STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G295	A. BUILDING _____ B. WING _____	R 04/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADLOFF PLACE	**50 ADLOFF LANE SPRINGFIELD, IL 62703**

(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 SECOND CERTIFICATION FOLLOW UP TO THE SURVEY OF 2/10/15-REPEAT W153 & W156	{W 000}		
{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: 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.	{W 153}		3/20/15

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.

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{W 153}	Continued From page 1 Report noted poison control requested that R2 be observed for 60 minutes and request emergency services for any adverse reactions. Report noted R2 had no reactions and facility RN consultant (no name stated) was contacted & E1 (Administrator). R2 is a 35 year old male with a diagnosis of Moderate Intellectual Disability, Downs Syndrome & depression. Review of facility policy: "3.401 REPORTING INDIVIDUAL UNUSUAL INCIDENTS POLICY, Effective April 1, 2014, documents "An unusual incident includes, but is not limited to ... Injury of an individual and or any activity which could cause injury (i.e. falls.....)". Operating Procedure 3.402, Abuse and Neglect documents;. "Upon being notified of any incident involving serious or suspicious injury ..... B. Notify the Public Health Department in Springfield, IL with-in 24 hours....." Interview with E1 on 4/27/15 @ 2:30PM; E1 confirmed the incident of 3/24/15 involving R2. E1 stated R2 was observed by staff and later IDT review determined programming aspects for R2's ADL's (denture cleaning) and staff where trained on new objective. E1 stated that the facility reviewed the incident but was unable to provide reproducible evidence to address the specific incident & investigation. E1 also confirmed that IDPH was not notified as staff failed to call & send the incident report in after its completion.	{W 153}		
{W 156}	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported	{W 156}		3/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{W 156}	Continued From page 2 to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. 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 within five working days 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. Report noted poison control requested that R2 be observed for 60 minutes and request emergency services for any adverse reactions. Report noted R2 had no reactions and facility RN consultant (no name stated) was contacted & E1 (Administrator). R2 is a 35 year old male with a diagnosis of Moderate Intellectual Disability, Downs Syndrome & depression.	{W 156}		

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{W 156}	Continued From page 3 Review of facility policy: "3.401 REPORTING INDIVIDUAL UNUSUAL INCIDENTS POLICY, Effective April 1, 2014, documents "An unusual incident includes, but is not limited to ... Injury of an individual and or any activity which could cause injury (i.e. falls.....)". Operating Procedure 3.402, Abuse and Neglect documents;. "Upon being notified of any incident involving serious or suspicious injury ..... B. Notify the Public Health Department in Springfield, IL with-in 24 hours....." Interview with E1 on 4/27/15 @ 2:30PM; E1 confirmed the incident of 3/24/15 involving R2. E1 stated R2 was observed by staff and later IDT review determined programming aspects for R2's ADL's (denture cleaning) and staff where trained on new objective. E1 stated that the facility reviewed the incident but was unable to provide reproducible evidence to address the specific incident & investigation. E1 also confirmed that IDPH was not notified as staff failed to call & send the incident report in after its completion within five working days.	{W 156}		