

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

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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>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 interview and record review, the facility failed to ensure that written guardian consent was obtained for the use of a drug to control maladaptive behavior for 1 of 2 individuals in the sample (R3) who require behavioral modifying medication.</p> <p>Findings Include:</p> <p>In review of a Physician Order Sheet, dated 7/1/15-7/31/15 & Individual Service Plan (ISP) dated 2/3/15; R3 is a 57 year old male who functions in the severe range of intellectual functioning & has a diagnosis of simple phobia & Behavior Problem Disorder. R3 receives behavioral modifying medications to address maladaptive behaviors associated with physical & verbal aggression.</p> <p>Current physician orders for 7/15; noted that R3 receives Lexapro 20mg & Seroquel 300mg daily to address current maladaptive behaviors. Review of R3's consents noted that R3's guardian</p>	W 263		7/16/15	

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

TITLE

(X6) DATE

07/17/2015

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.

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

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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 263	Continued From page 1 did not sign the current consents for the Lexapro & Seroquel. Interview with E1 Qualified Intellectual Disability Professional (QIDP) on 7/7/15 @ 2:00PM. E1 confirmed the current behavioral medication dosages for the Lexapro & Seroquel. E1 stated that the facility has mailed multiple copies of the current consents to R3's guardian. However E1 was unable to reproduce any evidence of review and determination of consent for the current medications.	W 263			
W 316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify and ensure a gradual withdraw of drugs used for behavior control at least annually for 1 of 2 clients (R3) in the sample. Findings include: 1) The 2/3/15 Individual Service Plan (ISP) states that R3 is a 57 year old male whose diagnoses is stated as Severe Intellectual Functioning, Simple Phobia and Behavior Problem Disorder The ISP further states that R3 takes the medication Lexapro 20mg & Seroquel 300mg daily for maladaptive behavior of physical/verbal aggression that disrupt his daily life/routine. According to R3's ISP and Human Rights Committee(HRC) minutes from 4/16/15; R3 began receiving Lexapro 20mg on 12/4/13 &	W 316		7/31/15	

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

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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 316	Continued From page 2 Seroquel 300mg on 12/4/13. In addition it was reviewed that R3's current ISP, Medication Administration Record(MAR)of 7/1/15-7/31/15 and Behavior Management Minutes of 4/16/15 do not specify any medication reduction of the Lexapro 20mg of 12/4/13 & Seroquel 300mg of 12/4/13. E1(Qualified Intellectual Disability Professional) confirmed on 7/7/15 @2:00PM that R3 did not have a medication reduction since 12/13 and the team had planned to reduce the Seroquel per the medication reduction plan, however there was no reproducible evidence to support the holding of an annual reduction or attempted reduction.	W 316			
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to comply with the physician's order for 1 of 1 individuals (R1) in the sample & 1 individual (R5) outside the sample; observed receiving medications. Findings Include: 1. Physician's Orders (dated 7/1/15-7/31/15) identifies R1 as a 56 year old individual who functions at the Mild level of Intellectual Disability. There is a written entry on the MAR & POS (dated 7/1/15) that states, Amitiza 24 MCG capsules @ 4:00PM & Oyster Shell 500mg W/D3 200IU @ 4:00PM every day by mouth.	W 368			

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

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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 368	<p>Continued From page 3</p> <p>R1's Medication Blister Pack of Amitiza 24 MCG capsules @ 4:00PM & Oyster Shell 500mg W/D3 200IU @ 4:00PM states R1 is to take both medications with food.</p> <p>Medication Record (dated 7/1/15- 7/31/15) states, Amitiza 24 MCG capsules @ 4:00PM & Oyster Shell 500mg W/D3 200IU @ 4:00PM and has documentation that these medications were given on 7/6/15 at the 4:00 PM medication pass.</p> <p>Observation of medication pass on 7/6/15 from 4:01 PM- 4:42 PM, E3 (Direct Support Person) assisted individuals in medication administration. At 4:15 PM, R1 received his medications which included Amitiza 24 MCG capsules & Oyster Shell 500mg W/D3 200IU. R1 was not provided with food to be taken with his medication. R1 left the medication room at 4:23 PM with staff to go to the day area. The facility served their evening meal at 5:28 PM.</p> <p>In an interview with E3 on 7/6/15 at 5:05 PM, E3 confirmed that she had not provided R1 with food during the medication administration of his Amitiza 24 MCG capsules & Oyster Shell 500mg W/D3 200IU.</p> <p>2. Physician's Orders (dated 7/1/15-7/31/15) identifies R5 as a 56 year old individual who functions at the Mild level of Intellectual Disability. There is a written entry on the MAR & POS (dated 7/1/15) that states, Propranolol 40mg tablet @ 4:00PM every day by mouth.</p> <p>R5's Medication Blister Pack of Propranolol 40mg tablet @ 4:00PM states R5 is to take medication with meals.</p>	W 368			

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

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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 368	Continued From page 4 Medication Record (dated 7/1/15- 7/31/15) states Propranolol 40mg tablet @ 4:00PM and has documentation that this medication was given on 7/6/15 at the 4:00 PM medication pass. Observation of medication pass on 7/6/15 from 4:01 PM- 4:42 PM, E3 (Direct Support Person) assisted individuals in medication administration. At 4:25 PM, R5 received his medications which included Propranolol 40mg tablet @ 4:00PM . R5 was not provided with food/meal to be taken with his medication. R5 left the medication room at 4:28 PM to go to the day area. The facility served their evening meat at 5:28 PM.	W 368			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure infection control measures were implemented during the medication pass on 7/6/15 for 1 of 1 individuals (R1) in the sample who was observed receiving medication. Findings Include: 1. Physician's Orders (dated 7/1/15-7/31/15)	W 455			

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

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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 455	<p>Continued From page 5 identifies R1 as a 56 year old individual who functions at the Mild level of Intellectual Disability. There is a written entry on the MAR & POS (dated 7/1/15) that states, Amitiza 24 MCG capsules @ 4:00PM; Baclofen 20mg @ 4:00PM; Isosorbide DN 20mg @ 4:00PM & Oyster Shell 500mg W/D3 200IU @ 4:00PM every day by mouth.</p> <p>Observation of medication pass on 7/6/15 from 4:01 PM- 4:42 PM, E3 (Direct Support Person) assisted individuals in medication administration. At 4:15 PM, R1 received his medications which included Amitiza 24 MCG capsules; Baclofen 20mg; Isosorbide DN 20mg & Oyster Shell 500mg W/D3 200IU. R1 was presented with his medications one tablet at a time by E3. It was observed that E3 did not have any gloves on during the administration and would punch each tablet out and drop into R1's mouth. E3 was observed several times during the medication administration to R1 to wipe at her face and touch her pants. R1 left the medication room at 4:23 PM with staff to go to the day area.</p> <p>E1 (Qualified Intellectual Disability Professional) confirmed on 7/7/15 @2:00PM that E3 should have either been wearing gloves that should have been exchanged during the medication administration or washed her hands after touching her face and/or pants during the medication pass.</p>	W 455			