AM, Z1 was policy on handwashing. Z1 tten policy. 8/4/14, E1 states all a the home attend the same raining on 8/4/14 11:30 to R2, R3, R4 and R7 were of day training. There were d. ed, "Time to eat." hished with eating. at 12:15 eating. At 12:25, R1 and R4 nd were seated in front of 14 at 12:30 PM, R1, R2, R3, ished eating. 14 12:30-1:00 PM, no , R4 and R7 were directed to	W -	120			
		ted in front of the television.					
	with his head against closed. 1:25 PM R1 was obs	erved in front of television the wall and his eyes erved in front of television the wall and his eyes					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/29/2014 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		14G236	B. WING		08/	/06/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BEARDST	OWN TERRACE			310 EAST EIGHTH STREET BEARDSTOWN, IL 62618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 120	closed. 1:45 PM R1 was observed in the page of the system for drug at the system for drug	erved in front of television the wall and his eyes sroom at 1:22 PM. n 8/4/14 at 1:37 PM, Z3 was ctivities R1 did while p. Z3 responded R1 did his and in the afternoon he y. 8/6/14, Z1 was asked what afternoon for R1, R2, R3 ed it was up to the staff what s asked what activities took 11:30-12:00 PM. Z1 stated, s such as handwashing are to confirm handwashing ADMINISTRATION administration must assure onnel are allowed to r if State law permits.	W 120			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/29/2014 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		14G236	B. WING			08/0	06/2014
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
BEARDST	OWN TERRACE		-	10 EAST EIGHTH STREET EARDSTOWN, IL 62618			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
W 370	Continued From page medication errors.	:5	W 370				
	after they occur for 2 in the sample and 2 o	errors within seven days of 2 individuals (R1 and R3) of 2 individuals outside the with documented medication					
	Findings include:						
	1.						
	116.70 c) states, "In the error, authorized direct immediately report the	nmunity Settings Section he event of medication					
	64 year old male with	physician order sheet as a diagnosis of Osteoarthrits ho functions in the Mild isability.					
	for R1, dated 3/11/14,	Medication Error Report , states, "Staff noticed that ed off on for the day before n the pack."					
	Medication Error Repu lists medication involv milligrams three times						
		ort for R1, dated 3/11/14 in ation: Registered Nurse					

Facility ID: IL6012363

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 08/29/2014 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		14G236	B. WING			08	/06/2014
NAME OF PI	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE		
BEARDST	OWN TERRACE				310 EAST EIGHTH STREET BEARDSTOWN, IL 62618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 370	R3 is identified on hei 44 year old female wi Fibrillation, Hypothyro functions in the Mode Disability. During record review, R3, dated 3/11/14 sta a.m. med and saw the in the pack." Medication Error Rep lists medication involv milligrams one time a Medication Error Rep section titled, "Notifica Trainer," line is blank. R5 is identified on his 42 year old male with and Autistic Spectrum the Moderate Level o During record review, R5, dated 1/27/14 sta creams on 1/26/14 p. discovered that they (opened." Medication Error Rep lists medications invo and Nystatin-Triaming Medication Error Rep section titled, "Notifica Trainer," line is blank.	r physician order sheet as a tith diagnosis of Atrial oldism and Psychosis who erate Level of Intellectual , Medication Error Report for ates, "Staff gave R3 her 6 e pill from yesterday was still ort for R3, dated 3/11/14 ved as "Metroprolol 100 day." fort for R3, dated 3/11/14 in ation: Registered Nurse s physician order sheet as a diagnosis of foot fungus n Disorder, who functions in f Intellectual Disability. , Medication Error Report for ates, "Staff restocked m. and on 1/27/14 p.m. (creams) had not been ort of R5, dated 1/27/14, lived as "Bethamethasone cinolone Cream."	w	370			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 14G236 B. WING 08/06/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **310 EAST EIGHTH STREET BEARDSTOWN TERRACE BEARDSTOWN, IL 62618** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 370 Continued From page 7 W 370 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 08/29/2014

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					PRINTED: 08/29/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	14G236	B. WING		_	08/06/2014
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST		
BEARDSTOWN TERRACE			10 EAST EIGHTH STREET BEARDSTOWN, IL 6261		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)	DATE
W 370 Continued From page 2.	∋ 8	W 370			
 116.100 c) states, "A medication errors for and recommending c conducted within sev Medication Error Rep section titled, Review Trainer, review is unc Medication Error Rep section titled, Review Trainer, review is unc Medication Error Rep section titled, Review Trainer, review is unc Medication Error Rep section titled, Review Trainer, review is unc Medication Error Rep section titled, Review Trainer, review is unc Medication Error Rep section titled, Review Trainer, review is unc Medication Error Rep in section titled, Review Trainer, review is dat The facility was unab quality assurance rev R1, R3, R5 and R6 o Interview with E1 on a documentation of me reviewed within sever W 376 The system for drug a that drug administrati 	nmunity Settings Section quality assurance review of the purpose of monitoring orrective action shall be en days after occurrence." Nort for R1, dated 3/11/14, in red by Registered Nurse dated. Nort for R3, dated 3/11/14, in red by Registered Nurse dated. Nort for R5, dated 1/28/14, in red by Registered Nurse dated. Nort for R6, dated 10/19/13, ewed by Registered Nurse ed 10/28/13. Net to provide evidence a riew of medication errors for ccurred within seven days. 8/5/14 confirms there is no dication errors were n days.	W 376			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/29/2014 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION		(X3) DATE	
		14G236	B. WING				08/	06/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BEARDST	OWN TERRACE				310 EAST EIGHTH STREET BEARDSTOWN, IL 62618			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 376	Continued From page	9	w	376	5			
	Based on record revi failed to report medica for 2 of 2 individuals in and and 2 of 2 individ	not met as evidenced by: ew and interview, the facility ation errors to the physician in the sample (R1 and R3) uals outside the sample (R5 inted medication errors.						
	Findings include:							
	64 year old male with	physician order sheet as a diagnosis of Osteoarthrits ho functions in the Mild isability.						
	for R1, dated 3/11/14,	Medication Error Report states, "Staff noticed that ed off on for the day before the pack."						
	Medication Error Rep lists medication involv milligrams three times							
		ort for R1, dated 3/11/14 in ation: Physician, " line is						
	44 year old female wi Fibrillation, Hypothyrc	physician order sheet as a th diagnosis of Atrial hidism and Psychosis who rate Level of Intellectual						
	R3, dated 3/11/14 sta	Medication Error Report for ates, "Staff gave R3 her 6 e pill from yesterday was still						

Facility ID: IL6012363

If continuation sheet Page 10 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/29/2014 / APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		14G236	B. WING			08/	06/2014
NAME OF PF	ROVIDER OR SUPPLIER		·		REET ADDRESS, CITY, STATE, ZIP CODE	-	
BEARDST	OWN TERRACE				0 EAST EIGHTH STREET EARDSTOWN, IL 62618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 376	Continued From page	÷ 10	W 3	76			
		ort for R3, dated 3/11/14 /ed as "Metroprolol 100 day."					
		ort for R3, dated 3/11/14 in ation: Physician, " line is					
	42 year old male with and Autistic Spectrum	physician order sheet as a diagnosis of foot fungus Disorder, who functions in f Intellectual Disability.					
	R5, dated 1/27/14 sta creams on 1/26/14 p.	Medication Error Report for ites, "Staff restocked m. and on 1/27/14 p.m. (creams) had not been					
	-	ort of R5, dated 1/27/14, lved as "Bethamethasone cinolone Cream."					
		ort for R5, dated 1/7/14, in ation: Physician," line is					
	a 29 year old female v Disorder, Glaucoma a	r physician order sheets as with diagnosis of Seizure and Seasonal Allergies who rate Level of Intellectual					
	R6, dated 10/19/13 st	Medication Error Report for tates, "Staff was doing 8 to the R6's eye drops were nome visit."					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 14G236 B. WING 08/06/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **310 EAST EIGHTH STREET BEARDSTOWN TERRACE BEARDSTOWN, IL 62618** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 376 Continued From page 11 W 376 Medication Error Report for R6, dated 10/19/13, lists medication involved as "Timolol and Trovatan eve 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.

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