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 _____	11/07/2013

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 SURVEY - FUNDAMENTAL LICENSURE SURVEY INSPECTION OF CARE	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to report a hospitalization to the Illinois Department of Public Health in accord with licensure regulations for 1 of 1 hospitalized individuals outside the sample of 4 , R5. Findings include: The clinical record documents R5 was hospitalized for Lithium toxicity September 22 - September 25, 2013. Review of the incident reports and reports to the Illinois Department of Public Health did not indicate the hospitalization was reported. E1, Administrator was interviewed on 11/7/13 at approximately 2:00 p.m. E1 said it was an oversight it is the facility's policy to report hospitalizations to the department.	W 104		11/15/13
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and	W 262		12/12/13

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

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W 262	Continued From page 1	W 262		

monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

This STANDARD is not met as evidenced by:
Based on interview and record review the facility failed to ensure Human Rights Committee approved current medication dose and dosage range for 1 of 3 individuals in the sample who receives behavior altering medication, R2 and 1 outside the sample, R5.

Findings include:

1. The Individual Service Plan of 6/20/13 states, R2 receives Zoloft for increased depressive tendencies. The Individual Service Plan dated 6/20/13 indicates the Zoloft dose was increased by 25 mg. The Interdisciplinary team (IDT) meeting notes read "This meeting of the IDT is to show consent for the start of this medication increase before the Human Rights Committee can meet to approve it on July 10, 2013 because of the nature of the behavioral situation."

During interview with E2, Qualified Intellectual Disability Professional (QIDP), on 11/7/13 at approximately 1:30 p.m., she confirmed the medication increase was started prior to the Human Rights Committee meeting.

2. R5's clinical record was reviewed and the most recent Human Rights Committee meeting minutes dated 9/10/13 were reviewed. The clinical record documents R5 has had several psychotropic medication adjustments. Z1,

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W 262	Continued From page 2 Psychiatrist was interviewed on 11/6/13 at 2:50 p.m. Z1 said R5 has a terrible psychiatric condition and has been taking Haldol for many years. The medication adjustments have been made in an effort to get R5 off Haldol and transition to an atypical anti psychotic, Latuda. The Human Rights Committee review dated 9/10/13 does not document the current dosages of the medications R5 receives for her Obsessive Compulsive disorder and Schizophrenia. During interview with E2, QIDP, at approximately 1:30 p.m., she said the Human Rights Committee is aware of the plan for R5's medications, but is not aware of current exact dosages. The exact ranges for which there is guardian approval were not discussed. They are aware of the plan to replace older medications with side effects with newer medications with less side effects.	W 262		
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 interview and record review the facility failed to ensure medications were recorded on the physician's order sheet in the correct dosage according to the prescribed physician order for 1 of 4 individuals in the sample, R2. Findings include: November/2013 Physician's orders sheet for R2 reads,"Sertraline 20mg/ml, give 2-1/2 ml	W 368		11/15/13

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W 368	Continued From page 3 Sertraline (25 mg) every evening po (by mouth.)" E3 Registered Nurse was interviewed on 11/7/13 at 10:20 a.m. E3 was asked about the order stating 2-1/2 ml and 25 mg. 2-1/2 ml of the medication would equal 50 mg not 25 mg based on the strength of the medication in the bottle. E3 said it is supposed to be 25 mg. not 50 mg and that she told staff to give 25 mg which is written on the dropper. E3 acknowledged it was an error and that the physician wanted R2 to receive Sertraline 50 mg.	W 368		