STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G294	A. BUILDING _____ B. WING _____	09/29/2015

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HARRIS PLACE	209 HARRIS ROAD EAST PEORIA, IL 61611

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W 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY - FUNDAMENTAL INSPECTION OF CARE LICENSURE SURVEY	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on chart review and interview the facility failed 2 of 4 individuals in the sample (R1 and R4) to maintain a record keeping system to accurately record health care and active treatment. Findings include: According to Physician's Order Sheet (POS) dated 9/1/15, R1 functions at a Mild Intellectual Disability Level with diagnosis of Hypothyroid and Bipolar Disorder. During record review of R1's chart, no documentation was provided for a Dental exam. During an interview with E1, Administrator/Qualified Intellectual Disability Professional QIDP), on 9/23/15 at 3:00 PM, E1 was asked if a current dental exam for R1 is available for review and E1 stated "R1 has had it but it is at (a neighboring facility), I do not know where but I will look for it and have it for	W 111		10/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/07/2015

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 111	Continued From page 1 tomorrow". During an interview with E1, Administrator/Qualified Intellectual Disability Professional (QIDP), on 9/24/15 at 2:40 PM, E1 was asked if she has R1's dental from the other facility and E1 stated "no I have not found it yet but I will have it for tomorrow". During an interview with E3, Vice President of Intermediate Care Facility Operations, on 9/25/15, at 2:00 PM, E3 stated "I have to call the dentist and get the information for you, R1 did go but we don't have anything here from the dentist, verifying she went". On 9/28/15 at 10:48 AM, a fax from the facility was sent verifying R1 went to the dentist on 4/18/15. According to R4's POS, dated 9/1/15, R4 functions at a Moderate Intellectual Disability Level with current diagnosis of Neurological Disorder and Autism. During record review of R4's chart, R4's Individual Program Plan (IPP) and medication consent form for Psychotropic Medication was missing in the chart. During interview with E1, Administrator/QIDP, on 9/24/15 at 12:30 PM, E1 was asked to provide a IPP for R4 and a medication consent for his psychotropic medication. E1 stated "I don't know what happened to it, I just had the IPP last month, I don't know where it is". What about his Psychotropic medication consent form, R4's medication was increased in March 2015, do you have a consent form signed to give that	W 111		

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W 111	Continued From page 2 medication? E1 stated "I don't know, it is the nurse who gets the consents, I don't know where it is". During an interview with E2, Licensed Practical Nurse (LPN), on 9/24/15 at 2:20 PM, E2 was asked to provide a current Medication consent for R4's Psychotropic Medication and E2 Stated "I don't see it, I know I got one, but it is missing. I will call and get another for tonight's dose."	W 111		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to provide evidence of reporting an allegation of mistreatment or abuse for 1 individual (R6) outside of the sample, for a peer to peer incident. Findings include: According to Physician's Order Sheet (POS) dated 9/1/15, R6 functions at a Severe Intellectual Disability Level with current diagnosis of Cerebral Palsy, Hypertension, Osteoporosis, Diabetes and Depression. During record review of General Event Reports (GER), on 7/18/15, at 3:00 PM, R6 was assaulted by another client in the living room when R6 came	W 153		10/29/15

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W 153	Continued From page 3 in from outside, another client came to R6 and began choking her which made her cry. In an interview with E1, Administrator/Qualified Intellectual Disability Professional on 9/24/15 at 2:40 PM, E1 was asked can you provide evidence that this incident involving R6 was reported to the Illinois Department of Public Health? No, I don't know where it is, I can't find it." According to Policy Name: Abuse and Neglect Program revision date: April 10, 2014, for Procedure - Investigation On page 5 number 6: states "An investigation will be initiated by the Administrator/RSD as soon as practicable after the alleged incident, but not later than 24 hours and will be concluded within 72 hours if possible, but not to exceed 5 days." On page 6, number 8. states "Upon completion of the incident report and investigation, the Administrator or the Corporate Compliance Officer will review for completion. The Administrator will be responsible for maintaining a file on all abuse and neglect reports and investigations." No evidence was provided of reporting to IDPH.	W 153		
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 record review and interview the facility failed to thoroughly investigate an incident	W 154		10/29/15

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W 154	Continued From page 4 between Peer to Peer of 1 out of 4 individual's in the sample (R1) and to review reports of investigation to determine that necessary information relevant to the incident was obtained and considered. Findings Include: According to Physician's Order Sheet (POS) dated 9/1/15, R1 functions at a Mild Intellectual Disability Level with diagnosis of Hypothyroid and Bipolar Disorder. During record review of General Event Reports (GER), dated 8/1/15 at 11:30 AM, "R1 was sitting on the couch and got up to put her clothes away and sat back down and then another client walked over and started chocking her and then hitting her on the face which led to her having a busted lip." During record review of the letter reporting to Illinois Department of Public Health (IDPH) dated 8/3/15, of a peer to peer incident stated "On 8/1/15, A client made contact with left open hand to the left side of R1's head behind her ear. R1 was assessed and showed no signs of injury." In an interview with E1, Administrator/Qualified Intellectual Disabilities Professional, on 9/24/15, at 2:40 PM, E1 was asked do you have your investigation report for the incident involving R1 on 8/1/15? E1 stated "I reported it to IDPH, I investigated it, I don't have any paperwork." E1 was asked why did the report state no injuries were noted and R1 had a busted lip from the incident? E1 stated "I don't know, I didn't see that report, I don't know why it says she was injured."	W 154		

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W 154	Continued From page 5 According to Policy Name: Abuse and Neglect Program revision date: April 10, 2014, for Procedure - Investigation On page 5 number 6: states "An investigation will be initiated by the Administrator/RSD as soon as practicable after the alleged incident, but not later than 24 hours and will be concluded within 72 hours if possible, but not to exceed 5 days." On page 6, number 8. states "Upon completion of the incident report and investigation, the Administrator or the Corporate Compliance Officer will review for completion. The Administrator will be responsible for maintaining a file on all abuse and neglect reports and investigations. " No evidence of a thorough investigation was provided.	W 154		
W 206	483.440(c)(1) INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to provide an Individual Program Plan for 1 of 4 individual's in the sample (R4), by not having a Individual Program plan in place.	W 206		10/29/15

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W 206	Continued From page 6 Findings include: According to R4's POS, dated 9/1/15, R4 functions at a Moderate Intellectual Disability Level with current diagnosis of Neurological Disorder and Autism. During record review of R4's chart, R4's Individual Program Plan (IPP) was missing in the chart. During interview with E1, Administrator/QIDP, on 9/24/15 at 12:30 PM, E1 was asked to provide a IPP for R4. E1 stated "I don't know what happened to it, I just had the IPP last month, I don't know where it is." No evidence of an IPP was provided.	W 206		
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to obtain participation by the client's legal guardian (Parent) for 1 of 4 individual's in the sample (R4), by not including them in the Individual Program Plan (IPP) session. Findings include: According to R4's POS, dated 9/1/15, R4 functions at a Moderate Intellectual Disability	W 209		10/29/15

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W 209	Continued From page 7 Level with current diagnosis of Neurological Disorder and Autism. During interview Z2, Legal guardian (Parent), on 9/23/15 at 5:36 PM, Z2 stated "I have no complaints except they didn't invite me to the IPP this year. They just sent me the paperwork to be signed. I usually go but they didn't let me know when it was." During an interview with E1, Administrator/Qualified Intellectual Disabilities Professional, on 9/24/15, at 2:40, E1 was asked if R4's parent Z2 was invited to the IPP? E1 stated yes. E1 was asked to provide evidence that Z2 was invited. E1 stated "I don't have anything, I know I invited her." No evidence of a letter of invite was provided for R4's IPP session date.	W 209		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure a plan to manage behavior was implemented for 1 of 3 individuals in the sample who have a behavior plan (R3).	W 249		10/29/15

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W 249	Continued From page 8 Findings include: Review of an Individual Service Plan (ISP) dated 5/20/15, R3 is a 23 year old female with diagnoses which include Mild Intellectual Disability, Bipolar and Depression. R3's Behavior Management Program was not found in a book provided by E1 containing all resident BMP's. E1, Administrator, provided a Behavior Management Program (BMP) for R3 dated 5/20/15 with a goal of reducing aggression. Review of R3's QIDP (Qualified Intellectual Disability Professional) Monthly Report for July and August 2015 has no review of her Behavior Management Program data. E3, Vice President of Operations was interviewed on 9/25/15 at 1:30pm and asked if there were any records of Behavior Event Reports or General Event Reports for R3. E3 said no. E3 was asked where documentation could be found on R3's program. E3 stated it should be on the Monthly QIDP Reports. E3 was asked if R3's BMP had been implemented. E3 stated no.	W 249		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including,	W 255		10/29/15

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W 255	Continued From page 9 but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure a plan to manage behavior was reviewed for 1 of 3 individuals in the sample who have a behavior plan (R3). Findings include: Review of an Individual Service Plan (ISP) dated 5/20/15, R3 is a 23 year old female with diagnoses which include Mild Intellectual Disability, Bipolar and Depression. E1, Administrator, provided a Behavior Management Program (BMP) for R3 dated 5/20/15 with a goal of reducing aggression. Review of R3's QIDP (Qualified Intellectual Disability Professional) Monthly Report for July and August 2015 has no review of her Behavior Management Program data. E3, Vice President of Operations was interviewed on 9/25/15 at 1:30pm and asked if there were any records of Behavior Event Reports or General Event Reports for R3. E3 said no. E3 was asked where documentation could be found on R3's program. E3 stated it should be on the Monthly QIDP Reports. E3 was asked if R3's BMP had been implemented. E3 stated no. E3 confirmed the QIDP Monthly Reports did not contain data reflective of the Behavior	W 255		

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W 255	Continued From page 10 Management Plan for R3.	W 255		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure a specially constituted committee approved a plan to manage behavior for 1 of 3 individuals in the sample who have a behavior plan (R3). Findings include: Review of an Individual Service Plan (ISP) dated 5/20/15, R3 is a 23 year old female with diagnoses which include Mild Intellectual Disability, Bipolar and Depression. R3's ISP has the following current medications: Depo-Provera 150 milligrams every 12 weeks for Contraception and Fluoxetine 20 milligrams every morning for Depression. E1, Administrator, provided a Behavior Management Program (BMP) for R3 dated 5/20/15 with a goal of reducing aggression. E3, Vice President of Intermediate Care Faculties Operations, was interviewed on 9/25/15 at 1:30pm and asked if there was review of R3's BMP or medications by the specially constituted	W 262		10/29/15

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W 262	Continued From page 11 committee. E3 stated no.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE 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. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 4 individuals (R4) in the sample that written consent is present prior to implementation of Psychotropic medication. Findings include: According to R4's POS, dated 9/1/15, R4 functions at a Moderate Intellectual Disability Level with current diagnosis of Neurological Disorder and Autism. During record review of R1's chart, no evidence of informed consent for medication Risperidone 1mg BID starting on 3/20/15 was obtained. In an interview with E1, Administrator/Qualified Intellectual Disabilities Professional, on 9/24/15, at 12:30, E1 was asked if there is a consent from guardian to give this medication? E1 stated "no, I don't know where it is, it is the nurse's responsibility to obtain it." In an interview with E2, Licensed Practical Nurse (LPN), on 9/24/15 at 2:20 PM, E2 was asked is there a medication consent for Psychotropic's from guardian for Risperidone 1mg BID starting	W 263		10/29/15

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W 263	Continued From page 12 on 3/20/15? E2 stated "No, I don't see it. I will call the parent and get it tonight before the next dose is due." According to Policy Name: Psychotropic Medication, revision date: March 2007. Page 1.) Procedure 1.5, states "Informed consent from individual/guardian prior to beginning the medication is absolutely required. Consent shall be in writing. In emergencies a telephone consent may be given with a minimum of two witnesses present and hearing consent." Page 3.) Informed Consent: 3.4, states "A consent must be obtained at the start of the medication and must be renewed annually or anytime there is a change." Documentation of telephone consent for Risperidone 1mg BID was obtained 9/24/15 from guardian."	W 263		
W 351	483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record review and interview the facility	W 351		10/29/15

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W 351	Continued From page 13 failed to ensure a dental exam was provided for 1 of 4 individuals in the sample (R3) Findings include: Review of an Individual Service Plan (ISP) dated 5/20/15, R3 is a 23 year old female with diagnoses which include Mild Intellectual Disability, Bipolar and Depression. During review of R3's chart, there was no consultation for dental since her admission in May 2015. E2, Nurse, and E4, Cook were interviewed on 9/23/15 at 1pm and asked if R3 they could provide a consultation from R3's dental appointment within a month of her admission date in May 2015. E4 stated no. R3 has not had an appointment with the dentist since she was admitted.	W 351		
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 interview and record review, the facility failed to be in compliance with Illinois Administrative Code 116 Administration Of Medication In Community Settings for 1 of 2 individuals in the sample who began a new medication in August 2015. (R3) Findings Include:	W 370		10/29/15

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(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 370	Continued From page 14 Illinois Administrative Code 116.10 states, "The purpose of this Part is to ensure the safety of individuals in programs funded by the Department of Human Services (DHS) by regulating the storage, distribution, and administration of medications in specific settings; training of non-licensed staff in the administration of medications. This applies exclusively to all programs for individuals with a developmental disability in settings of 16 persons or fewer that are funded or licensed by the Department of Human Services and that distribute or administer medications and all intermediate care facilities for the developmentally disabled with 16 beds or fewer that are licensed by the Illinois Department of Public Health." 1) Illinois Administrative Code 116.40 c) states, "Non-licensed direct care staff who are to be authorized to administer medications under the delegation of the registered professional nurse shall meet the following criteria: 6) receive specific additional competence-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 individuals that requires medication enters the program." Review of an Individual Service Plan (ISP) dated 5/20/15, R3 is a 23 year old female with diagnoses which include Mild Intellectual Disability, Bipolar and Depression. A Prescription dated 8/31/15 for R3 is for Metronidazole 500 milligrams, take one by mouth twice daily for 7 days.	W 370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G294	A. BUILDING _____ B. WING _____	09/29/2015

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W 370	Continued From page 15 R3's Medication Record has a handwritten entry dated 8/31/15. R3's medication is initialed as being given 9/1 at 7am through 9/7/15 at 8pm. E5, Direct Service Person (DSP), initialed R3's Medication Record on 9/1/15, 9/2/15, 9/3/15 and 9/4/15 at 7am. Review of E6's (RN Trainer) Medication Oversight Education for staff dated 8/31/15 has information regarding administration of R3's Flagyl / Metronidazole. E5's signature is not listed on this form. During an interview with E1, Administrator, on 9/24/15 at 11:15am, E1 was asked if E5 signed the Medication Oversight education provided by E6 prior to administering R3's newly prescribed medication. E1 stated no.	W 370		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a fire/evacuation drill was performed quarterly on the second shift and third shift for 14 of 14 individuals in the facility (R1 - R14). Findings include: In review of the facility submitted roster that validates level of functioning, 5 individuals function in the Mild range of Intellectual Disabilities, 6 individuals function in the Moderate	W 440		10/29/15

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W 440	Continued From page 16 range of Intellectual Disabilities; and 3 individuals functions in the Severe range of Intellectual Disabilities. The facility evacuation drills were reviewed from September 2014 to current date. There is no evidence of a fire/evacuation drill for the second shift, in the second quarter (2015) and the fourth quarter(2014). There is no evidence of a fire/evacuation drill for third shift for second quarter(2015). In an interview, E1, Administrator/Qualified Intellectual Disabilities Professional, on 9/24/15 at 12:30 PM, confirmed that the fire/evacuation drill for the second shift, second quarter (2015) and fourth quarter (2014) and third shift second quarter (2015) was not completed.	W 440		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure a specially-prescribed diet was provided for 1 of 4 individuals in the sample (R3) Findings include: Review of an Individual Service Plan (ISP) dated 5/20/15, R3 is a 23 year old female with diagnoses which include Mild Intellectual	W 460		10/29/15

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W 460	Continued From page 17 Disability, Bipolar and Depression. A Prescription dated 8/13/15 and signed by R3's physician office shows she is on a low sugar/low sodium diet. A Dietary Recommendations/Follow Up dated 9/10/15 by Z1, Dietician, and signed by R3's physician office reads, "Recommend LCS/NAS (Low concentrated sweets/no added salt) diet to be prescribed by physician order." Supper meal was observed 9/22/15 at 5pm. R3 had Baked Chicken with celery, Pineapple, red juice, mild, cornbread, mashed potatoes and green beans. During observation of the kitchen on 9/22/15 at 5:10pm, there was a marker board which had all residents listed with their specific diets. R3 was not listed on this board. E1, Administrator, provided a Diet Listing at the beginning of the survey. This was printed 9/21/15. All residents and their diets are listed except for R3. E1 was asked if R3 was receiving her prescribed diet and if employees had been instructed of her change in August. After review of R3's order, E1 could not provide evidence that R3 was receiving the specifically ordered diet. E1 confirmed the house does not add salt to meals but R3's diet outside of the house in her community workplace setting is not monitored to ensure no added salt or low concentrated sweets.	W 460		
W 474	483.480(b)(2)(iii) MEAL SERVICES	W 474		10/29/15

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W 474	Continued From page 18 Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 1 individual who had an order for ground meat was served a meal in the correct consistency. (R12). Findings include: Based on review of a Physician Order Sheet (POS) for September 2015, R12 is a 68 year old male with diagnoses which include Intellectual Disability and Reflux Esophagitis. R12's POS has a diet order for Heart Healthy/Low Fat diet with ground meat. A Diet Listing provided by E1, Administrator, and dated 9/21/15 shows R12 has a Heart Healthy / Low Fat diet with ground meat. During meal observations on 9/24/15 at 5:08pm, E1 was assisting R12 with his plate. E1 offered to cut R12's chicken breast into pieces. E1 was asked what R12's diet order consistency should be for meat. E1 read R12's chart and noted his order reads ground meat. E1 then provided R12 ground chicken.	W 474		