STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G251	A. BUILDING _____ B. WING _____	01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN CENTER SERVICES	8345 SOUTH AUSTIN AVENUE BURBANK, IL 60459

(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 ANNUAL LICENSURE SURVEY INSPECTION OF CARE	W 000		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure that access to all information contained in the individuals record is kept confidential. This occurred for 1 of 4 individuals in the sample (R3). Record review of R3's Individual Support Plan (ISP) dated 02/27/13 indicates another individuals' name in the section for "Name" under "Protective and Restrictive Measures" on page 4 and in the section for "Other Assessments" on page 15. R6 is the individual whose name is identified. R6 resides in the home with R3. An interview was conducted on 01/09/14 at 12:34pm with E1 (Qualified Intellectual Disability Professional) at the facility. E1 stated that she used the wrong name in R3's Individual Support Plan dated 02/27/13 on page 4 and page 15. E1 stated that she uses a template and must have "copied and pasted" the information of R6 into R3's ISP not knowing that this was the wrong name, and no one else noticed it. E1 went on to	W 112		

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

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W 112	Continued From page 1 state that this is embarrassing.	W 112		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy for 1 of 4 in the sample, R2, and for 1 person outside the sample, R5. Findings include: 1) Observation were conducted at the residential site on 1/8/14 from 6:30am thru 8:30am. At 6:30am surveyor observed on the bulletin board as you enter the kitchen 2 postings specific to R5 These include the results of a Urology follow up completed on 8/16/12 and information with R5's name for Fat Restricted Diet Guidelines. This information was clearly visible to anyone entering the kitchen area. Residents were observed bringing their dishes after breakfast on 1/8/14 into the kitchen area. Surveyor brought E1, Qualified Intellectual Disability Professional, into the kitchen area and asked why the information on R5's diet or follow up medical appointment were on the kitchen bulletin board. E1 said they should not be and removed them. 2) On 1/7/13 at 2:50pm with all the residents in the living room watching a movies due to day training being closed R2 received a phone call. Staff placed the call on speaker and everyone who was in the living room could hear the	W 130		

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W 130	Continued From page 2 conversation between R2 and her mother. On 1/7/14 at 2:55pm surveyor asked E8, Team Leader, why the phone call was placed on speaker so that R2's privacy was not maintained. E8 states her mom asked that she talk to her on speaker and she had called the living room phone. Surveyor asked if their was another phone R2 could have used to speak to her mother that would ensured additional privacy and E8 stated the hallway phone. E8 said R2's mom was not asked to call her on the hallway phone.	W 130		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to notify the Illinois Department of Public Health, IDPH, of a visit to Urgent Care for 1 of 1 individuals outside the sample, R5, who sustained a fractured right 4th metatarsal (foot bone near his toes). Findings include: Per a General Event Report dated 10/11/113, "While assisting R5 with his socks staff noticed that all his toes on his right foot are bruised and purple. Staff asked R5 what happened to his toes and he told staff that he hurt his foot in the fall that he had in the bathroom the other day."R5	W 153		

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W 153	Continued From page 3 was taken to Urgent Care and returned with a diagnosis of fractured right 4th metatarsal (foot bone near his toes). On 1/7/14 at 3:29pm E1, Qualified Intellectual Disability Professional, was asked if R5's fracture was reported to IDPH. E1 stated, "No." E1 added since he went to Urgent Care as opposed to a hospital and saw a Doctor they were not required to report it to IDPH.	W 153		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to implement the use of a Rolling walker for individual (R1) who requires this use at all times. This occurred for 1 of 1 individuals inside the sample (R1). R1is 74 years old and has a Diagnosis of Dementia. She is prescribed and takes Aricept 10mgs. daily in the am and Namenda 5mgs. daily at 8am for this. An interview was conducted on 01/08/14 at 2:45pm with E1 (Qualified Intellectual Disability Professional) at the facility . E1 stated " R1 should use her Rolling walker at all times, but the more that you tell her, the more she will not use it". E1 stated that R1 is unsteady on her feet and should use the Rolling walker even when she takes her plate of food to the kitchen. E1 stated that staff should remind R1 to use her Rolling	W 192		

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W 192	Continued From page 4	W 192		

walker at all times.

An interview was conducted on 01/08/14 at 3:10pm with E3 (Registered Nurse) at the facility. E3 stated "R1 requires the use of a Rolling walker at all times and staff should be encouraging her to use it at all times".

Record review of "Safety and Risk Assessment and Planning Tool" dated 10/28/13 notes " R1 often will refuse to take her walker and all we can do is remind her that we do not want her to fall". Review of "Quarterly Nursing Assessment" dated 10/30/13 notes "Physical Limitations; As tolerated uses Rolling walker". Review of Individual Support Plan (ISP) dated 11/05/13 notes " R1 has an unsteady gait and should be reminded to use her Rolling walker for her own safety, although she often refuses it and leaves it behind. All staff can do is prompt her to use it, stressing the issue of safety, which often does not help. R1 should always be assisted on stairs". The ISP states that R1 should use her Rolling walker when ambulating.

On 1/8/14 R1 was observed at 8:07am walking in the kitchen area. R1's walker was inside the dining area. E6, Direct Service Person at 8:08am on 1/8/14 was asked if R1 should be using her walker. E7 stated, "I don't think she has to use all the time if it's short distances."

2) On 10/21/13 R4 saw the dentist and was diagnosed with Gingivitis. R4 has a physician's order for a gel to apply to his toothbrush for gingivitis and for periogard rinse twice daily.

On 1/8/14 at 7:30am Surveyor observed taking 7 medication pills mixed in chocolate pudding. R4

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W 192	Continued From page 5 was assisted with his medications by E7, Direct Service Person. Immediately after taking his medications with pudding E7 gave R4 his periogard and told him to rinse. R4 put some of it in his mouth from a small cup and in the other hand was an empty cup. R4 was told to spit it out the rinse into the cup. R4 swallowed it and poured the remaining rinse into the empty cup. No further instruction was provided by E7. At 7:32am on 1/8/14 E7, Direct Service Person, was asked why she didn't provide any instruction to R4. E7 stated she usually does tell him not to swallow it but that she was a little nervous On 1/8/14 at 3:10pm E1, Qualified Intellectual Disability Professional, stated R4's rinse should be used after he brushes as part of his oral hygiene.	W 192		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure physician's orders were followed for 1 of 2 in the sample, R4, during a medication pass. Findings include: The morning medication pass conducted by E7, Direct Service Person, DSP, was observed on 1/8/14 at 7:30am for R4. The physician's orders for R4 dated 1/14 include the medication	W 369		

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W 369	Continued From page 6 Levothyroxine. It is to be taken by mouth every morning 30 minutes before breakfast. At there conclusion of the medication pass R4 went into the dining area and began to eat his breakfast. R4 was observed to take a bite out of a biscuit. R4 did not consume his entire breakfast but did eat before 30 minutes had expired contrary to the physician's orders. On 1/8/14 at 7:37am E7, DSP, was asked regarding the medication Levothyroxine for R4 and his eating immediately after ingesting the medication. E7 stated they try to give him time. E7 added she thought since E6, DSP, who also assists with medications was in the dining area would have told R4 to wait.	W 369		