STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G325	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BJORKLUND HOUSE	15841 TERRACE DRIVE OAK FOREST, IL 60452

(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 ANNUAL CERTIFICATION - INSPECTION OF CARE - FUNDAMENTAL SURVEY	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the outside service, day training, utilizes a gait belt when assisting 1 of 1 individuals who has a gait belt R12, Ensure for 1 of 1 in the sample, R2, with a communication book day training had a communication book to use at day training. Findings include: 1) Record review of the Rehab in Motion and Physical Therapy dated 2/10/15 references R12 has a gait device and it is checked under "maximum" current functional status. In the Yearly Nursing Assessment dared 8/24/15 under supplemental notes it includes,"Gait belt and wheelchair being used." Observations were conducted at the day training site on 9/2/15 from 10:00am thru 11:35am. At 10:10am surveyor observed Z3, Instructor for Seniors, assisting ambulating R12 without a gait belt. Surveyor observed in R12's wheelchair her gait belt. Surveyor asked Z3 why she was not using R12's gait belt during ambulation. Z3 stated, "She does pretty good here, does okay with assist in and out of chairs."	W 120		

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

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W 120	Continued From page 1 On 9/2/15 at 2:OOpm E1, Administrator, and E2 Qualified Intellectual Disability Professional, were asked should R12 when ambulating be using a gait belt with staff assist at day training. E2 stated day training needs to keep the gait belt on her. E1 stated R12 has fallen in the past and do to her regressing mental state and diagnosis of dementia will while she is walking stop and sit down. 2) R2, per her Individual Service Plan, dated 12/5/14, can communicate with the use of pictures and some sign language. The Monthly Review of Progress dated 7/15 notes R2 has a day training objective to demonstrate the ability to appropriately ask for hugs from staff members by using sign language or her communication book . Under Progress: The goal was not achieved with 0/10 for 0% for 3x month. At 10:30am on 9/2/15 Z4, Day raining Instructor, was asked if R2 has a communication book at this site. Z4 stated, "We don't know what happened to it, it got lost a couple of months ago and we haven't replaced it. We now have an intern that just started and it will be replaced." On 9/2/15 at 2:00pm E2, Qualified Intellectual Disability Professional, stated the day training site did not communicate with her the communication book was lost.	W 120		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and	W 247		

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W 247	Continued From page 2 self-management. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure for 3 of 4 in the sample, R1, R2 and R3 and for 8 of 11 outside the sample, R5, R6, R7, R8, R9, R11, R13 and R14 were given opportunities for self management in setting the table and for serving their own cereal. Findings include: Observations were conducted at the residential site on 9/2/15 from 6:55am thru 8:32am. Breakfast included toast, cold cereal and yogurt. At 6:55am residents were in the middle of breakfast. Surveyor asked at 7:00am E7, Direct Service Person, who set the table. E7 stated, "The overnight did, that 's their job. We have a sheet that tells staff what to do." Surveyor reviewed a sheet for overnight responsibilities and it included, "Set tables - Please remember to include special utensils, mats, etc." Surveyor asked E7 which individuals are capable given the opportunity of assisting with setting of the breakfast table. E7 stated R1, R2,. R3. R5. R6. R7, R8, R9, R11, R13 and R14. Surveyor asked E7 who poured the cold cereal into the bowls for the individuals. E7 stated E10. Food Service. E7 was asked are there any individuals who could have poured their own cereal. E7 stated R1, R2, R6, R7, R8, R9, R11 and R13. At 7:20am E0, Food Service, was why she put the cereal in bowls as opposed to individuals doing it for themselves. E10 stated, "I put the cereal in bowls. I f you don't they will just sit and look at it."	W 247		

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W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observations, record review, and interview, the facility failed to assure that referrals to specialist for eye disorders are provided consistent with the individual's need. This occurred with 1 of 1 (R3) individuals in the sample who were referred to see an ophthalmologist. Findings include: Observations were made of R3 at the daytraining site on 9/2/15 at 9:35am. R3 was observed in the production area sitting in her wheelchair working on assembling cards. She had on eyeglasses and had a pink and white colored helmet attached to the back of her wheelchair. R3 is verbal and observed to be active as she moves quickly with fine and gross motor movements. R3's eyeglasses were tight at the bridge of her nose, the bridge of the nose had a lateral red mark where the eyeglasses were positioned against that area and the frame extension connected to the lenses were hyperextended at both ears and would not secure behind her ears. Record review include an Individual Service Plan dated 2/20/15 which states R3 is 34 year old with an Intelligent quotioint of 72 and several diagnoses including Cerebellar Ataxia, Emotional Behavior Disorder, and depression. The same	W 322		

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W 322	Continued From page 4 record includes a note written by the optometrist, Z2 on visit with R3 on 10/22/2014. The notes states, "why visual acuity/VA decreasing - send to ophthalmologist" As of survey date 9/2/15, R3 have not seen the ophthalmologist. An interview was conducted with E2 (QIDP) on 9/2/15 at 1:30pm , E2 was asked why R3 have not seen the ophthalmologist as of date (10 months past the order from the optometrist) E2 states we would have to check with E6 (program coordinator) about the appointment. E6 was interviewed the same day at 1:45pm, E6 states the appointment was delayed because R3 "have public aide insurance and the wrong birthdate is on her insurance card but she is getting these things straightened out." On 9/3/15, E1 gave surveyor an appointment slip for R3 to see the opthalmologist on September 24, 2015.	W 322		
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 observations, record review, and interview, the facility failed to assure that all medications are administered in compliance with the physician's order. This occured with 1 of 1 (R4) in the sample who received medications ordered to be given at a specific time. Findings include:	W 368		

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W 368	Continued From page 5 Observations were made of the medication pass on 9/1/15 at 4:48pm. R4 was given Felbamate 400mg three tablets by mouth with water at 4:48pm. R4 was then observed starting to eat dinner at 6:10pm (over an hour after receiving the medication.) Record review include a physician's order dated 7/22/15 states R4 to receive, "Felbamate 400mg take three tablets by mouth with dinner." An interview was conducted with E8 (direct Support Person) at 6:15pm after R4 was observed eating dinner and was asked why was the medication (Felbamite) not given with dinner, E8 stated the "medication is given with the medpass." Another interview was conducted with E4 (Registered Nurse) on 9/2/15 at 1:30pm, E4 is also the nurse trainer and was asked about R4 not receiving his seizure medication Felbamate with dinner as ordered , E4 states, "she knows better than that, we have a two hour window to give medications."	W 368		
W 383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the keys to the medication cabinet were not left in the lock and unattended. This affects 15 of 15 individuals R1 - R15.	W 383		

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W 383	Continued From page 6 Findings include: Observations were conducted at the residential site on 9/2/15 from 6:55am thru 8:32am. E7, Direct Service Person, was assisting with the medication pass in a common area utilized by R1 - thru R15. At 8:13am surveyor observed the keys left in the cabinet lock on the the door which contained the facility's medications. No staff was in the immediate area and anyone in the area would have access to the area where medications are kept. Interview with E7 at 8:25am stated the keys were in the lock but the medication cart within the cabinet was locked, Upon review the medication cabinet was locked however, the box containing R8's insulin was unlocked. When asked why the keys were in the cabinet left unattended stated, "Ever since I've been here that's how it's been done."	W 383		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to assure that eyeglasses and safety helmets are kept in good repair. This occurred with 1 of 2 (R3) individuals	W 436		

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in the sample who was found to have a helmet that was taped and ripped at edges and eyeglasses that were in a poor fitting state.

Findings include:

Observations were made of R3 at the daytraining site on 9/2/15 at 9:35am. R3 was observed in the production area sitting in her wheelchair working on assembling cards. She had on eyeglasses and had a pink and white colored helmet attached to the back of her wheelchair. R3 is verbal and observed to be active as she moves quickly with fine and gross motor movements.
R3 was asked if the surveyor could take a look at her helmet as the helmet had was taped up in the back and looked dirty. R3 said yes , gave surveyor the helmet and the following was noted:
a) the back of the helmet was taped to secure the rear band.
b) the interior and exterior of the helmet had black substance throughout which appeared to be dirt.
c) the edges of the helmet had material that was unraveled.
d) the area of the helmet that secure the ear appeared hyperextended.

R3's eyeglasses were tight at the bridge of her nose, the bridge of the nose had a lateral red mark where the where the eyeglasses were positioned aginst that area and the frame extension connected to the lenses were hyperextended at the ear and would not secure behind her ear.

An interview was conducted wit R3 at the time of the above finding, R3 states that the eyeglasses do "hurt my nose when I wear them with the

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helmet on but that's just how it is." " The glasses don't go behind my ear but they have to stay like this to make the helmet fit, but I really don't have to wear the helmet that much."

An interview was conducted with E2 (Qualified Intellectual Disability Professional) and E1 (Administrator) on 9/2/15 at 12:45pm, E2 states the facility recently got a order for a new helmet. E1 was asked how long has it been since the need for a new helmet was identified and E1 stated, "a couple of months."

Record review includes an Individual Service Plan dated 2/20/15 which list adaptive equipment as walker, wheelchair, eyeglasses, and helmet. E6 (program coordinator) gave surveyor a prescription dated 8/21/15 written by Z1 (medical doctor) for a helmet for R3.

An interview was conducted with E6 (program coordinator) on 9/2/15 at 1:45pm, according to E6, R3's new eyeglasses are pending because of her insurance and that she have public aide and that her insurance card have the wrong birthdate on it."