PRINTED: 01/21/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		14G233	B. WING		11	C / <b>19/2015</b>	
NAME OF PROVIDER OR SUPPLIER  DOUGLAS TERRACE				STREET ADDRESS, CITY, STATE, ZIP CO 324 EAST DOUGLAS AVENUE JACKSONVILLE, IL 62650		710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENT	rs .	W 0	000			
	COMPLAINT INVE	STIGATION SURVEY					
	COMPLAINT #1546	6029/IL81236					
	&						
W 148	COMPLAINT #1546 483.420(c)(6) COM CLIENTS, PARENT	MUNICATION WITH	W 1	48		12/1/15	
	parents or guardian changes in the clier	tify promptly the client's of any significant incidents, or nt's condition including, but not lness, accident, death, abuse, sence.					
	Based on file revier determined that the guardians for 11 of concerning an inter	s not met as evidenced by: w and staff interview it was facility failed to notify 11 individuals (R#1-R#11) nal pest infestation that from an outside contractor.					
	@ 11:00AM; noted	roster submitted on 11/17/15 I 11 individuals requiring les with current family or the rdianship.					
	R15 current family i guardian.	R6, R7, R8, R9, R10, R11 & member as court appointed te Guardianship as court					
	Review of facility "B	Bed Bug" procedural guideline					
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

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

12/01/2015

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.

Facility ID: IL6012389

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G233	B. WING _				C <b>19/2015</b>	
NAME OF PROVIDER OR SUPPLIER  DOUGLAS TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE  324 EAST DOUGLAS AVENUE  JACKSONVILLE, IL 62650				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		JLD BE COMPLÉTION		
W 148	Notify regulatory ag Have exterminator Attempt to identify a In-service staff on u infection control pol Add to Quality Assume Review of local pess 10/5/15 noted deter requirement of treat residential facility.  Review of facility "A Bugs" (no date state Every morning luncin order to be disposed Mattresses are encencasements Bed bug traps are of issues. Residents are encounted in order to be disposed from day and the staff inspect beds of the common staff in	a ator/Executive Director ency if required verify problem and the extent source universal precautions and icies irance Committee Report.  It control agency bill dated ction of bedbugs and tment for all rooms in the action Taken to Address Bed ed): hes are packed in plastic bags sable ased entirely in mattress on beds to recognize bug uraged to leave all personal der to prevent transportation ay program couraged to shower eturning home from day daily as they are cleaning beds ug they are to contact tenance, pest control agency,	W 14	48				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		14G233	B. WING			C <b>19/2015</b>	
NAME OF PROVIDER OR SUPPLIER  DOUGLAS TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 324 EAST DOUGLAS AVENUE JACKSONVILLE, IL 62650	1 11/	13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE OF THE AP	LD BE	(X5) COMPLETION DATE	
W 148	completed on 10/5/bed bugs were local R1 & R2. E2 confirmate treated based on recontrol agent. E2 st R2 where notified obedbugs and treatmorovide any reproduct conversations with addition E2 confirmate were not contacted and action plan requirecommendations a address bed bugs."  483.460(c) NURSINATION The facility must proservices in accordate that the nursing services for (R#1-R#15) concernater an internal pest that required treatmorter contractor. Findings.  1. Review of facility @ 11:OOAM; noted guardianship service guardians; or The CA. R1, R2, R3, R5, R15 current family in guardian.	15 facility wide. E2 stated that ted in the bedroom containing med that entire facility was ecommendations of pest ated that guardians of R1 & f the occurrence of the nent plans. E2 was unable to ucible evidence of the R1 & R2's guardians. In ed that guardians for R3-R11 concerning the bed bug issue uiring the clients to follow new as outlined in "Action plan to NG SERVICES by de clients with nursing nce with their needs.  Is not met as evidenced by: w and staff interview it was facility failed to provide 15 of 15 individuals ning nursing assessments at infestation was discovered tent from an outside	W 1			12/1/15	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G233	B. WING				C 1 <b>9/2015</b>	
NAME OF PROVIDER OR SUPPLIER  DOUGLAS TERRACE				STREET ADDRESS, CITY, STATE, ZIP 324 EAST DOUGLAS AVENUE JACKSONVILLE, IL 62650	CODE	1 11/	13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPI	BE	(X5) COMPLETION DATE	
W 331	Mild Intellectual fun Moderate Intellectual functioning-R1,R4,F Severe Intellectual Profound Intellectual Profound Intellectual Profound Intellectual Profound Intellectual Profound Intellectual Review of local pes 10/5/15 noted detect requirement of treat residential facility.  Review of facility "A Bugs" (no date state Every morning luncin order to be dispo Mattresses are encencasements Bed bug traps are of issues Residents are encoitems at home in or of bed bugs from da All residents are enimmediately after reprogram Staff inspect beds of rooms and making If staff find a bed but Administrator, main and guardians of af Interview with E2 (C Professional) on 11 E2 confirmed that the	self-guardians.  Illowing Intellectual levels: ctioning-R3,R6,R8 & R13. al R5,R7,R9,R10,R11 & R12. functioning-R2 & R15. al functioning-R14.  It control agency bill dated ction of bedbugs and tment for all rooms in the  ction Taken to Address Bed ed): hes are packed in plastic bags sable ased entirely in mattress on beds to recognize bug  uraged to leave all personal der to prevent transportation ay program couraged to shower eturning home from day  daily as they are cleaning beds ag they are to contact tenance, pest control agency, fected rooms.  Qualified Intellectual Disability	W3	331				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		14G233	B. WING		11	C / <b>19/2015</b>
NAME OF PROVIDER OR SUPPLIER  DOUGLAS TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 324 EAST DOUGLAS AVENUE JACKSONVILLE, IL 62650		119/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
W 331	bed bugs were loca R1 & R2. E2 confirmation treated based on recontrol agent. E2 st examined for any obites. E2 was unable evidence of the state addition E2 confirm R1-R15 was not cobug issue and did not client's physician(s)	ge 4 15 facility wide. E2 stated that ted in the bedroom containing med that entire facility was ecommendations of pest rated that R1 & R2 were occurrences of bedbugs and le to provide any reproducible of evaluations of R1 & R2. In ed that RN consultant (E3) for intacted concerning the bed not communicate with the concerning the bed bugs and or needed assessments.	Ws	331		