

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

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/16/2015
NAME OF PROVIDER OR SUPPLIER DEARBORN COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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 120}	<p>MFU / FIRST FOLLOW UP TO INCIDENT INVESTIGATION SURVEY OF 4/3/15</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: REPEAT</p> <p>Based on record review, observation and interview, it was determined the facility failed to ensure:</p> <ol style="list-style-type: none"> 1) The Facility's Plan of Correction, for the Incident Survey of 4/3/15, was implemented. 2) The Day Program site was clean and hygienic for 2 residents in the sample (R1, R2) and for 2 out of the sample (R4, R5). 3) The Day Program provides the needed equipment and furniture, such as comfortable chairs, a clean changing table, and a mechanical lift, to provide services for 1 of 1 resident in a wheelchair (R1) <p>Findings include:</p> <ol style="list-style-type: none"> 1) According to the Plan of Correction, submitted by the facility in response to an Incident survey conducted on 4/3/15, the facility was to train the Day Program site regarding their abuse and neglect policy, including notification of any incidents, and the conduction of a thorough investigation. <p>E1 (QIDP) stated on 7/15/15 at 11:30 AM, that this training was not done.</p>	{W 120}			

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

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/16/2015
NAME OF PROVIDER OR SUPPLIER DEARBORN COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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 120}	Continued From page 1 2,3) The Day Training (DT) site for R1, R2, R4, R5 was toured on 7/15/15, at 9:30 AM. R1 is in a motorized wheelchair. It was noted that the two main bathroom doors, across from the dining area, were propped open with half used, dirty, rusty paint cans. The women's bathroom was observed with Z2 (DT Human Resource Manager), Z3 (Rehabilitation Lead Supervisor), Z4 (Production Manager) and Z1 (Supervisor). The linoleum floor was gray with layers of dirt covering it, and debris and cobwebs were in the corners. The white shower curtains, over only half of the showers, had a black moldy looking substance down the length of the curtains. There was a recliner in one shower which was wet, with black mold looking substance on it, along with the wet pillow on the floor. There was a changing table in the last stall area, with dirty: gloves, wipes, and a used diaper on it. The cabinet next to the changing table, to hold supplies, had dirt and black mold-looking substance on it, along with dirty gloves and wipes. The male bathroom has no changing table in it. Z4 said during the observation that the men get changed in their wheelchairs, there is not a changing table for the men. The Senior Rooms were toured. Multiple wheelchair residents are these rooms, along with elderly residents. The rooms have hard, stackable plastic chairs. There are no padded, reclining chairs for residents to rest in or raise their feet. Z4 showed this surveyor the two recliners the DT has, which were ripped, dirty with crumbs, missing arm rests and with rusty metal parts. Z4 said that there are no chairs for residents to rest and raise there feet if needed.	{W 120}			

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

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/16/2015
NAME OF PROVIDER OR SUPPLIER DEARBORN COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 520 SOUTH DEARBORN STREET KANKAKEE, IL 60901		
(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 120}	Continued From page 2 R1 was observed in her work area. R1 uses a mechanical lift at the home for transfers and changing. R1's DT Program Manager (Z1) said that R1 stands up to get changed and holds onto railings, because the DT has no mechanical lift. Z4 and Z2 said they thought the DT had a mechanical lift, but it was from another consumer's family, just for that person's use. Z2 said staff manually lift the residents if needed.	{W 120}			