

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2014
NAME OF PROVIDER OR SUPPLIER HICKORY STREET PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3905 EAST HICKORY STREET DECATUR, IL 62521		
(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	W 000			
W 263	<p>ANNUAL CERTIFICATION SURVEY - FUNDAMENTAL</p> <p>LICENSURE SURVEY</p> <p>INSPECTION OF CARE</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written guardian consent for behavior modifying medications for 2 of 2 individuals in the sample who receive behavior modifying medications(R1, R2).</p> <p>Findings include:</p> <p>1. Per the 4/11/14 Annual Interdisciplinary Team Evaluation (IDT), R1 has diagnoses of Psychosis and Mood Disorder.</p> <p>In further review of the IDT Evaluation dated 4/11/14, R1's parents are his guardian.</p> <p>In review of the Physician's Order Sheet (POS) dated 11/2014, R1 has orders for Wellbutrin 100 mg daily; Clonidine 0.1mg daily and 2mg twice a day; Trileptal 1200mg in AM and 900mg at bedtime; Seroquel 200mg in AM, 300mg in evening and at 6PM.</p>	W 263			

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

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 263	<p>Continued From page 1</p> <p>During review of R1's record, the current medication consent is dated 7/25/13.</p> <p>There is no evidence of a more current consent for 2014.</p> <p>In an interview on 11/7/14 at 12:55 PM, when asked if there was a current consent for R1's behavior modifying medications, E1 (Resident Services Director - RSD), stated, no she could not find one.</p> <p>2. Per the 4/11/14 Annual Interdisciplinary Team Evaluation (IDT), R2 has diagnosis of Schizophrenia, Anxiety, Paranoid Behavior.</p> <p>In further review of the IDT Evaluation dated 4/11/14, R2 is his own guardian.</p> <p>In review of the Physician's Order Sheet (POS), dated 11/01/2014, R2 has orders for Luvox 50mgs at bedtime, Zyprexa 2.5mg at bedtime, Gabapentin 100mg in AM & bedtime.</p> <p>During review of R2's record, the current medication consent is dated 7/25/13.</p> <p>There is no evidence of a more current consent for 2014.</p> <p>In an interview on 11/7/14, at 11:16 AM, when asked if there is a current consent for R2's behavior modifying medications, E1 (RSD), stated, no she could not find one.</p>	W 263			