STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G346	A. BUILDING _____ B. WING _____	06/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOSSMOOR TERRACE	3951 WEST 190TH STREET FLOSSMOOR, IL 60422

(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 LICENSURE CERTIFICATION SURVEY FUNDAMENTAL INSPECTION OF CARE	W 000		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Qualified Intellectual Disability Professional revise active treatment programs based on individual need and performance. This occurred with 2 of 2 individuals in the sample (R1 and R2). Findings include: R1's individual service program was reviewed. The following programs were noted without revisions from the original dates: a) Coin Combination program has a start date of April 2009 (5 years ago). The program has 14 steps to for coin identification. Step one requires R1 to identify a penny. The record failed to include any revisions to the objectives, nor does the program data clearly outline if the individual is progressing or not. b) Setting and Clearing Table program has a start of date of April 2008 (6 years ago). The program objective has 19 steps, according to the monthly QIDP's note for April 2014, R1 is on step 3 of 19.	W 159		

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 159	Continued From page 1 The record failed to include any revisions to the objectives, nor does the program data clearly outline if the individual is progressing or not. c) Self Medication program has a start date of April 2006 (8 years ago). The program objective has 15 steps, according to the monthly QIDP's note for April and May 2014, R1 is on step 7 of 15. The record failed to include any revisions to the objectives. R2's Individual service program was reviewed. The following programs were noted without revisions from the original start dates : Program titled: Alphabet Identification has a start date of November 2000. R4's Individual service program was reviewed. The following programs were noted without revisions or program data that clearly outlines if R4 is progressing or not. Program titled: Orientation program has a start date of November 2008 (7 years ago). The program objective has 14 steps, according to the monthly QIDP's note for April 2014, R4 is on step 4 of 15. The record failed to include any revisions to the objectives, nor does the program data clearly outline if the individual is progressing or not. An interview was conducted with E1 (Qualified Intellectual Disability Professional) on 6/25/14 at 11:00am. E1 states that she "realize the dates show a long time but that she did not want to take the individuals out of the programs even if they had progressed." The surveyor inquired about R1's program objective that data indicates she	W 159		

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W 159	Continued From page 2 has been required to identify a penny for the past 5 years and has not progressed to step 2 which is to identify a nickel, E1 confirmed that R1 is still on step 1 of 14 at this current time. E1 also states that there may be an error on the program data listed in the monthly QIDP notes for R1. E1 states she "is not going to go scramble for something. I don't have anything else." E1 was not able to present evidence that the programs for R1, R2, or R4 have been revised since their original start date based on their individual performance.	W 159		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation and record review the facility failed to reinforce learning when medication programs were partially run. This affected 2 of 4 individuals in the sample (R1 and R2) and 1 individual outside of the sample (R4). Findings include: Medication observations were conducted on 6/24/14 at 4:10pm. E3 (Direct Support Person) was observed administering 4pm medications to R1, R2 and R4. E3 pre-selected the medication bubble packs for each individual prior to	W 249		

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W 249	Continued From page 3 administering the medication and failed to run all of the steps in the task analysis for the self medication programs for R1, R2 and R4. Record review of facility documents for "Self Medication" programs for R1, R2 and R4 are as follows: 1) R1= 8 Task analysis steps. E3 did not complete task 8. 2) R2=11 Task analysis steps. E3 did not complete tasks 2,3,5,6,7 and10. 3) R4= 9 Task analysis steps. E3 did not complete tasks 1,3,5 and 6.	W 249		
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 that only "Authorized persons" have access to medication keys and keys gaining access into the facility. This occurred when the facility left keys for medication and all access doors unsecured. This affected 4 of 4 individuals R1 and R2 who are inside the sample and R3 and R4 who are outside of the sample. Findings include: Observations were conducted in the home on 6/24/14 at 3:00pm. Surveyor observed a set of keys attached to a long pink strap laying on top of a three tier stand in the living room. All 4 individuals residing in the home were presently seated in the living room. A non-authorized	W 383		

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W 383	Continued From page 4 person came into the facility seeking employment and walked passed the keys twice. An interview was conducted with E1 (Administrator) on 6/24/14 at 5:10pm. E1 confirmed that "Staff should have the keys on their person at all times or on the hanger in the med room. They should not be left out unattended".	W 383		