

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
Z 000	COMMENTS Annual Health Survey Licensure Findings	Z 000		
Z9999	FINDINGS Licensure Violations 350.620a 350.1210b)c)d) 350.1220j) 350.1230d)1)2) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:	Z9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

Z9999	<p>Continued From page 1</p> <p>b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.</p> <p>c) Dental services to provide evaluation, diagnosis, treatment and annual review, including care for dental emergencies, administered by or under the supervision of a dentist licensed in the State to practice dentistry or dental surgery.</p> <p>d) Physical and occupational therapy services for purposes of initiating, monitoring and follow-up of individualized treatment programs rendered by or under the supervision of a physician with special training or experience in the specialty or a physical therapist or an occupational therapist.</p> <p>Section 350.1220 Physician Services</p> <p>j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.</p>	Z9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

Z9999	<p>Continued From page 2</p> <p>2) Basic skills required to meet the health needs and problems of the residents.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview, nursing failed to ensure:</p> <ol style="list-style-type: none"> thorough monitoring of weight of 1 of 1 individual outside the sample (R4) who fell below his ideal body weight. An assessment was completed for 1 of 1 individual inside the sample (R2) who had an allegation of abuse . <p>Finding include:</p> <ol style="list-style-type: none"> The Individual Service Plan (ISP) dated 3/25/20 identifies R4 as a 63 year old male who functions within the Profound Range for Individuals with Intellectual Disabilities. R4's ISP has additional information documented, "R4 has significantly limited verbal ability and is unable to express his basic needs and wants around him. R4 has a history of being underweight." <p>Facility Policy W7.02 Nursing Services dated 3/19 documents, "The home shall provide nursing services necessary to meet individuals' needs</p>	Z9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
Z9999	<p>Continued From page 3</p> <p>and to comply with licensing standards. 5. The following procedures shall be used to report minor illnesses or injuries to the R.N. Trainer: d. If symptoms worsen at any point, the R.N. Trainer shall be notified for further instructions/follow-up."</p> <p>Facility Investigative Committee Minutes dated 8/27/20 documents, "Synopsis: R4 was assessed by E4 (Registered Nurse Trainer-RNT) due to a fall that caused a contusion (bruise) to the right eye. While completing the assessment E4 noticed 7 other bruises. Investigation: R4 has 7 unknown bruises. Staff was interviewed and medial records reviewed. Analysis: Upon review of the statements, medical reports, the RN-T report and staff statement, it appears that R4 has had a change in condition starting sometime within the last three months with the month of August being the most noticeable change in condition. They also noted that he was not feeding himself and then eventually not even with staff."</p> <p>Facility RE: Bruises of Unknown Origin dated 8/27/20 documents, "R4 did not have issues addressed in a timely manner due to poor communication between the E2 (Qualified Intellectual Disabilities Professional -QIDP) and E4 to address issues that may have contributed to his bumping into walls and walking around with his eyes closed, such as depression and weight loss. Retraining with E4 and E2 on checking on issues of concern and improving communication with the staff and each other.</p> <p>Facility Interview with E2 on 8/27/20 E2 documented, "she noticed a change in R4's condition around August 1st. E2 stated that R4 prior to August he would eat on his own. After that he needed staff to assist with eating and then</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
Z9999	<p>Continued From page 4</p> <p>eventually he was refusing to eat."</p> <p>Facility Interview with E6 (House Manager) on 8/27/20 documents: "R4 just started eating less and less about 3 months ago, and one month ago not eating at all. R4 has also lost a significant amount of weight over the past three months."</p> <p>Facility Statement, undated, with E4 documents: "E2 mentioned to me at the end of July that R4 was losing weight, I evaluated him in August when I was looking at bruising that was reported. E2 did mention that he looked like he had lost a lot of weight, but it did not sound extremely bad. It was not until the investigation that I started to realize how big of an issue it was."</p> <p>Facility Medication Administration Record for R4 dated 7/1/20 documents: weight 124</p> <p>Facility Medication Administration Record for R4 dated 8/1/20 documents: weight 112</p> <p>Facility Medication Administration Record for R4 dated 9/15/20 documents: weight 102</p> <p>Interview on 10/28/20 at 2:28 pm: E4 was asked if she should have been notified sooner of R4's weight loss? E4 stated: "Yes, any significant change I would expect to be notified immediately." E4 was asked if she was aware that R4 had dropped even more weight from August to September? E4 stated: "No."</p> <p>2. Facility ISP dated 3/25/20 identifies R2 as a 70 year old male who functions within the Severe Range for Individuals with Intellectual Disabilities. R2 has additional diagnosis of depression and organic personality disorder.</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

Z9999	<p>Continued From page 5</p> <p>Facility Investigation dated 9/23/20 documents: "On 9/23/20 at approximately, 8:20 am E7 (DSP) was witnessed hitting R2 in the face while attempting to do vitals."</p> <p>Interview on 10/29/20 9:20 am: E1 (Administrator) was asked if a full body assessment by the nurse was done on R2 after the allegation? E1 stated: "No."</p> <p>1. The Individual Service Plan (ISP) dated 3/25/20 identifies R4 as a 63 year old male who functions within the Profound Range for Individuals with Intellectual Disabilities. R4's ISP also documents: "R4 has significantly limited verbal ability and is unable to express his basic needs and wants around him. R4 has a history of being underweight."</p> <p>Facility Policy 5.57 Physical Injury and Illness/Individual Medical Emergencies dated 5/19 documents: "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness."</p> <p>Facility Policy W7.02 Nursing Services dated 3/19 documents: "The home shall provide nursing services necessary to meet individuals' needs and to comply with licensing standards. 5. The following procedures shall be used to report minor illnesses or injuries to the R.N. Trainer: d. If symptoms worsen at any point, the R.N. Trainer shall be notified for further instructions/follow-up."</p> <p>1a. Facility Investigative Committee Minutes dated 8/27/20 documents: "Synopsis: R4 was assessed by E4 (Registered Nurse Trainer-RNT) due to a fall that caused a contusion (bruise) to the right eye. While completing the assessment</p>	Z9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

Z9999	<p>Continued From page 6</p> <p>E4 noticed 7 other bruises. Investigation: R4 has 7 unknown bruises. Staff was interviewed and medial records reviewed. Analysis: Upon review of the statements, medical reports, the RN-T report and staff statement, it appears that R4 has had a change in condition starting sometime within the last three months with the month of August being the most noticeable change in condition. They also noted that he was not feeding himself and then eventually not even with staff."</p> <p>Facility Investigation Interview (signed and dated on 8/27/20 by E2) documents: "she noticed a change in R4's condition around August 1st. E2 stated that prior to August, R4 would eat on his own. After that he needed staff to assist with eating and then eventually he was refusing to eat."</p> <p>Facility Investigation Interview (signed and dated on 8/27/20 by E6-House Manager) documents: "R4 just started eating less and less about 3 months ago, and one month ago not eating at all. R4 has also lost a significant amount of weight over the past three months."</p> <p>Facility Statement, undated, with E4 documents: "E2 mentioned to me at the end of July that R4 was loosing weight, I evaluated him in August when I was looking at bruising that was reported. E2 did mention that he looked like he had lost a lot of weight, but it did not sound extremely bad. It was not until the investigation that I started to realize how big of an issue it was."</p> <p>Interview on 10/28/20 at 2:28 pm: E4 was asked if she should have been notified sooner of R4's weight loss? E4 stated: "Yes, any significant change I would expect to be notified</p>	Z9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
Z9999	<p>Continued From page 7</p> <p>immediately." E4 was asked if she was aware that R4 had dropped even more weight from August to September? E4 stated: "No."</p> <p>Facility Reportable dated 8/27/20 documents: "R4 did not have issues addressed in a timely manner due to poor communication between E2 (Qualified Intellectual Disabilities Professional -QIDP) and E4 to address issues that may have contributed to his bumping into walls and walking around with his eyes closed, such as depression and weight loss. Retraining with E4 and E2 on checking on issues of concern and improving communication with the staff and each other."</p> <p>On 10/29/20 at 9:20 am E1 (Administrator) was asked for proof of the retraining and E1 stated: "I haven't done it yet."</p> <p>1b. Facility Quarterly Nutritional Progress Notation dated 8/3/20 documents: "R4 Ideal Weight Range 125-148. Recommendations: by mouth intake greater than 75 percent, monitor weight, labs and appetite."</p> <p>Facility Medication Administration Record for R4 dated 7/1/20 documents: weight 124</p> <p>Facility Medication Administration Record for R4 dated 8/1/20 documents: weight 112</p> <p>Facility Medication Administration Record for R4 dated 9/15/20 documents: weight 102</p> <p>Intake Record for R4: Missing Meal Intake Data for 93 meals in August, 35 meals in September, 36 meals in October.</p> <p>Interview on 10/28/20 at 2:49 pm: Z1 (Dietician) was asked should the staff at the facility have be</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
Z9999	<p>Continued From page 8</p> <p>documenting R4's meal intakes. Z1 stated, "Yes."</p> <p>Interview on 10/29/20 at 9:00 am: E2 (QIDP) was asked if she looks at weights when she does her monthly QIDP notes? E2 stated: "Yes." E2 was asked when the last note was done for R4? E2 stated: "1/20." E2 was asked if the QIDP notes would have been done on time would R4's weight loss been caught quicker? E2 stated: "Yes."</p> <p>1c. Facility Investigate Committee Minutes dated 8/27/20 documents: "8/14/20 R4 followed up with physician for ER visit and weight loss. With concerns to weight loss lab work was ordered, order for ensure at every meal or in between meals."</p> <p>Observation of lunch on 10/28/20 at 12:18 pm: R4 two ground sandwich, one puree cookie and one helping of fruit and a cup of tea.</p> <p>Observation of breakfast on 10/29/20 at 7:00 am: R4 received cheerios in milk, a scoop of sausage and a scoop of waffles, apple juice and 2% milk.</p> <p>Interview on 10/28/20 at 2:53 pm: Z2 (Physician Nurse) was asked when R4 was seen? Z2 stated: "9/18/20. Z2 was asked what R4 was seen for? Z2 stated: "ER follow up." Z2 was asked what R4 was diagnosed with? Z2 stated: "Urinary Tract Infection and weight loss." Z2 was asked if there were any diet orders given? Z2 stated: "Double portions with each meal, power pudding with each meal and ensure with each meal."</p> <p>2. Facility ISP dated 3/25/20 identifies R2 as a 70 year old male who functions within the Severe Range for Individuals with Intellectual Disabilities. R2 has additional diagnosis of depression and</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

Z9999	<p>Continued From page 9</p> <p>organic personality disorder.</p> <p>Facility Roster undated identifies R1 and R3 as a individual who functions within the Mild Range for Individuals with Intellectual Disabilities.</p> <p>Facility Investigation dated 9/23/20 documents: "On 9/23/20 at approximately, 8:20 am E7 (DSP) witnessed E3 (DSP) and R2 throwing the blood pressure cuff back and forth and E3 said to R2: "You need to take your vitals and eat your breakfast. You need to get your butt up." R2 attempted to get up and E7 pushed R2 down twice. After that, E7 moved the chair that R2 was sitting in to face the kitchen table and E7 picked up the back of the chair, forcing R2 to stand up. R2 then walked to the kitchen table and sat down and E7 went to take another client to the bathroom. A few momments after R2 started crying and E3 asked R2 if he was ok and R2 kept motioning that he was hit. R2 then said E7 hit him. E3 then called E1 (Administrator) and reported the incident. E7 was terminated. All staff were to be inserviced on how to report abuse and neglect and all staff were to be inserviced on all policies regarding abuse and neglect including who to call and how to report incidents."</p> <p>Interview on 10/29/20 9:20 am: E1 was asked if a full body assessment by the nurse was done on R2 after the abuse allegation? E1 stated: "No." E1 was asked if the retraining was done? E1 stated: "No, I haven't done it yet."</p> <p>R1 received the following medication at 6:00am medication pass on 10/29/20: Fiber-Lax 625mg , 1 tablet by mouth once daily taken with 8 ounces of fluid, Furosemide 40mg daily, Sertraline 10mg daily, Vitamin D one capsule once weekly on</p>	Z9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
Z9999	<p>Continued From page 10</p> <p>Thursday, Xarelto 10mg once daily, Calcium 600mg, Reglan 10mg, Prilosecn 40mg, Klor0Con 10mg, Flexeril 5mg, Depakote 125mg, Depakote 500mg and Ensure Max 3 times a day.</p> <p>Observation of medication pass on 10/29/20, R1 received all of his medication. E5 (Direct Support Person) was not observed to give R1 eight ounces of fluids with his Fiber-Lax 625mg.</p> <p>2. The Individual Service Plan (ISP) dated 3/25/20 identifies R4 as a 63 year old male who functions within the Profound Range for Individuals with Intellectual Disabilities.</p> <p>Facility Investigate Committee Minutes dated 8/27/20 documents: "8/14/20 R4 followed up with physician for ER visit and weight loss. With concerns to weight loss lab work was ordered, order for ensure at every meal or in between meals."</p> <p>Interview on 10/28/20 at 2:53 pm: Z2 (Physician Nurse) was asked when R4 was seen. Z2 stated, "9/18/20. Z2 was asked what R4 was seen for. Z2 stated, "ER follow up." Z2 was asked what R4 was diagnosed with. Z2 stated, "Urinary Tract Infection and weight loss." Z2 was asked if there were any diet orders given. Z2 stated, "Double portions with each meal, power pudding with each meal and ensure with each meal."</p> <p>Physician Consultation Report dated 8/19/20 documents: "Ensure/other meal supplement with meals or between meals."</p> <p>Observation 10/28/20 at 12:18 pm: R4 two ground sandwich, one puree cookie and one helping of fruit and a cup of tea. Double portions were not provided as ordered. Ensure</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ABERDEEN TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4029 ABERDEEN ALTON, IL 62002
---	---

(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) COMPLETE DATE
Z9999	<p>Continued From page 11</p> <p>suppliment was not given as ordered.</p> <p>Observation on 10/29/20 at 7:00 am: R4 received cheerios in milk, a scoop of sausage and a scoop of waffles, apple juice and 2% milk. Double portions were not provided as ordered. Ensure suppliment was not given as ordered.</p> <p>Interview on 10/28/20 at 2:16 pm: E3 was asked what individuals received ensure? E3 stated: "R1." E3 was asked if R2, R3 or R4 receives ensure? E3 stated: "No."</p> <p>(B)</p>	Z9999		