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

PRINTED: 05/13/2015 FORM APPROVED OMB NO. 0938-0391

REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [W 000] INITIAL COMMENTS SECOND CERTIFICATION FOLLOW UP TO THE SURVEY OF 2/10/15-REPEAT W153 & W156 [W 153] 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ADLOFF PLACE STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADLOFF LANE SPRINGFIELD, IL 62703 [X4) ID PREFIX TAG [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [W 000] INITIAL COMMENTS SECOND CERTIFICATION FOLLOW UP TO THE SURVEY OF 2/10/15-REPEAT W153 & W156 [W 153] 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of		
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SECOND CERTIFICATION FOLLOW UP TO THE SURVEY OF 2/10/15-REPEAT W153 & W156 {W 153} 483.420(d)(2) STAFF TREATMENT OF CLIENTS {W 153} The facility must ensure that all allegations of	(X5) COMPLETION DATE	
THE SURVEY OF 2/10/15-REPEAT W153 & W156 {W 153} 483.420(d)(2) STAFF TREATMENT OF CLIENTS {W 153} The facility must ensure that all allegations of		
The facility must ensure that all allegations of	/00/1F	
	/20/15	
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: REPEAT		
Based on file review and staff interview it was determined that the facility failed to report significant incident to the Illinois Department of Public Health for 1 of 1 individuals (R2) that required outside medical consultation in the sample. Findings include:		
1. Review of facility "Individual Unusual Incident Report" dated 3/24/15 @ 5:00PM; R2 came into the living room when E3 (Direct Service Provider-DSP) noticed that R2's mouth was really white around his lips/mouth. E3 asked R2 what he was eating; R2 responded nothing and E3 requested R2 to remove his false teeth/dentures. E3 noted white substance on the teeth and noted R2 was still chewing on something white. E3 requested R2 to remove item and E3 noted the item was a denture cleaning tablet. E3 notified E2 (Qualified Intellectual Developmental Professional-QIDP) who was present in the building and notified poison control hotline.		
	6) 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.

Facility ID: IL6013445

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
14G295		B. WING			R 04/28/2015		
NAME OF PROVIDER OR SUPPLIER ADLOFF PLACE				S1 50	TREET ADDRESS, CITY, STATE, ZIP CODE O ADLOFF LANE PRINGFIELD, IL 62703	<u> U4//</u>	20/2013
PREFIX (EACI	H DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Report no observed services R2 had r (no name (Adminis R2 is a 3 Moderate & depres Review of "3.401 R INCIDEN documer not limite activity where the confirment of the confirme	d for 60 min for any ad no reaction e stated) we strator). 55 year old e Intellectures ion. of facility por EPORTING TS POLICE "An unued to Injury hich could ge Procedure serious or e Public Held, IL with- with E1 or ed the incide 2 was observed enture clear bijective. Ed the incide exible evider & investigation in the serious or existence of the incide enture clear incide existence enture clear incide existence exi	n control requested that R2 be nutes and request emergency verse reactions. Report noted s and facility RN consultant vas contacted & E1 male with a diagnosis of al Disability, Downs Syndrome	{W 1!	53}			
{W 156} 483.420	(d)(4) STAI	FF TREATMENT OF CLIENTS vestigations must be reported	{W 1	56}			3/20/15

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		14G295	B. WING				R 28/2015
NAME OF PROVIDER OR SUPPLIER ADLOFF PLACE				50	TREET ADDRESS, CITY, STATE, ZIP CODE O ADLOFF LANE PRINGFIELD, IL 62703	1 04//	20/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 156}	or to other officials within five working within five working of the second of the sec	or designated representative in accordance with State law days of the incident. In and staff interview it was a facility failed to report to the Illinois Department of a five working days for 1 of 1 at required outside medical sample. Findings include: Individual Unusual Incident (15 @ 5:00PM; R2 came into the E3 (Direct Service the that R2's mouth was really as move his false teeth/dentures. Stance on the teeth and noted g on something white. E3 move item and E3 noted the cleaning tablet. E3 notified E2 all Developmental who was present in the dipoison control hotline. In control requested that R2 be nutes and request emergency werse reactions. Report noted is and facility RN consultant	{W 1!	56}			
		male with a diagnosis of al Disability, Downs Syndrome					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ADLOFF PLACE				STREET ADDRESS, CITY, STATE, ZIP CO 50 ADLOFF LANE SPRINGFIELD, IL 62703		4/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
{W 156}	INCIDENTS POLICE documents "An unus not limited to Inju activity which could Operating Procedur documents;. "Upor involving serious or Notify the Public He Springfield, IL with-i Interview with E1 or confirmed the incide stated R2 was obse review determined ADL's (denture clea on new objective. E reviewed the incide reproducible evider incident & investiga IDPH was not notifi	olicy: G INDIVIDUAL UNUSUAL EY, Effective April 1, 2014, usual incident includes, but is ury of an individual and or any cause injury (i.e. falls)". The 3.402, Abuse and Neglect to being notified of any incident suspicious injury B. The alth Department in	{W 1	56}		