PRINTED: 06/17/2021 **FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 1L6000947 04/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6301 HUMBERT ROAD BEVERLY FARM FOUNDATION** GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z 000 Z 000 COMMENTS ANNUAL CERTIFICATION SURVEY-EXTENDED INSPECTION OF CARE COMPLAINT INVESTIGATION 2142180/IL132314 Z9999 Z9999 FINDINGS Statement of Licensure Violations (Violation 1 of 3) 350.620a) 350,700a) 350.1210b) 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 350,700 Incidents and Accidents a) The facility shall maintain a file of all written

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

reports of each incident and accident affecting a

resident that is not the expected outcome of a

resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BORDING.			
		IL6000947	B. WING		04/2	22/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BEVERL	Y FARM FOUNDATION	M	IBERT ROAI /, IL 62035	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
Z9999	Continued From page 1		Z9999	76		
	progress notes or n	urse's notes of that resident.				
	Section 350.1210 H	lealth Services		¥		44
	maintain each resid	ovide all services necessary to lent in good physical health. ude, but are not limited to, the				
	supervision of the h	to provide immediate lealth needs of each resident lessional nurse or a licensed he equivalent.				
	Section 350.3240 A	buse and Neglect				
		ee, administrator, employee or nall not abuse or neglect a -107 of the Act)				
	These regulations v	vere not met as evidence by:				
	Based on observati review, the facility fa	on, interview and record ailed to ensure:		3C 5'		*
	1) safeguards were physical harm to him	in place to protect R10 from mself;				
	as addressed in R1	observations were completed 0's Individual Service Plan anagement Plan (BMP);				
		entation of 15-minute npleted as addressed in R10's				
		reviewed and revised to to decrease his behaviors ner injuries;				

Illinois Department of Public Health

STATE FORM

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:		COMP	LETED
		IL6000947	B. WING		04/2	2/2021
NAME OF F	PROVIDER OR SUPPLIER		2012	STATE, ZIP CODE		•
BEVERL	Y FARM FOUNDATIO	NI .	IBERT ROAI /, IL 62035	ע -		
(V.4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN NC	(VE)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
	<u></u>					l .
Z9999	Continued From pa	ge 2	Z9999			
	5) follow-up physicia	an visits were complete as				
		R10's left ankle fracture;				
	6) all of R10's injurie	es were thoroughly				
	investigated.					
	Findings include:			%		
	J					
	Review of the Facility Policy of Abuse/Neglect (Dated 5/16) documents, "The Facility has a proactive approach to the prevention of abuse and neglect and believes in the mission to provide each individual with a dignified quality of			,		
,						
				•		
		ed as failure to provide goods				
		ary to avoid physical or		·		
	psychological harm					
	The 7/22/20 Individ	ual Service Plan (ISP)				
		a 36 year old male who		-		
		Profound Range for				
		llectual Disabilities. R10 has				
		s of autism, anxiety, seizures,				
	unspecified mood of bipolar disorder.	lisorder, conduct disorder, and				
	Dipolal disorder.					
	R10 displays the fol	llowing maladaptive behaviors:		4		
	Attempts to Hurt oth	ner Residents (defined as				
,		resident but he either missed			76.	,
		ny injury); Attempted to hurt ratch/bite staff but he either	K.			
		e able to prevent it); Banging				
		onment, Banging head on				
	Environment (hitting	g head on wall, floor, table,				
		ng staff on any part of their				
		Rocking (Exaggerated				
		ming himself into the en he rocks); Hit Staff (Hitting				
		r closed hand); Hit/scratch				
		Hitting or scratching another				
		edroom Wall (Kicking the				

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FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6000947 04/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6301 HUMBERT ROAD **BEVERLY FARM FOUNDATION** GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) Z9999 Continued From page 3 Z9999 walls of his bedroom); Refusing Participation in Activities (Refusing to participate in activities offered to him by staff); Scratching (Scratching staff with his fingernails); Screaming (Loud. agitated or verbalizations); Taking items that don't belong to him (Taking items that do not belong to him and putting them into his pocket): Tearing up bedding (Tearing apart his sheets, blankets, pillow, etc.). R10's most significant behaviors are property destruction and Self Injurious Behaviors. R10 has destroyed all his furniture in his bedroom and only has a mattress and a blanket. R10's walls are concrete with brick pattern. R10 has a door alarm located on the outside of the door to notify staff when he leaves the room. Review of R10's behavioral documentation notes: 4/20 - 100 incident documented of banging head on environment, no recommendations by the team: 5/20 - 263 documented incidents of banging head on environment, no recommendations by the team; 7/20 - 9 documented incidents of banging head on environment, no recommendations by the team: 8/20 - 24 documented incidents of banging head on environment, no recommendations by the team; 9/20 - 16 documented incidents of banging head on environment, 4 documented incidents of kicking bedroom wall; 10/20 - 11 documented incidents of banging head on environment, 13 documented incidents of kicking bedroom wall with no recommendations by the team; 11/20 - 18 documented incidents of banging head on environment, 16 documented incidents of kicking

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bedroom wall with no recommendations by the team: 12/20 - 9 documented incidents of banging head on environment, 14 documented incidents of kicking bedroom wall; 1/21 - 11 documented

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of behavior."

was noted. This is likely the cause of the bruising to his foot. R10 does have a BMP (Behavior Management Program) which addresses this type

Facility Investigation Report dated 12/5/20 documents, "While hospitalized, the bruising to his foot (left foot) was assessed. X-ray noted an

acutely displaced fracture of the medial malleolus. It is likely that R10's behavior of Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
:		IL6000947	B. WING	E	0.4"	20/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	04/2	22/2021
g 8		6301 HUN	IBERT ROA			
BEVERL	Y FARM FOUNDATIO	N	Y, IL 62035			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
Z9999	Continued From pa	ge 5	Z9999			
	kicking the walls lea	ad to this injury."				
	"Reason: Follow Up Fracture involving to detailed above, age	dated 3/10/21 documents, o Fracture. Impression: he medial malleolus, as o undetermined. Direct int priors may be helpful."				
	R10's Physician Order Sheet dated 3/21 documents, "Non weight bearing left lower extremity."			10'		7000450
		te dated 2/16/21 documents, ambulate full weight bearing left leg."				
		te dated 2/18/21 documents, ambulate full weight on left leg,				
:		te dated 2/19/21 documents, healing left ankle fracture. ate with limp."				
¥33	"6-2 and 2-10, R10	te dated 2/20/21 documents, continues to ambulate full (B) to left leg, slight limp		9		
	"R10 continues to a	te dated 3/5/21 documents, ambulate full weight bearing on left leg, limp noted."				
		rterly dated 12/30/20 - no arding non weight bearing				
	R10's Nursing Quar documents, "Ambul to left leg. Status po	lates full weight bearing. Limp		(d)		

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING 04/22/2021 1L6000947 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6301 HUMBERT ROAD **BEVERLY FARM FOUNDATION** GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 6 Observation on 4/6/21 at 12:17 pm showed: E5 (Qualified Intellectual Disabilities Professional/QIDP) and E12 (Direct Support Profession/DSP) went into R10's room to get R10 dressed. At 12:19 pm E5 and E12 came out of R10's room. No wheelchair seen outside R10's room. E12 proceeded to walk with R10 down to dining room for lunch. Observation on 4/7/21 at 11:02 am showed: R10 walked in from outside with a staff member through the day room to his bedroom. Observation on 4/7/21 at 11:26 am showed: R10 walked out of his bedroom. Staff approached him and walked him to the bathroom. No wheelchair seen outside R10's room. During interview on 4/12/21 at 2:00 pm, E6 (Behavior Specialist) was asked what the facility implemented for R10's non weight bearing status upon readmit to facility. E6 stated, "R10 has a wheelchair outside his room and he's to be wheeled to and from meals and to and from the bathroom." D. Facility Incident Report dated 3/12/21 documents, "Staff assisted R10 up in the morning and noted a cut to the back of his head. 1 1/2 by 1 inch laceration to left side of head. R10 sent to local hospital. CT of head with contrast completed. 10 staples were placed." E. Facility Incident Report dated 4/1/21 documents, "R10 walked out of bedroom with BM (Bowel Movement) in his hands. E10 (Direct Support Professional/DSP) told R10 to go throw it

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in the trash and told R10 to wash his hands. That's when staff noticed blood on his hands and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6000947	B. WING	B. WING		22/2021
	PROVIDER OR SUPPLIER Y FARM FOUNDATION	6301 HUM	DRESS, CITY, SIBERT ROAL	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
Z9999	genital area. Staff to the blood away and his penis shaft area to right side of penis. Per Hospital Paper how the injury occu conscious sedation using local anesthe length. 9 sutures with the supervision (as of a supervision during bedroom at home a Day Training. When door alarm to alert froom. The supervision extensive history of staff and other residure property destruction. R10 is also on a 15 bedroom due to agree behavior of kicking fracture left ankle of Facility Visual Checkshows no document. Facility Visual Checkshows no document. Facility Visual Checkshows no document. S10 was mattress. No staff p. Checkshows No staff p. Checks	old nurse. We both washed we saw the laceration around a Approximately 4 cm from left s. R10 taken to local hospital. Work, R10 unable to report red. R10 was placed under Laceration was repaired tic. Laceration was 7 cm in the laceration was 7 cm in laceration was 10 cm in laceration washing hours when out of his land same room supervision at a laceration in his bedroom, R10 uses a staff when he has left his laceration laceration laceration washing hours when out of his laceration washing hours when laceration washing hours washing hours when laceration washing has laceration washing hours washing hours washing hours washing has laceration around the laceration around his laceration washing hours when laceration around his laceration washing has laceration around his laceration washing has laceration washing has laceration washing has laceration washing his laceration washing has laceration washing his laceration washing has laceration washing his la	Z9999			

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(X3) DATE SURVEY

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(X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
IL6000947		B. WING	04/	04/22/2021	
	N 6301 HUN	BERT ROAD			
ACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
vation on 4/6 fied Intellectusional/QIDP room, no visitif has perform vation at 12: R10's bedro yor can hear own. When low to inspect, or. No staff can vation at 12: R10's room down to inspect proom. No staff can vation on 4/7 room. No staff vation on 4/7 room. No staff vation on 4/7 visual check ocumentation of interview or what supervier room super	n of visual checks done since droom lying on mattress. 21 at 11:51 am showed: E5 al Disabilities) walked into office across ual check on R10 performed. med a visual check on R10. 3 pm showed: Surveyor down om door outside dining room. loud noise coming from R10's oking through R10's bedroom R10 was observed hitting fist ame to intervene. E5 and E31 in R10's room in their office. 5 pm showed: Surveyor down and heard loud noise again. ect noise and saw R10 if his head off the wall. No staff visually checked on R10. 21 at 11:25 am showed: R10 if visually checked on R10. 221 at 11:25 am showed: sheet for 4/7/21 shows no on of visual checks done since and 4/7/21 at 10:30 am, E5 was ision R10 was. E5 stated, "He ervision while outside his room.	Z9999			
	summary stract Deficience Gulatory or Locumentation in R10 in between the signal Property of the signal Compared to the signal Compared t	STREET AD 6301 HUN GODFRE SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) Funded From page 8 Industrial of visual checks done since and the state of the st	ROR SUPPLIER STREET ADDRESS, CITY, S' 6301 HUMBERT ROAD GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) DIVERSE OF THE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) DIVERSE OF THE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) DIVERSE OF THE PRECEDED BY FULL TAG TAG Z9999 Z999 Z9999 Z999 Z9999 Z9999 Z9999 Z9999 Z9999 Z9999 Z9999 Z9999 Z999 Z9999 Z	R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6301 HUMBERT ROAD GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG PREFIX TAG PROVIDER'S TAG PROVI	ROR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6301 HUMBERT ROAD GODFREY, IL. 62035 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES GULATORY OR LSC IDENTIFYING INFORMATION) DREET TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) JUNE OF THE APPROPRIATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) JUNE OF THE APPROPRIATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) JUNE OF THE APPROPRIATE DEFICIENCY Z9999 JUNE OF THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY JUNE OF THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PROVIDER'S ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PROVIDE THE ACTION SHOULD BE CROSS-REFERINCED TO THE APPR

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

Illinois Department of Public Health (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:

IL6000947

B. WING ___

04/22/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEVERL	V EXPMI EQUINDATION	JMBERT ROAD EY, IL 62035		
(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	Continued From page 9 is the staff to document every 15-minutes. E5 stated, "I'll get 15-minute sheets made up." E5 confirmed since R10 was placed on 15-minute monitoring the documentation sheets for the staf from 6:00 am - 10:00 pm were for 30-minute checks and not 15-minute checks.	Z9999	.c. ™	
	(B) (Violation 2 of 3)			
٥	350.1082a)3) 350.1082a)4) 350.1210b) 350.1230b)3) 350.1230b)7)			
	Section 350.1082 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:		10 No.	
	3) consultation with appropriate health professionals, such as rehabilitative nurses and occupational or physical therapists, which indicates that the use of less restrictive measure or therapeutic interventions has proven ineffective; and	s		UA.
linois Dena	4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or tment of Public Health		5.4	

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STATEMENT OF DEFICIENCIES (X1) PR

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	i;	001111	CCTCD	
	<u> </u>	IL6000947	B. WING		04/:	04/22/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
BEVERL	Y FARM FOUNDATION	N	IBERT ROA 1, IL 62035			!	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETE DATE	
Z9999	Continued From pa	ge 10	Z9999				
	psychosocial well b Act)	eing. (Section 2-106(c) of the					
	Section 350.1210 H	lealth 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:		=1				
	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.						
	Section 350.1230 N	lursing Services					
	services, in accorda	e provided with nursing noce with their needs, which e not limited to, the following: icipate in:					
29	3) Periodic reevalua quality of services a	ntion of the type, extent, and nd programming.					
		e resident care plan, in terms y needs, as needed.		i.			
	These regulations w	vere not met as evidence by:					
	Facility failures resu statements.	Ited in two deficient practice		1.27			
	review the facility fai to manage inapprop	ation, interview and record iled to develop interventions viate behavior with sufficient te the safety and welfare of 1 in the sample.					
	B. Based on observa	ation, interview and record					

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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: ___ B. WING IL6000947 04/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6301 HUMBERT ROAD **BEVERLY FARM FOUNDATION** GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 11 review, the facility failed to ensure restrictive measures were not utilized for the convenience of staff for 2 of 2 individuals (R2 and R10) in the sample of 10 with restrictive measures. Findings include: A. R10's Individual Service Plan (ISP) of 7/23/20 identifies R10 as a 36 year old ambulatory male with limited communication skills who functions in the Profound Range of Intellectual Disabilities with additional diagnoses of Autistic Disorder, Bipolar Disorder and Unspecified Mood Disorder. R10 displays the following maladaptive behaviors: Attempts to Hurt other Residents (defined as going after another resident but he either missed or staff prevented any injury); Attempted to hurt staff (Tried to hit/scratch/bite staff but he either missed or staff were able to prevent it); Banging Arm/Hand on Environment, Banging head on Environment (hitting head on wall, floor, table, etc.): Bite Staff (Biting staff on any part of their body); Harsh Body Rocking (Exaggerated body-rocking, Slamming himself into the chair/couch/etc. when he rocks); Hit Staff (Hitting staff with an open or closed hand); Hit/scratch Another Resident (Hitting or scratching another resident); Kicking Bedroom Wall (Kicking the walls of his bedroom); Refusing Participation in Activities (Refusing to participate in activities offered to him by staff); Scratching (Scratching staff with his fingernails); Screaming (Loud, agitated or verbalizations); Taking items that don't belong to him (Taking items that do not belong to him and putting them into his pocket); Tearing up bedding (Tearing apart his sheets, blankets, pillow, etc.).

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R10's most significant behaviors are property

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document:

team.

incidents of banging head on environment, 15 documented incidents of kicking bedroom wall with no recommendations by the team; 2/21 - 11 documented incidents of banging head on environment, 47 documented incidents of kicking bedroom wall with no recommendations by the

Review of Nursing Notes from 4/20 to 12/14/20

- 4/17/20 at 9:00pm, hit his head on his window

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		IL6000947	B. WING		04/2	2/2021
NAME OF PROVIDER OR S	UPPLIER			TATE, ZIP CODE		8
BEVERLY FARM FOU	NDATIO	N	IBERT ROAL /, IL 62035		77.0	
PREFIX (EACH DI	EFICIENC'	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
Z9999 Continued	From pa	ige 13	Z9999			
- 4/18/20 at yelling - 4/18/20 at 6.5/2/20 at 6.5/2/20 at 6.6/5/20 at 6.6/9/20 at 6.6/10/20 at 6.6/11/20 at 6.7/24/20 at with hand of 7/25/20 at 7/26/20 at 6.7/26/20 at 6.7/26/20 at 6.7/26/20 at 6.7/20 at 6	4:19am 8:46, b 8:03pm, 2:33am, 9:26pm, 12:43, b 11:09, 10:30a 11:52, or feet 12:41p 13:21am 4:40am, 4:30pm 4:40pm, 13:07am 13:17am 11:35a 13:24pm 13:00pm 13:17am 13:24pm	utting head on door window hitting back of head on floor hitting back of head hitting back of head hitting head on floor anging elbow resident banging elbow m, hitting things in room continues to hit walls, door m, heard hitting mat quite a bit n, screaming and hitting hand resident banging head on wall hitting environment esident had 3 unknown hitting his head against wall n, yelling out and pound fist on m, hitting head on floor and n, area to back of head				

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Illinois Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: B. WING 04/22/2021 IL6000947 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6301 HUMBERT ROAD **BEVERLY FARM FOUNDATION** GODFREY, IL. 62035 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** DEFICIENCY) Z9999 Z9999 Continued From page 14 discharged." Facility Incident Report dated 9/23/20 documents, "R10 was running back and hit head on the door frame of his bedroom. Laceration to left eye noted, gaping 2 cm at corner. Called for transport. Per Hospital Paperwork, Staff note that patient will pull out sutures and request skin glue if at all possible. Skin glue was applied." Facility Incident Report dated 11/27/20 documents, "R10 came out of his room and appeared to be limping. Staff report that R10 was kicking and hitting at the wall in his bedroom the day before the limping was noted." Facility Investigation Report dated 12/5/20 documents, "While hospitalized, the bruising to his foot (left foot) was assessed. X-ray noted an acutely displaced fracture of the medial malleolus. It is likely that R10's behavior of kicking the walls lead to this injury." Facility Incident Report dated 3/12/21 documents, "Staff assisted R10 up in the morning and noted a cut to the back of his head. 1 1/2 by 1 inch laceration to left side of head. R10 sent to local hospital. CT of head with contrast completed. 10 staples were placed." Facility Incident Report dated 4/1/21 documents, "R10 walked out of bedroom with BM (Bowel Movement) in his hands. E10 (Direct Support Professional/DSP) told R10 to go throw it in the trash and told R10 to wash his hands. That's when staff noticed blood on his hands and genital area. Staff told nurse. We both washed the blood away and we saw the laceration around his penis

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shaft area. Approximately 4 cm from left to right side of penis, R10 taken to local hospital. Per

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 IL6000947 04/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6301 HUMBERT ROAD **BEVERLY FARM FOUNDATION** GODFREY, IL 62035 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 15 Hospital Paperwork, R10 unable to report how the injury occurred. R10 was placed under conscious sedation. Laceration was repaired using local anesthetic. Laceration was 7 cm in length. 9 sutures were used to close the injury." B.1. R10's ISP indicates R10's current Level of Supervision (as of 4/6/21) is same room supervision during waking hours when out of his bedroom at home and same room supervision at Day Training. When in his bedroom, R10 uses a door alarm to alert staff when he has left his room. The supervision level is due to R10's extensive history of aggressive behavior towards staff and other resident as well as severe property destruction. R10 is also on a 15-minute monitoring in his bedroom due aggressive self-injurious behavior of kicking the wall which lead to a fracture left ankle on 11/27/20. Facility Visual Check's for R10 dated 4/1/21 shows no documentation. Facility Visual Check's for R10 dated 4/2/21 -4/5/21 shows documentation for R10 for 30-minute checks from 6:00 am - 10:00 pm. Observation on 4/6/21 from 8:20 am - 11:20 am showed: R10 was in his bedroom lying on mattress. No staff performed visual checks on R10. Observation on 4/7/21 from 11:02 - 11:26am showed: No visual checks on R10 until he came out his room and alarm sounded.

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The door alarm is utilized to monitor R10 instead

of the staff visually checking on him.

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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	 .	IL6000947	B. WING		04/2	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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		GODFRE	r, IL 62035			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE
Z9999	Continued From page 16		Z9999		56	×
83	on 4/7/21 at 3:19pn	th E10 (Direct Support Person) n, E10 stated, "SIB (which is ng) occurs multiple times ."				
		th E11 (DSP) on 4/7/21 at R10 has injuries once per d.		<i>(</i> -		
	E5 (QIDP) was asked if there had been any environmental changes to R10's bedroom to prevent injuries when R10 exhibits behavior of head banging. E5 stated, "Not since I've been here." (E5 has been working in the building for 2 years.) E5 was asked what safety measures have been put in place for R10. E5 responded, "Only redirection."		-		N.M.	
а	identifies R2 as a 6 diagnoses including	Service Plan) dated 6/8/2020 3 year old female with 3 anemia, epilepsy and spastic 9 nctions at the Profound Level 9 bility.				
	15-minute monitor of has been a same rother (disposable brief happening during the seatbelt that she can be seatbelt that	s, "(R2) will now be a when she is out of her bed. R2 com supervision due to eating efs). This has not been he day, due to her new innot remove. (If) she has no ecrease to a 30-minute		٤.		
	monitor at some tim will have a PM (nigh she should have on	ne in the future. Also she (R2) nt) service need stating that a one piece pajama at night ating the (disposable briefs)."		O.		
	night. Procedure: P	s, "Service Need: Pajamas at M staff should remember to one piece pajamas at night to		.3		<u> </u>

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING IL6000947 04/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6301 HUMBERT ROAD BEVERLY FARM FOUNDATION GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 17 keep her from eating her (disposable briefs)." R2's ISP does not include a behavior intervention plan to address tearing up and eating disposable briefs. On 4/6/21 at 11:14 AM and on 4/7/21 at 8:47 AM, R2 was seated in a wheelchair. The wheelchair belt was secured around R2. On 4/7/21 at 8:50 AM, E19 (Qualified Intellectual Disability Professional) was asked if R2 had a behavior intervention plan for tearing up and eating her disposable briefs. E19 responded, "No." E19 was asked if R2 tearing up and eating her disposable briefs was considered a behavior. E19 responded, "Not really. It doesn't (does not) happen often enough. (R2) has really stopped since we started using one piece pajamas and got her a new seat belt for her wheelchair." E19 was unable to state how often R2 tore up her disposable briefs because no data was kept. E19 was asked if the R2's one piece pajamas and wheelchair restricted R2 from tearing up her disposable briefs and eating them. E19 responded, "Yes." On 4/8/21 at 9:30 AM, E6 (Behavioral Specialist) was asked if R2 had a behavior intervention plan related to tearing up and eating her disposable briefs. R2 responded, "No." E6 was asked if one piece pajamas and wheelchair seat belt were being used to restrict R2 from tearing up disposable briefs and eating them, would she consider that a restriction. E6 responded, "Yes." (B)

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(X3) DATE SURVEY

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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	PROVIDER OR SUPPLIER Y FARM FOUNDATION	6301 HUN	DRESS, CITY, SIBERT ROA	STATE, ZIP CODE D		
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Z9999	Continued From pa	ge 18	Z9999			
	(Violation 3 of 3)					
:	350.1210a) 350.1210b) 350.1040b)1) 350.1420a) 350.1450a) 350.3220f) 350.3220h)2)					1979
N I	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:					
	physical examination	es including a complete n at least annually and formal ovide for medical emergencies a day-a-week basis.		8		
	supervision of the h	to provide immediate ealth needs of each resident essional nurse or a licensed ne equivalent.				
	Section 350.1040 S Audiology Services	peech Pathology and				
•9		y and audiology services ity shall include the following:				
8		valuation of residents with nd hearing functions.				
	Section 350.1420 C Prescriber's Orders	ompliance with Licensed				

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women shall include the following:

2) Mammography. The frequency and administration of mammograms shall be according to the guidelines set forth in the Guidelines for Women's Health Care.

These regulations were not met as evidence by:

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9) quarterly nursing assessments for 7 of 10 individuals in the sample (R1, R2, R4, R6, R8, R9

individuals outside the sample (R167);

10) medications were administered in compliance with Physicians Order Sheets (POS) for 1 of 6

and R10) were complete;

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: __ B. WING IL6000947 04/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6301 HUMBERT ROAD **BEVERLY FARM FOUNDATION** GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Z9999 Z9999 Continued From page 21 11) medications were properly disposed, potentially affecting all 36 individuals residing in the Herring Cottage (R9, R10, R12, R13, R36 -R39, R76 - R85, R112 - R129); Findings include: 1. The 7/23/20 Individual Service Plan (ISP) documents R10 as a 36 year old male who functions within the Profound Range for Individuals with Intellectual Disabilities, R10 has additional diagnosis of autism, anxiety, seizures, unspecified mood disorder, bipolar, conduct disorder, and bipolar disorder. Facility Incident Report dated 11/27/20 documents, "R10 has very limited verbal skills and was unable to say what occurred. Staff reported that R10 was kicking and hitting at the wall in his bedroom the day before the limping was noted. This is likely the cause of the bruising to his foot. R10 does have a BMP (Behavior Management Program) which addresses this type of behavior." Facility Investigation Report dated 12/5/20 documents, "While hospitalized, the bruising to his foot (left foot) was assessed. X-ray noted an acutely displaced fracture of the medial malleolus. It is likely that R10's behavior of kicking the walls lead to this injury. He was referred to orthopedic surgeon for surgical intervention following treatment of the pneumonia. R10 was discharged from the local hospital on 12/9/20. R10 was placed on 15-minute monitor. Staff and nursing continued to redirect R10 from removing the fracture boot and

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from continuing to kick at the walls. He will be seen by orthopedic surgeon in 6 weeks for follow Illinois Department of Public Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BEVERL	Y FARM FOUNDATIO	NI .	IBERT ROAI /, IL 62035	D .		
(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 SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
Z9999	"Reason: Follow Up Fracture involving to detailed above, age comparison to recent R10's Physician Or documents, "readment weight bearing left." R10's Physician Or documents, "Non we extremity." Facility Nursing Not "R10 continues to a with noted limp to left." Facility Nursing Not "R10 continues to a limp noted." Facility Nursing Not "R10 continues with Continues to ambuted." Facility Nursing Not "6-2 and 2-10, R10 weight bearing (FW noted." Facility Nursing Not "6-2 and 2-10, R10 weight bearing (FW noted."	dated 3/10/21 documents, or Fracture. Impression: the medial malleolus, as a undetermined. Direct ant priors may be helpful." der Sheet dated 12/9/20 at: fracture left ankle. R10 non lower extremity." der Sheet dated 3/21 aright bearing left lower te dated 2/16/21 documents, ambulate full weight bearing left leg." te dated 2/18/21 documents, ambulate full weight on left leg, ambulate full weight on left leg, the dated 2/19/21 documents, and healing left ankle fracture.	Z9999			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER:	A. BUILDING	B:	СОМ	PLETED	
		IL6000947	B. WING		04/	04/22/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
BEVERL	Y FARM FOUNDATIO	N	BERT ROA				
- 10	0.11.01.12.1.02.1	GODFREY TEMENT OF DEFICIENCIES	Y, IL 62035				
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Z9999	Continued From pa	ge 23	Z9999				
85 74	R10's Nursing Quarterly dated 3/12/21 documents, "Ambulates full weight bearing. Limp to left leg. Status post ankle fracture."						
×	Observation on 4/6/21 at 12:17 pm showed: E5 (Qualified Intellectual Disabilities Professional/QIDP) and E12 (Direct Support Profession/DSP) went into R10's room to get R10 dressed. At 12:19 pm E5 and E12 came out of R10's room. No wheelchair seen outside R10's room. E12 proceeded to walk with R10 down to dining room for lunch.						
		21 at 11:02 am showed: R10 ide with a staff member m to his bedroom.					
	walked out of his be	21 at 11:26 am showed: R10 edroom. Staff approached him he bathroom. No wheelchair room.		7			
	a 15-minute monitor	ents, "R10 also currently has r when in his bedroom due to inkle and being a non-weight		9			
	Facility Visual Checkshowed no staff doo	k's for R10 dated 4/1/21 cumentation.					
	4/5/21 showed docu	k's for R10 dated 4/2/21 - imentation for R10 for om 6:00 am - 10:00 pm.				-	
	R10's visual check s staff documentation	21 at 11:20 am showed: sheet for 4/6/21 shows no of visual checks done since froom lying on mattress.					

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY
		IDENTIFICATION NOTIFICAL	A. BUILDING:		СОМІ	PLETED
	·	IL6000947	B. WING		04/:	22/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
BEVERL	Y FARM FOUNDATIO	N	MBERT ROAL Y, IL 62035	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Z 9999	Observation on 4/6, walked into office a visual check on R10 performed a visual Observation on 12: R10's bedroom doc Surveyor heard a lobedroom. Surveyor noise was and whe bedroom window, Fon floor. No staff ca	/21 at 11:51 am showed: E5 cross from R10's room, no 0 performed. No staff has	Z9999			
	Observation on 12: R10's room and head went down to inspet the back of his head intervened.	15 pm: Surveyor down hall of ard loud noise again. Surveyor ct noise and saw R10 banging d on the wall. No staff (20 at 11:02 am showed: R10 ide with a staff member m to his bedroom.				
	in bedroom. No staf Observation on 4/7/ R10's visual checks	20 at 11:20 am showed: R10 f visually checked on R10. 21 at 11:25 am showed: sheet for 4/7/21 shows no of visual checks done since				
	asked what supervisis same room super While he is in his ro E5 was asked since how often should the	4/7/21 at 10:30 am, E5 was sion R10 was. E5 stated, "He vision while outside his room. om, he is a 15-minute check." R10 is a 15-minute monitor e staff be documenting. E5 inutes " F5 was asked." R10				

Illinois Department of Public Health

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _____ IL6000947 04/22/2021

BEVERL	Y FARM FOUNDAIRON	BERT ROAD ', IL 62035		
(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	Continued From page 25 has document sheets for 30-minute checks from 6am - 10 pm, not 15-minute checks sheets; how is the staff to document every 15-minutes. E5 stated, "I'll get 15-minute sheets made up." E5 confirmed since R10 was placed on 15-minute monitoring the documentation sheets for the staff from 6:00 am - 10:00 pm were for 30-minute checks and not 15-minute checks. During interview on 4/12/21 at 2:00 pm, E6 (Behavior Specialist) was asked what the facility implemented for R10's non weight bearing status upon readmit to facility. E6 stated, "R10 has a	Z9999		
	wheelchair outside his room and he's to be wheeled to and from meals and to and from the bathroom. He was also placed on 15-minute checks while he is inside his room." 3) Facility Notes from Orthopedic Surgeon dated 12/10/20 document: "We are to treat R10 non operatively. R10 should follow up in about 6 weeks with repeat x-rays. Spoke with E32 (Assistant Director of Nursing/ADON) and appointment for 6 weeks will be made. E32 will check on x-rays. E32 states he may try to do those at their facility where they have help. If this is done, they will bring x-ray disc with them."			
٥	During interview on 4/12/21 at 1:13 pm, E4 (Director of Nursing/DON) was asked when the orthopedic surgeon's office made facility aware that R10 was to follow up in 6 weeks and have a repeat x-ray. E4 stated, "12/10/20." E4 was asked were the x-rays obtained within those 6 weeks. E4 stated, "No." E4 was asked when R10 got x-ray taken. E4 stated, "3/10/21." E4 was asked what the results of the x-ray showed. E4 stated, "R10 still has a fracture." E4 was asked what is in place for R10's fracture. E4 stated, "R10 is to be non weight bearing."			

STATE FORM

Illinois D	epartment of Public	Health	<u>–</u>		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IL6000947	B. WING		04/22/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE	
BEVERL	Y FARM FOUNDATIO	N .	BERT ROAD ', IL 62035		
(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 SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE COMPLETE
Z9999	Continued From pa	ge 26	Z9999		
	asked who ordered stated, "Primary Ca R10's orthopedic pi "I don't know." E4 v with orthopedic phy know of." E4 was a	4/12/21 at 3:40 pm, E4 was the x-ray on 3/10/21. E4 are Physician." E4 was asked if hysician was aware. E4 stated, was asked if R10 followed up visician. E4 stated, "Not that I sked if there were any nursing place for R10 for his fracture.			
	(Physician's Regist was asked if the phhospital. Z6 stated, consulted with him hospital and he wa have surgery. R10 hospital on 12/9/20 was aware of the nphysician agreed to surgically and to refollow up appointm 12/10/20 and said facility and they wo appointment. On 1 notified the facility appointment and it that day. On 12/12 picked up by facility did the facility send the appointment. Z was scheduled for show and there wadidn't. They did not asked if the physic from 3/10/21. Z6 signal.	ered Medical Assistant/RMA) eysician saw R10 while in the "The physician's assistant on 12/7/20 while in the supposed to follow up and was discharged from the back to his home (facility) and eed for surgery. On 12/10/20 onot treat the fracture peat the x-rays and have a ent. E32 acknowledged that on x-rays would be done at the uld bring them to the 2/11/20 our physician assistant that we could do a telemed was scheduled with the facility /20 an aircast was ordered and y on 12/14/20." Z6 was asked I in the x-rays or show up for 6 stated, "The appointment 1/21/21 and they were a no is no reason as to why they bring any x-rays." Z6 was ian was aware of the x-ray tated, "They were unaware." ey should have notified the d, "Yes."			

Illinois Department of Public Health STATE FORM

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/\$UPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
		IL6000947	B. WING		04/2	22/2021
	PROVIDER OR SUPPLIER Y FARM FOUNDATION	6301 HUN	DRESS, CITY, S IBERT ROAD Y, IL 62035	TATE, ZIP CODE		N
(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 SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
Z9999	4) ISP dated 5/21/2 female with diagnos recent fracture of righthe Profound Level Nursing Operations revised 2/06 docum will have a monthly licensed staff members of the facility was una R1's monthly Breas and March 2021. On 4/8/21 at 9:50 A stated, "Building Nuperforming monthly the facility had no exams were comple 2021. Review of R6's ISP functions in the Mod Disability with additing Pain Syndrome, Sc Mass/Goiter, Sleep Spastic and Flaccid Encephalopathy, Hy R6's chart review had Exams for 5/10/20, 11/5/20, 4/8/21. There is no evidence Breast Exams for Je 2020 or January, Fe During interview on	O identifies R1 as 69 year old ses including anemia and ght lower leg who functions at of Intellectual Disability. Manual: Breast Examinations tents, "1. All female residents breast examination by Der (2-10 PM Nurse)." Able to provide evidence of the Examinations for February M, E4 (Director of Nursing) tree is responsible for breast exams." E4 confirmed vidence R1's monthly breast eted in February or March dated 9/8/20 documents R6 derate Range of Intellectual onal diagnosis of Chronic hizophrenia, Left thyroid Apnea, Cerebral Palsy, Paraplegia, Hypertension, Paraplegia, Hypertension, Pertension, Obesity. ad completed Monthly Breast 8/27/20, 9/20/20, 10/20/20, the of completed Monthly une, July and December of Ebruary, March of 2021. 4/8/21 at 12:30 PM with E4), E4 confirmed that was all	Z9999			

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

1	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE	SURVEY
			A. BOILDING.			
		IL6000947	B. WING		04/2	22/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BEVERL	Y FARM FOUNDATIO	N	MBERT ROAI Y, IL 62035	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROVIDENCY)	DBE	(X5) COMPLETE DATE
Z9999	Continued From pa	ige 28	Z9999			
	identifies R1 as 69 diagnoses including	e Plan (ISP) dated 5/21/20 year old female with g anemia and recent fracture ho functions at the Profound Disability.		20		
	The facility was una annual physical had	able to provide evidence R1's dibeen completed.				
14	female with diagnos and spastic quadrip	identifies R2 as a 63 year old ses including anemia, epilepsy plegia who functions at the intellectual Disability.	7	**		
	The facility was una annual physical had	able to provide evidence R2's dibeen completed.				
	confirmed R1 and F been completed. E- appointments had t Covid-19 restriction appointments for R	peen postponed due to		×		
= 29	functions in the Pro with Intellectual Dis Review of R4's med	0/2020 documents R4 found Range of Individuals abilities. dical record documents R4's an Physical was completed on		<u>s</u>		9.
		O AM, E3 (Unit Director) last Annual Physical was on			* op op grade state de san	W
	female with diagnos	0 identifies R1 as 69 year old ses including anemia and ght lower leg who functions at				

Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY
	<u>.</u>	IL6000947	B. WING		04/2	22/2021
	PROVIDER OR SUPPLIER Y FARM FOUNDATIO	N 6301 HUN	DRESS, CITY, SIBERT ROAL	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z9999	R1's Annual Vision 12/19/2019 docume to Clinic) and Cond SLE/DFE/TA (Slit L: Exam/Tension by A 12/19/2020 for Con R1's Functional Vis On 4/8/21 at 12:15 screen is dated 9/1: no date of completi should be completi screenings annually ISP dated 6/8/2020 female with diagnos and spastic quadrip Profound Level of It R2's Annual Vision documents, "Care It and Conduct the fo Lamp Exam/Dilated Applanation." In add Comprehensive En The facility was una R2's follow up appor examination. R7's POS (Physicia 3/2021 documents Range of Intellectual	of Intellectual Disability. Examination dated ents, "Care Plan: RTC (Return uct the following tests: amp Exam/Dilated Fundus pplanation." In addition, "RTC hprehensive Encounter." ion Test is dated 9/18. PM, E4 confirmed R1's vision 8 and R1's hearing screen has on. E4 stated, "Building nurses ng vision and hearing y." identifies R2 as a 63 year old ses including anemia, epilepsy plegia who functions at the intellectual Disability. Examination dated 4/11/2019 Plan: RTC (Return to Clinic) Illowing tests: SLE/DFE/TA (Slit of Fundus Exam/Tension by dition, "RTC 4/11/2020 for counter." able to provide evidence of pointment or annual vision an's Order Sheet) dated R7 functions in the Profound al Disabilities.	Z9999			
	1/13/20 documents	annual eye exam dated , "Care Plan: RTC (Return to Comprehensive Encounter and				,

Illinois Department of Public Health

STATE FORM

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		IL6000947	B. WING		04/22/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•
DEVEDI	Y CADAL COUNDATIO	6301 HUN	BERT ROAD		
BEVERL	Y FARM FOUNDATIO	GODFRE	Y, IL 62035		· · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPRODEFICIENCY)	D BE COMPLETE
Z9999	Continued From pa	nge 30	Z9999		
	conduct the following	ng tests: SLE/DFE/TA (Slit d Fundus Exam/Tension by			
	R7's Functional Vis	sion Test is dated 1/13/2020.			
		2021 documents R8 functions ange of Intellectual Disabilities.			
UA HM	2/21/19 documents Clinic) 2/21/20 for 0 conduct the following	annual eye exam dated s, "Care Plan: RTC (Return to Comprehensive Encounter and ng tests: SLE/DFE/TA (Slit d Fundus Exam/Tension by			
	R8's Functional Vis	ion Test is dated 2/21/2019.			
		able to produce evidence of a sion exam for R7 and R8.			
d)	E3 (Unit Director),	nce on 4/9/21 at 9:19 AM with E3 confirmed the most recent as 1/13/20 and the most or R8 was 2/21/19.			
:	stated, "Vision Clini	AM, E4 (Director of Nursing) ic has not been restarted since and no date yet when they will		A	
; •	R5 functions in the Intellectual Disabilit of Cyclothymia with Impaired Vision, Ar Aggression. R5's Phave a hearing eva	OS further documents R5 is to			

Illinois Department of Public Health

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6000947	B. WING		04/	22/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BEVERL	Y FARM FOUNDATION	N.	IBERT ROAI 1, IL 62035	D			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULDBE	(X5) COMPLETE DATE	
Z9999	Continued From pa	ge 31	Z9999				
	Evaluation 2/21/17 that demonstrated left ear hearing loss. R5's record documents R5's last annual hearing screen was 1/10/20 and was adequate with hearing aids. No evidence R5 had an annual hearing evaluation since 1/10/20 or an Audiological Evaluation since 2/21/17.			77			
		4/8/21 at 2:30 PM, E4 i) confirmed that was the last					
	identifies R1 as 69 diagnoses including	e Plan (ISP) dated 5/21/20 year old female with ganemia and recent fracture no functions at the Profound Disability.		5.			
3	documents orders f Count) every 6 mor Metabolic Profile) e	er Sheet (POS) dated 3/21 for CBC (Complete Blood hths, CMP (Comprehensive very 6 months, Magnesium bid Panel every 6 months and very 6 months.					
	are dated 6/23/20, I 6/23/20 and 3/2/21 6/23/20. The facility evidence R1's lab le	re dated 3/3/21, CMP results Magnesium results are dated and Lipid profile dated was unable to provide evels were obtained as ny Lamotrigine levels.					
	female with diagnos and spastic quadrip	identifies R2 as a 63 year old ses including anemia, epilepsy legia who functions at the ntellectual Disability.				2 4	

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING IL6000947 04/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6301 HUMBERT ROAD **BEVERLY FARM FOUNDATION** GODFREY, IL 62035 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Z9999 Continued From page 32 Z9999 R2's POS dated 3/21 documents orders for Lipid Panel every 6 months. R2's Lipid Panel results are dated 6/8/20. The facility was unable to provide evidence R2's Lipid Panel was obtained as ordered. On 4/8/20 at 12:15 PM, E4 (Director of Nursing) confirmed labs had not been obtained as ordered. R3's ISP dated 12/1/2020 documents R3 functions in the Moderate Range of Individuals with Intellectual Disabilities. R3's Most current signed Physician Order Sheet (POS) dated 3/2021 documents: Laboratory Orders: CBC (complete blood count), Depakote Level, CMP (Comprehensive Metabolic Panel) Lipid Panel and Ammonia Level every three months. Review of R3's medical health record documents the last day labs were drawn is dated 12/4/2020. On 4/8/2021 at 9:10 AM, E4 (Director of Nurses) confirmed that the last labs that R3 had drawn was on 12/4/2020. R4's ISP dated 7/30/2020 documents R4 functions in the Profound Range of Individuals with Intellectual Disabilities. R4's most current signed Physician Order Sheet dated 3/2021 documents: Laboratory: Prostate-Specific Antigen (PSA) yearly, Folic Acid vearly. Lacosamide Level ordered on 8/7/2020 for next day and then every 6 months. Hydroxy-Vit D level ordered 8/7/2020 for next day then every 6 months.

Illinois Department of Public Health

Review of R4's medical health record showed

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6000947	B. WING		04/	22/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BEVERL	Y FARM FOUNDATION	N	BERT ROA	D		
0/4) [5	CLIMATA DV CTA	TEMENT OF DEFICIENCIES	/, IL 62035	DROVIDER'S BLANCE CORRECTION	211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIDEFICIENCY)	.D BE	(X5) COMPLETE DATE
Z9999	Continued From pa	ge 33	Z9999			
	there is no evidence Folic Acid, Lacosan	e of laboratory results for PSA, nide or Vit-D levels.		0		
	On 4/7/2021 at 3:25 PM, E4 stated, "There were no lab results for R4's orders for the PSA, Folic Acid, Lacosamide or Vit-D levels."					
×	in the Moderate Rawith additional diag	8/20 documents R8 functions nge of Intellectual Disabilities noses of Hypothyroidism, Apnea, Post Seizure Disorder blar Disorder.			la is	
		documents "Laboratory oglobin) A1c every 6 months."		22		1 0
	Review of R8's mos dated 5/13/20.	st recent HgbA1c result is				
	The facility was una HgbA1c result from	able to produce evidence of a 11/2020.				
		M, E3 (Unit Director) A1c most recent laboratory		¥		
	female with diagnost recent fracture of rig	0 identifies R1 as 69 year old ses including anemia and ght lower leg who functions at of Intellectual Disability.				
	8/14/20 and 11/15/2	erlies are dated 5/27/20, 20. The facility was unable to Quarterly for February 2021.				
	female with diagnos	identifies R2 as a 63 year old ses including anemia, epilepsy legia who functions at the ntellectual Disability.				1

Illinois Department of Public Health STATE FORM

) DATE SURVEY COMPLETED		
		IL6000947	B. WING		04/:	22/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE	1 0-1,2	
BEVERL	Y FARM FOUNDATIO	N ·	MBERT ROAD Y, IL 62035			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
Z9999	3/24/21. The facility Nursing Quarterlies 2020. On 4/7/21 at 2:45 F should be four nurs R4's ISP dated 7/30 functions in the Prowith Intellectual Dis Review of R4's Quassessments docur completed on 9/9/2 3/6/2021. There we Summaries prior to record.	erlies are dated 12/24/20 and was unable to provide for June and September PM, E4 (DON) stated, "There ing quarterlies." D/2020 documents R4 found Range of Individuals abilities. arterly Nursing Summary ment the assessments were 020, 12/10/2020 and re no Quarterly Nursing 9/9/2020 within R4's medical D PM, E4 (DON) stated, Quarterly Nursing	Z9999			
	dated 9/8/20 docum Moderate Range of additional diagnose Schizophrenia, Left Apnea, Cerebral Pa Paraplegia, Hyperte Hypertension, Obes Completed Nursing the past year show There is no evidence the second and four	Quarterlies in R6's chart for 11/5/20 and 4/5/21. The of Nursing Quarterlies for the quarter.				
llinois Denad		4/8/21 at 12:30 PM with E4), E4 confirmed that was all				

(X3) DATE SURVEY

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

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
	ē:	IL6000947	B. WING		04/	22/2021
	PROVIDER OR SUPPLIER Y FARM FOUNDATION	6301 HUN	DRESS, CITY, SIBERT ROALLY, IL 62035	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z9999	Continued From pa	ge 35	Z9999			
Œ	the completed quar	terlies.				
	in the Moderate Ra with additional diag	3/20 documents R8 functions nge of Intellectual Disabilities noses of Hypothyroidism, Apnea, Post Seizure Disorder plar Disorder.				
	12/8/20 and 9/9/20.	sments are dated 3/20/21, The facility was unable to a prior quarterly nursing				
	E3 (Unit Director), I	nce on 4/9/21 at 9:19 AM with E3 confirmed nursing was pursing assessment prior to				
	male who functions	ntifies R9 as a 45 year old within the Profound Range for ellectual Disabilities. R9 has s of Cerebral Palsy.				
	There is no evidend for R9.	ee of nursing quarterly for 3/21				
	old male who functi	0 identifies R10 as a 36 year ons in the Profound Range of ies with additional diagnosis of				
	There is no evidend for R10.	ce of nursing quarterly for 3/21				0.
	- 4/30/21) documer Severe Range of In additional diagnose Stimulator, Hypothy	an Order Sheets (dated 4/1/21 ats R167 functions in the tellectual Disabilities with as of Epilepsy, Vagus Nerve proidism, Osteoporosis, sorder, Psychosis, Barrets				

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION		(X3) DATE SURVEY	
ANDFLAN	TOP CORRECTION	IDENTIFICATION NOMBER:	A. BUILDING	UILDING:		PLETED
		IL6000947	B. WING		04/2	22/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY,	STATE, ZIP CODE	-	
BEVERL	Y FARM FOUNDATION	N	MBERT ROA Y, IL 62035			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD IT			N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
Z9999	Continued From pa	ge 36	Z9999			
		a. R167 is to receive Felbatol nsion. Take 3.3 ml by mouth at om.				
	(Registered Nurse) liquid by drawing up	s on 4/6/21 at 3:00 PM, E25 administered R167's Felbatol o in a 3 ml syringe. There was nge for 3.3 ml. E25 drew liquid administered.				
:	asked how they me stated, "I just pull it	4/6/21 at 3:05 PM, E25 was asure the 3.3 ml required. E25 all the way back past the 3 nge. This is all the pharmacy				
	white 1/2 pill capsul outside the dining ro	ion on 4/6/21 at 11:51 am, e was sitting on windowsill bom in Herring Cottage. to expel powder out of			nds.	
	(Director of Nursing nurses are to ensure of the capsules whe stated, "Yes." E4 wa ensure that the caps trash and out of reactions.	4/7/21 at 2:56 pm, E4 /DON) was asked if the e all medication is poured out en passing medication. E4 as asked if the nurses were to sules were disposed of in the ch of the individuals. E4 edicine that was found was nged to R127."				
1 = 11		that R9, R10, R12, R13, R36 112 - R129 reside in the				
		(B)				·
.57						330

Illinois Department of Public Health