Illinois Department of Public Health

	11 0042240						
	11 0042240	A. BUILDING:		c			
	IL6013346	B. WING		10/11/2021			
R OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
			311				
ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE			
MENTS		Z 000					
NGS		Z9999					
nent of Licens	sure Violations:						
210b) 230b) 230e) 240a)			S.				
n 350.620 Re	esident Care Policies						
lures governi which shall be ement of the a e available to These writte ing the facility	ng all services provided by the be formulated with the administrator. The policies of the staff, residents and the en policies shall be followed in						
n 350.1210 H	lealth Services						
in each resid services incl	ent in good physical health.						
ision of the h gistered prof al nurse, or t	ealth needs of each resident essional nurse or a licensed		Attachment A Statement of Licensure Violations				
	ACH DEFICIENCY GULATORY OR LE MENTS PLAINT 78/IL138438 NGS nent of Licens 20a) 210b) 230b) 230b) 230e) 240a) 750 In 350.620 Re the facility shall be the available to the av	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) MENTS PLAINT 78/IL138438 NGS ment of Licensure Violations: 20a) 210b) 230e) 240a) 750 In 350.620 Resident Care Policies The facility shall have written policies and dures governing all services provided by the which shall be formulated with the ement of the administrator. The policies are available to the staff, residents and the These written policies shall be followed in ing the facility and shall be reviewed at annually. In 350.1210 Health Services Icility shall provide all services necessary to ain each resident in good physical health, services include, but are not limited to, the ng: Nursing services to provide immediate vision of the health needs of each resident registered professional nurse or a licensed cal nurse, or the equivalent.	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) MENTS PLAINT 78/IL138438 NGS Deficiency Must be preceded by Full Free Must be preceded by Full Fr	EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) MENTS PLAINT 78/IL 138438 NGS nent of Licensure Violations: 20a) 210b) 230b) 230b) 230b) 240a) 750 In 350.620 Resident Care Policies ne facility shall have written policies and dures governing all services provided by the which shall be formulated with the ement of the administrator. The policies ne valiable to the staff, residents and the ment of the administrator. The policies ne available to the staff, residents and the Threes written policies shall be followed in ing the facility and shall be reviewed at innually. In 350.1210 Health Services ciclity shall provide all services necessary to ain each resident in good physical health, services include, but are not limited to, the ng: Nursing services to provide immediate vision of the health needs of each resident gistered professional nurse or a licensed all nurse, or the equivalent. Statement of Licensure Violations			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/14/2021 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **209 HARRIS ROAD** HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Z9999 Continued From page 1 Z9999 Section 350.1230 Nursing Services Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Section 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced

Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 10/11/2021 1L6013346 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Z9999 Continued From page 2 Z9999 Based on observation, record review and interview the facility failed to ensure there was a local facility nurse available to address the known medical needs of R1 with the potential to affect 12 of 12 residents living in the facility (R1-R12). Findings include: A Facility Roster provided at the beginning of the survey marked revised 09/28/2020 shows there are 12 individuals residing in the facility of which four function at the level of Mild Intellectual Disability (R2-R4, R9), seven function at the level of Moderate Intellectual Disability (R1, R5, R6, R8, R10, R11, R12) and one functions at the level of Severe Intellectual Disability (R7). A Policy titled Nursing Services dated August 2021 reads, "It is the policy of the facility to provide at minimum the following nursing services by a designated Registered Nurse (RN) Trainer." A section titled "Unusual Occurrences" reads, "1. Assessment completed within 24 hours of occurrence or as delegated by the RN." A section titled "Travel" reads, "1. Weekly visits (minimum) to assigned sites." A Policy titled, "Contacting the RN protocol" with a revision date of May 2021 has a protocol for "When should I contact/notify the RN". It continues, "4. Any significant change in condition. 5. When the individuals is not acting as usual, or appears to be ill...7. Anytime there is an injury in which the client may need medical attention. 8. Anytime there is an incident with injury - cut skin

Illinois Department of Public Health STATE FORM

tear, bruise, swelling, etc."

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 3 1) An internal computerized note written by Z6, DSP (Direct Service Person) on 08/23/21 (Monday) at 9:39am states, "(R1) got off the bus and went to the crew. Many staff noticed that (R1) smelled like urine. This odor was very very strong. (R1) sat in the recliner and was making faces of almost pain. (R1) then got up and went to the bathroom. I (Z6) went with him in hopes to change his clothes since he was wearing the same clothes that he was wearing on Friday. (R1) refused my help in changing his clothes. While (R1) was peeing I noticed (R1) was holding on the rails in the bathroom, his arms were shaking and his face was cringed. I asked (R1) if he was okay. (R1) started to cry and said 'It hurts'." (R1's) urine was a very dark brown yellow color." An internal computerized note written by Z1 (Day Training Qualified Intellectual Disability Professionals) on 08/23/21 at 10:42am states Z1 notified E1 (facility Residential Service Director) of R1's body odor and urine. The note reads E1 will call R1's doctors office and let them of of the pain and color (of his urine). An internal computerized note written by Z6 on 08/26/21 at 10:12am reads, "Once in the crew room. (R1) used the restroom. (R1's) urine is still very dark and he is still cringing when he pees and even making faces of pain while sitting in the recliner." Anote written by Z6 on 08/27/21 at 12:20pm reads, "(R1's) urine is also very dark and has a smell. (R1) is making cringing faces of being in pain almost all day." An email written by Z1 and addressed to E1 and

E2 on 08/27/21 at 10:34am reads, "Just wanted

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING: _ C B. WING IL6013346 10/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **209 HARRIS ROAD** HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD) BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 4 Z9999 **Z9999** to follow up to see if an appointment was made for (R1) to see the doctor. His urine is still very dark and he is making a grimacing face." An email written by Z4 SST (Social Skills Training) on 08/27/21 at 11:33am reads, "It sounds like he's had an issue for quite awhile can an appointment be made, rather than calling the nurse and waiting for a call back? Or can a urine dip be done at the house?" On 08/27/21 at 11:33am, E1 responded, "I have spoken with the (physician's nurse). They do not feel he will cooperate with a urine test so it sounds like they will be sending over an antibiotic for him. We also cannot current do a urine dip at the facility since our nurse in on leave." E1 confirmed during interview on 9/30/21 at 1:53pm R1 did not see his physician but the physician called in an antibiotic on 08/27/21, four days after day training notified of R1 showing signs of a urinary tract infection. 2) R1's most recent fall assessment was documented on 07/21/21 and is scored as follows: General health - Good, Gait and Balance - Good, Daily medications causing dizziness or drowsiness - more than three, Mental status occasional disorientation, Elimination -Independent and continent, Falls in past three months - Zero. An internal computerized note written by Z6 DSP (Direct Service Person) on 08/30/21 at 10:06am

Illinois Department of Public Health

states when R1 was getting off the bus, "(R1) was shuffling his feet pretty bad causing him to almost trip and fall, I held onto both of his hands. (R1) then closed his eves and fell to the side. I held onto his hands and held him up... (R1) continued

PRINTED: 12/14/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **209 HARRIS ROAD** HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 5 to walk shuffling his feet and falling asleep jerking himself back awake. Once in the crew (R1) held onto the counter with both hands facing the counter. (R1) kept bobbing in and out of sleep, when he did this his knees would buckle." An internal computerized note by Z6 on 09/09/21 at 10:14am reads, "The past two days (R1) has been walking very weird. He has been shuffling his feet and almost falling...(R1) also had a fresh scrape on his right knee. I cleaned up the blood and put a (bandage) on him. I asked him if he fell. he shook his head yes." Z6's 09/09/21 note at 2:53pm reads, "(R1) slept almost the entire day...(R1) drank zero liquids and had zero voids today...". An email sent to E1 and E2 by Z1 on 09/09/21 at 9:57pm asks, "Did (R1) fall before getting on the bus this morning? He arrived with a bloody knee." An internal computerized note written by Z6 on 09/10/21 at 1:50pm reads, "(R1) yelled for a small amount this morning but that was it. (R1) slept the entire day. (R1) did not have any voids and did not intake any liquids." An email from Z4, SST (Social Skills Training) member on 09/15/21 at 9:57am and addressed to E2. Administrator, asks, "Was there/is there any reason given for the couple of days last week that

Illinois Department of Public Health

concern, or simply a refusal?"

he (R1) refused to eat and had balance problems at (day training)? Was this the same type of

Z1 (Day Training Qualified Intellectual Disability Professional) replied to Z4, E1 and E2 on

09/15/21 at 10:18am, stating, "(R1) came in today again unsteady. He typically does not need

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 10/11/2021 IL6013346 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 6 Z9999 **Z9999** assistance getting off the bus but he could not remember how to unbuckle himself. He required staff assistance walking down the hallway." Z1 wrote an internal computerized note on 09/15/21 at 2:55pm which reads, "While looking over (R1) today, I noticed the two red parallel lines go all the way around (R1). I also found a bruise on (R1's) left hip it is purple and yellow. (R1) was sleeping in the recliner. I took off (R1's) sweats while he was in the recliner sleeping (R1) had shorts on under his pants. When I took his pants off (R1) did not wake up or even move. When I finally got his pants off I noticed the (bandage) on (R1's) right knee that I had put there a week ago. When I removed the (bandage) there was a very strong foul odor coming from his open scrape on his knee. Due to the (bandage) being on for such a period of time the cut has not had time to scab over. The inside of the (bandage) was red and green. I threw the (bandage) away and cleaned (R1's) cut with soap and water. (R1) did not wake up while I did this, he did cringe a bit but that's all." An internal computerized note from Z6 on 09/16/21 at 10:16am states, "I tried to assist (R1) in changing his clothes but he is so tired he does not want to stand up...(R1) has a new fresh scrape on his right knee, I cleaned it with warm water and put a (bandage) on it. The driver said that he fell getting on the bus and this was the left knee where his old cut was, it was bleeding and he, the bus driver put a (bandage) on his knee." An email dated 09/22/21 at 3:05pm written by Z7 (day training nurse) to E1 and E2 states, "Medical concern FYI: it was brought to my attention this

Illinois Department of Public Health

STATE FORM

(morning) that (R1) has a pretty bad open pressure sore to his posterior left ankle from his

PRINTED: 12/14/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C IL6013346 B. WING 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **209 HARRIS ROAD** HARRIS PLACE **EAST PEORIA, IL 61611** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG **DEFICIENCY**) Z9999 Continued From page 7 Z9999 shoes rubbing. I wasn't able to get a real close look but it looks like there is necrotic tissue in the center of it that may require some type of debridement and there was quite a bit of redness surrounding the open area. He allowed the DSP. under my supervision, apply some TAO (triple antibiotic ointment) and cover with dry dressing and large (bandage). Wound on his left knee is also open and was rubbing on his pants, so I had her apply TAO to this site also and cover with a large (bandage). Please follow up with these wounds as they are causing him discomfort and the ankle wound may become infected and difficult to heal. During observations on 09/23/21 at 1:20pm, R1 was sitting in his day training classroom in a reclined position with his feet propped up. R1 was

was sitting in his day training classroom in a reclined position with his feet propped up. R1 was observed to have large bandages to his right and left knee as well as his posterior left heel. Staff removed the bandages and R1's right knee had an old light brown bruise approximately 3 inches x 2.5 inches in the center of his kneecap. R1 also had three round scabbed areas to his right knee area. R1 had a large, approximately 5 inch x 3 inch abrasion which was unscabbed and largely necrotic appearing to his left knee cap.

E1 (facility Residential Service Director) was interviewed on 09/23/21 at 9:49am and confirmed she could not provide documentation in the form of treatment administration records, general event reports or nursing notes regarding R1's ongoing wounds, treatments or mental status changes.

E1 was interviewed on 09/21/21 at 2:00pm and asked when R1's wounds to his knees began. E1 stated she "wasn't sure when they were first discovered. Day training put a (bandage) on them

Illinois Department of Public Health

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCEIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED				
		IL6013346	B. WiNG	WING C				
NAME OF S			DESC CITY S	STATE ZID CODE	710/11/2021			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD								
HARRIS	HARRIS PLACE EAST PEORIA, IL 61611							
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
Z9999	Continued From pa	ge 8	Z9999		7.0			
	Thursday (09/23/21)."						
	necrotic pressure u	n she first discovered R1's Icer to his left heel. E1 stated, 11) when the day training nurse		×				
5	was provided for his "This morning it wa was applied." E1 wa	t medical care or treatment R1 s pressure ulcer. E1 stated, s changed and triple antibiotic as asked she notified the E1 stated, "No I didn't."						
	E4, Registered Nurse Trainer covering the facility was interviewed on 09/23/21 at 10:39am and asked if she was covering the residents living in the facility. E4 stated, "I am covering their medications."		9					
	advised she was "n ulcer." E4 stated "I only." E4 confirmed facility and had not when he had fallen pressure ulcer. E4 weekly checks to the	on 09/23/21 at 2:08 pm and ot notified of (R1's) pressure have oversite of medications she lived 3-4 hours from the been called to assess R1 or assess his open areas and advised she had not made be facility or completed by resident who lives there.	i	Ē				
	Registered Nurse T	nterview on 10/06/21 that E3 rainer left on leave 08/06/21 ok over as Registered Nurse						
	10:13am that E4 ha	nterview on 09/23/21 at as never been to the facility, duals or reviewed their		g-1		:		

PRINTED: 12/14/2021

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C B. WING ___ IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **209 HARRIS ROAD** HARRIS PLACE EAST PEORIA, IL 61611 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) Z9999 Continued From page 9 Z9999 (B)

illinois Department of Public Health

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) {Z 000} COMMENTS ${Z 000}$ FORTY-FIVE DAY FOLLOW-UP TO ANNUAL **CERTIFICATION SURVEY OF 8/19/21.** COMPLAINT 2126978 / IL138438 {Z9999} FINDINGS {Z9999} Statement of Licensure Violations: 350.620a) 350.1210b) 350.1230b) 350.1230e) 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: Nursing services to provide immediate supervision of the health needs of each resident

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

practical nurse, or the equivalent.

by a registered professional nurse or a licensed

TITLE

Attachment A Statement of Licensure Violations

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {Z9999} Continued From page 1 {Z9999} Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced Based on observation, record review and interview the facility failed to follow the facilities' policies to prevent neglect and provide nursing services when they failed to: 1) Ensure R1 received adequate hygiene or skin checks twice weekly for the months of August and September 2021 2) Identify a stage two necrotic pressure ulcer to R1's left heel until discovered and reported to the facility by day training on 09/22/21 2a) Seek prompt medical evaluation of R1's left heel pressure ulcer after notified 2b) Notify nursing, provide medical treatment or document on superficial injuries reported to the

Illinois Department of Public Health

Illinois Department of Public Health

PRINTED: 12/14/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {Z9999} Continued From page 2 {Z9999} facility by day training which involved R1's right and left knees between the dates of 09/09/21 and date of survey 09/23/21 3) Obtain timely medical attention for R1 after day training reported R1 showed signs and symptoms of a urinary tract infection 4) Ensure there was a local nurse available to address R1's known medical needs These failures resulted in neglect of medical needs for 1 of 3 individuals in the sample (R1) with the potential to affect 11 other individuals residing in the facility (R2-R12). Findings include: R1's Individual Service Plan (ISP) dated 01/20/21 shows R1 is a 46 year old male with diagnoses which include Moderate Intellectual Disability and Schizoaffective Disorder. R1's ISP states he is independent in toileting and does not require any assistance. It also states R1 requires staff assistance with personal hygiene and requires staff assistance with the bathing process as he is unable to bathe independently. R1's Pressure Ulcer Scale Assessment dated 07/21/21 and completed by E3. Registered Nurse, has charted that R1 is in "Good" physical condition, "Alert" mental state, "Ambulant" for activity, "Full" for mobile, and "Not" for incontinence. R1's total Pressure Ulcer Score is 19 which puts him at low risk. Ten (10) or below is considered high risk according to the key.

Illinois Department of Public Health

A Facility Policy named "Abuse and Neglect Program dated August 2021 states, "It is the policy of this facility that all residents have the right to be free from verbal, sexual, physical and

PRINTED: 12/14/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ R B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {Z9999} {Z9999} Continued From page 3 mental abuse, corporal punishment, involuntary seclusion, misappropriation of property and neglect." Neglect is defined as, "Failure to provide good and/or services necessary to avoid physical harm, mental anguish or mental illness." 1) Review of R1's Active Treatment Programs show he is on a formal program to shower. This program includes: "(R1) will shower with staff assistance with complete independence in all trials." The Short Term Goal is, "(R1) will allow staff to assist him with a shower 2x (two times) weekly with 3 verbal prompts in 25% of all trial for 3 consecutive months." Review of R1's Shower Program for August, 2021 has 12 days of documentation. Each date of documentation shows R1 did not complete his shower. In September, 2021, there are 16 days of documentation for R1. Of these days of documentation. R1 completed a shower on two dates between September 1 through September An email from Z1, Day Training Qualified Intellectual Disability Professional (QIDP) dated August 6, 2021 and sent to E1, Residential Service Director (RSD) and E2, Administrator states in part, "We have also tried to help clean (R1's) nails. They are very long and dirty. When he arrived today he had two pairs of pants on."

An internal computerized note logged by Z6, Direct Support Person (DSP) on 8/23/21 at 9:39am states, "(R1) got off the bus and went to the crew. Many staff noticed that (R1) smelled like urine. The odor was very very strong."

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 10/11/2021 IL6013346 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {Z9999} {Z9999} Continued From page 4 Z6's note on 08/26/21 at 10:12 states, "(R1's) outfit today consisted of his shoes that have two very large holes in the soles, he was wearing two t-shirts. The top shirt was to (too) small for him and inside out." Z6's note dated 09/08/21 at 9:50am states, "(R1) arrived at workshop wearing the same clothes that he was wearing the day before." Z6's note dated 09/09/21 at 10:14am states. "(R1) came in today wearing the grev shirt and red shorts that I changed him into yesterday. (R1) has had the same socks on for three days." Z6's note dated 09/16/21 at 10:16am states. "(R1) arrived at workshop today wearing the same clothes that I changed him into yesterday. The clothes are now filled with stains and he has ahuge urine stain on the back of his shorts. The smell of urine that is coming from (R1) is so strong." An internal note logged by Z1 (QIDP) on 08/23/21 at 10:42am states, "I informed the home of both the body odor and his urine (R1). E1 stated she did not have available staff to pick him up to take him home to be showered..." Z1's note on 09/15/21 at 10:33am by Z1 states, "(R1) arrived at workshop today looking very unkempt. He has boogers on his face, his facial hair is getting long, he had dried food around his mouth, his nails are long and jagged with black dirt and who knows what else underneath. (R1) was wearing a black (movie title) shirt that has stains, old food and other mystery spots on his

Illinois Department of Public Health

shorts underneath."

shirt. (R1) had dark grey sweats on with red

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R B. WING 10/11/2021 IL6013346 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {Z9999} Continued From page 5 {Z9999} E1 was asked during interview on 09/23/21 at 10:01 am how many times R1 showered during the months of August 2021 and September 2021. E1 stated, "zero for August and three times for September, he had one yesterday but it's charted refused." E1 was asked when skin checks are performed. E1 stated, "They are to be done during showers." 2/2a) An internal computerized note logged by Z6 on 09/22/21 at 10:22am states, "When (R1) sat down, there appeared to be left over BM (bowel movement) on his sock. We took his sock off and saw that it was dried brown / green blood. We looked at the back of his left ankle and noticed there was a half dollar sized open wound. The wound was red and almost purple around it. green in the middle and almost looked like there were holes in it." An email written by E7, Day Training Nurse, on 09/22/21 at 3:05pm and sent to email addresses for E1 and E2 states, "It was brought to my attention this (morning) that (R1) has a pretty bad open pressure sore to his posterior left ankle from his shoes rubbing. I wasn't able to get a real close look but it looks like there is necrotic tissue in the center of it that may require some type of debridement and there was quite a bit of redness surrounding the open area." During observations on 09/23/21 at 1:20pm, R1 was sitting in his day training classroom in a reclined position with his feet propped up. R1 was observed to have large bandages to his right and left knee as well as his posterior left heel. Staff

Illinois Department of Public Health

removed the bandages and R1's right knee had an old light brown bruise approximately 3 inches x 2.5 inches in the center of his kneecap. R1 also

FORM APPROVED **Illinois Department of Public Health** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ R B. WING 10/11/2021 IL6013346 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **209 HARRIS ROAD** HARRIS PLACE EAST PEORIA, IL 61611 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD) BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {Z9999} {Z9999} Continued From page 6 had three round scabbed areas to his right knee area. R1 had a large, approximately 5 inch x 3 inch abrasion which was unscabbed and largely necrotic appearing to his left knee cap. Apressure ulcer was noted to R1's left posterior heel which measured approximately 2 inches wide by 1.5 inches with the center being necrotic. The skin surrounding this pressure ulcer appeared dark red and shiny. The pressure ulcer was at minimum a stage II, however it is unknown if it is deeper as it will require debridement. R1's left ankle was slightly edematous. E1 was asked during interview on 09/23/21 at 2:00pm when R1's pressure ulcer was first discovered. E1 stated, "Yesterday, I got an email from (licensed nurse) at daytraining." E1 was asked what medical treatment was provided to R1. E1 advised the morning of 09/23/21, triple antibiotic ointment and a bandage was applied. E1 was asked if R1 was seen by a nurse or physician. E1 stated, "No." R1 was seen in the local emergency room after the initiation of the survey. R1's After Visit Summary dated 09/24/21 has a diagnosis of "Pressure injury of heel, stage 2, left". R1 was referred to the wound clinic. R1's left foot x-ray findings were as follows: "Soft tissue swelling overlying the calcaneus is seen...Mild sclerosis is visualized involving the calcaneus. Cannot rule out osteomyelitis.

or bone scan for further evaluation."

Recommend MRI (Magnetic Resonance Imaging)

2b) An email sent by Z1 on 09/09/21 at 9:57am to E1 and E2 inquires if R1 fell before getting on the bus this morning. R1 arrived to workshop with a

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN	OFCORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED		
	180	IL6013346	B. WING		F 10/1	1/2021	
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HARRIS	PLACE	209 HARR					
	0191140407		DRIA, IL 616				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
{Z9999}	Continued From pa	ge 7	{Z9999}				
	bloody knee.		ie		,		
	"(R1) also had a fre	erized log written by Z6 states, esh scrape on this right knee. I od and put a (bandage) on					
		21am, Z1 notified E1 and E2 and a bloody knee. The bus bandage)."					
	An internal computerized log written by Z6 on 09/15/21 at 2:55pm notes, "When I finally got his pants off I noticed the (bandage) on (R1's) right knee that I had put there a week ago. When I removed the (bandage) there was a very strong foul odor coming from his open scrape on his knee. Due to the (bandage) being on for such a period of time the cut has not had time to scab over. The inside of the (bandage) was red and green."		<				
	has a new fresh so cleaned it with warr on it. The driver sai bus and that his lef	dated 09/16/21 states, "(R1) rape on his right knee, I m water and put a (bandage) d that he fell getting on the t knee was where his old cut g and he, the bus driver, put a nee."					
	facility investigation	eport sent to Illinois lic Health on 09/28/21 shows a found R1's dressing to his left ged on 09/18/21, 09/19/21 or					
	Record have no do R1's wounds. There	d or Treatment Administration cumentation of treatment to e is no documentation in R1's arding his wounds to his right		19			

Illinois Department of Public Health STATE FORM

PRINTED: 12/14/2021 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	BOILDING.			
		IL6013346	B. WING		R 10/11/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		.,=0=1	
HARRIS	PLACE	209 HARF					
			DRIA, IL 616				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
{Z9999}	Continued From pa	ige 8	{Z9999}				
	initiation, 09/23/21.	0/09/21 through date of survey E1 confirmed she could not umentation of care provided to					
	phone on 09/23/21	rse Trainer, was interviewed by at 2:08pm. E4 confirmed she R1's wounds to his knees or a his left heel.					
	08/23/21 at 9:39am and went to the cre (R1) smelled like us strong. (R1) was in faces of almost pair to the bathroom. I (change his clothes same clothes that I refused my help in (R1) was peeing I refused in the bath and his face was clokay. (R1) started to	outerized note written by Z6 on a states, "(R1) got off the bus ew. Many staff noticed that rine. This odor was very very the recliner and was making n. (R1) then got up and went (Z6) went with him in hopes to since he was wearing the ne was wearing on Friday. (R1) changing his clothes. While noticed (R1) was holding on room, his arms were shaking ringed. I asked (R1) if he was to cry and said 'It hurts'." (R1's ark brown yellow color."		÷		Ti de la constante de la const	
	08/23/21 at 10:42a body odor and uring	erized note written by Z1 on m states Z1 notified E1 of R1's e. The note reads E1 will call and let them of of the pain and					
-	08/26/21 at 10:12a room, (R1) used th very dark and he is and even making farecliner."	erized note written by Z6 on m reads, "Once in the crew e restroom. (R1's) urine is still still cringing when he pees aces of pain while sitting in the 6 on 08/27/21 at 12:20pm					

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
	·- <u>-</u>	IL6013346	B. WING		10/1	1/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HARRIS	PLACE	209 HARR	RIS ROAD DRIA, IL 616	311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
{Z9999}	Continued From pa	ge 9	{Z9999}		22	
	reads, "(R1's) urine smell. (R1) is makir pain almost all day.	is also very dark and has a ng cringing faces of being in				
18	E2 on 08/27/21 at 1 to follow up to see it for (R1) to see the	Z1 and addressed to E1 and 10:34am reads, "Just wanted if an appointment was made doctor? His urine is still very ing a grimacing face."				
	1:53pm R1 did not physician called in	g interview on 9/30/21 at see his physician but the an antibiotic on 08/27/21, four ing notified of R1 showing act infection.		∝ ⊃		
	2021 reads, "It is the provide at minimum	rrsing Services dated August ne policy of the facility to n the following nursing nated Registered Nurse (RN)				
	Assessment compl	usual Occurrences" reads, "1. leted within 24 hours of elegated by the RN."				
	Asection titled "Tra (minimum) to assig	evel" reads, "1. Weekly visits ned sites."		>		
	revision date of Ma "When should I cor continues, "4. Any s 5. When the individ appears to be ill7 which the client ma Anytime there is an tear, bruise, swelling					
	E1 was interviewed	on 09/23/21 at 9:49am and				

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. Bollbirds.		R	
		IL6013346	n 111110		1/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HARRIS	PLACE	209 HARR				
			ORIA, IL 616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
{Z9999}	Continued From pa	age 10	{Z9999}			
	in the form of treatr general event report	d not provide documentation ment administration records, rts or nursing notes regarding ds, treatments or mental				
	asked when R1's wasn't	on 09/21/21 at 2:00pm and wounds to his knees began. E1 sure when they were first aining put a (bandage) on them 1)."				
	necrotic pressure u	n she first discovered R1's ulcer to his left heel. E1 stated, 21) when the day training nurse				
	was provided for hi "This morning it wa was applied." E1 w	t medical care or treatment R1 is pressure ulcer. E1 stated, as changed and triple antibiotic as asked if she notified the E1 stated, "No I didn't."				
	1:53pm R1 did not physician called in	ng interview on 9/30/21 at see his physician but the an antibiotic on 08/27/21, four hing notified of R1 showing ract infection.				
Δ	was interviewed or asked if she was o	rse Trainer covering the facility n 09/23/21 at 10:39am and overing the residents living in ed, "I am covering their				
	advised she was "r ulcer." E4 stated "I only." E4 confirmed	d on 09/23/21 at 2:08 pm and not notified of (R1's) pressure have oversite of medications d she lived 3-4 hours from the t been called to assess R1				

Illinois Department of Public Health

PRINTED: 12/14/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R B. WING IL6013346 10/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 HARRIS ROAD HARRIS PLACE EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {Z9999} Continued From page 11 {Z9999} when he had fallen or assess his open areas and pressure ulcer. E4 advised she had not made weekly checks to the facility or completed assessments of any resident who lives there. E1 advised during interview on 10/06/21 that E3 Registered Nurse Trainer left on leave on 08/06/21 at which time E4 took over as Registered Nurse Trainer. E1 advised during interview on 09/23/21 at 10:13am that E4 has never been to the facility. assessed the individuals or reviewed their medications. (B)

Illinois Department of Public Health