FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ R-C IL6013445 B. WING 06/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **50 ADLOFF LANE** ADLOFF PLACE SPRINGFIELD, IL. 62703 SUMMARY STATEMENT OF DEFICIENCIES (X4IID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREEX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Z 000 COMMENTS Z 000 Follow -Up to Complaint Investigation of 5/13/21 **Z9999 FINDINGS** Z9999 Statement of Licensure Violations: 350.620 a) 350.1230 d)2) 350.1230 d)3) Section 350.620 Resident Care Policies 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 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. These requirements are not met as evidenced by:

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

2) physician order sheet was up to date, affecting

Based on observation, record review and interview, nursing failed to ensure:

1) all staff were efficiently and competently

trained on R1's colostomy bag;

TITLE

Attachment A Statement of Licensure Violations

(X6) DATE

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 3:		SURVEY
		IL6013445	B. WING			-C 29/2021
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ADLOFF	PLACE	50 ADLO	FF LANE IELD, IL 62	703		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOUL_D BE	(X5) COMPLETE DATE
Z9999	Continued From page 1		Z9999			
	1 of 1 in the sample epinephrine injection	who has allergies requiring (R1);				
	communication w R1's colostomy bag.	rith day training, regarding /care;		30		
	4) communication v R1's epinephrine pe	vith day training, regarding n.				
,,,,	Findings include:		w. n		=	
	individual who functi	ated, identifies R1 as an ons within the Moderate s with Intellectual Disabilities.	·			
	documents additiona	n Administration Record al diagnosis of, "Constipation, vical Region, and Epilepsy."		¥1 ₂		
#n :	"Policy: The facility surving services in a The Health Services and conduct in-servi individuals, facility st Nurses, under the di Direct and teach nur be safely performed within state guideline that nursing staff conto current standards	i i				
	Interview on 6/24/21 (Administrator) was a HSD in the Nursing S "Yes."	at 10:22 am: E1 asked if E3 is considered the Services Policy? E1 stated,				
ž	in wheelchair at day	21/21 at 12:00 pm: R1 sitting training. Clear colostomy ma red beefy color. Scar				

(X2) MULTIPLE CONSTRUCTION

PRINTED: 08/31/2021 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-C IL6013445 B. WING 06/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADLOFF LANE **ADLOFF PLACE** SPRINGFIELD, IL 62703 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) **Z**9999 Continued From page 2 Z9999 located to the right of stoma. Observation on 6/22/21 at 9:20 am: R1 sitting in wheelchair at day training. R1's shirt was covering her seatbelt, which was belted across her colostomy bag one inch below her stoma site. Interview on 6/22/21 at 2:15 pm: E3/Registered Nurse Trainer (RNT) was asked if she has inserviced the staff on how to care for R1's colostomy? E3 stated, "I didn't inservice E10/Direct Support Person (DSP), she quit. I haven't inserviced E5 (DSP) or E8 (DSP)." E3 was told the wheelchair seatbelt was across R1's colostomy bag this morning upon arrival to day training, and about one inch below her stoma. Survey inquired, "Should the staff be placing the wheelchair seatbelt there?" E3 stated, "No, we need to have her seat belt moved." E3 was asked if she has inserviced the staff on positioning of the seatbelt regarding the colostomy bag? E3 stated, "No." Facility Staff List and Start Date documents, "E4 (DSP) start date: 6/4/21; E8 (DSP) start date: 5/21/21; E9 (DSP)start date: 6/8/21; and E10 (DSP) start date: 5/24/21." Interview on 6/22/21 at 2:49 pm: E1 (Administrator) was asked if E10 is still employed

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"No."

needed)."

with the facility? E1 stated, "Yes, she is PRN (as

Interview on 6/23/21 at 9:13 am: E4 was asked if she has ever been inserviced at the facility on R1's colostomy bag/colostomy care? E4 stated,

Interview on 6/23/21 at 10:00 am: E3 was asked if E4, E8, E9, and E10 had been trained on R1's

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	Department of Public	Health			FOR	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6013445	B. WING _			R-C 6/29/2021
NAMEOF	PROVIDER OR SUPPLIER	STREET AC	DORESS, CITY	Y, STATE, ZIP CODE	1 00	# Z SI Z U Z I
ADLOF	F PLACE	50 ADLO				
(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRF	(X5) COMPLETE DATE
Z 9999	Continued From page 3		Z9999			
	is E8?" R11 (House new." E3 then state she had training at a asked if she has per	stomy care? E3 stated, "Who e Manager) stated, "She's ed, "I didn't train E4 because another facility." E3 was then rsonally trained E4, E8, E9 or my bag/colostomy care? E3				
	asked if her training was hands on? E5 training." E5 was as	at 11:11 am: E5 (DSP) was on colostomy care for R1 stated, "No, it was verbal sked if E3 has ever done a with her regarding R1's stated, "No."				
	if she had done hand	at 12:51 pm: E3 was asked ds on evaluations with the my bag/colostomy care? E3				
	she had seen E3 dor staff for R1's colosto.	at 1:25 pm: E1 was asked if ne hands on training with the my care? E1 stated, "I've er today it had to be hands				
	evidence that a "hand	provide any documented ds on" competency based completed for any staffs colostomy care.				
	dated 5/7/21, docume Allergic Reaction. Co referral to allergist for Take steroids as pres further reaction occur	ergency Department Note, ents, "Discharge Information: omments: Recommend further evaluation/testing. cribed. Use EpiPen if s. Return to emergency evere reactions or needed				

FORM APPROVED Illimois 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-C B. WING IL6013445 06/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **50 ADLOFF LANE** ADLOFF PLACE SPRINGFIELD, IL 62703 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Z9999 Continued From page 4 Z9999 R1 Allergen Test, dated 5/24/21: R1 allergic to egg whites, milk, shrimp, dust mite and cockroach. R1's Physician's Order Sheet (POS), dated 5/21, documents, "No Known Drug Allergies." No allergies documented anywhere else on 5/21 POS. R1's Physician's Order Sheet (POS), dated 6/21. documents, "No Known Drug Allergies." No allergies documented anywhere else on 6/21 POS. R1's POS, dated 6/21, documents, "Epinephrine Inj 0.3 mg inject into thigh for severe reaction. may repeat in 5 minutes. If necessary, call 911." Interview on 6/23/21 at 12:51 pm: E3/Registered Nurse Trainer (RNT) was asked why R1 has an Epinephrine Pen? E3 stated, "They thought she had an allergic reaction." E3 was asked what is R1 allergic to? E3 stated, "Shrimp, egg whites, dust, and milk." E3 was asked if allergies should be listed on the POS? E3 stated, "Yes." E3 was asked if it was her responsibility to write them in? E3 stated, "Yes." Day Training Note, dated 6/18/21, documents. "R1 showed up this morning at day training with

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new bag put on her."

her colostomy bag overflowing and the bag popped open and pulled away from her skin. R1 had BM (bowel movement) stuck on her stomach up to her chest. R1 has been cleaned up and a

Picture taken on 6/18/21, depicts R1's colostomy bag full of BM with the bag popped off at the top right corner and BM seeping out of the open corner of the bag. Dried BM is shown in the

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	IL6013445		B. WING			R-C 06/29/2021	
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
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(X4)ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOUL DIBE		(X5) COMPLETE DATE	
Z9999	Continued From pa	ge 5	Z9999			- 65	
		tht of the colostomy bag. 1 at 11:39 am: Z4 (Day					
***	Training Licensed F there has been com E3 regarding R1's o Z4 was asked if the	Practical Nurse) was asked if immunication between you and colostomy? Z4 stated, "No." by get supplies for R1's facility? Z4 responded "No, I		ų.	v ,		
	have one bag. We colostomy when she have not talked to E One of the staff tool	didn't know she even had a returned to day training. I say ever about R1's colostomy. I her to the bathroom and liced the colostomy. We					
	called and they said off often so we didn' know. That was not been no communica staff here. I can't tra	, well the bag doesn't come It feel the need to let you It the nurse. But there has still ation on instructions for the ain them since I'm not an	ā				
	Registered Nurse." Interview on 6/23/21	at 12:51 pm: E3/RNT was					
	asked if she has trai colostomy bag/care' asked if she has had	ned day training staff on R1's? E3 stated, "No." E3 was d communication with Z4 stomy bag? E3 stated, "No."		·	d.		
	Training, dated 7/21,	rder Sheet given to Day , documents, "Allergies: No ." No allergies listed on et.					
	Observation on 6/22 Pen on back of R1's	/21 at 9:20 am: Epinephrine wheelchair.			,		
	Training DSP) was a	at 11:55 am: Z5 (Day sked if she knows why R1 Pen? Z5 stated, "No."				G	
'	Interview on 6/23/21 Training DSP) was a ment of Public Health	at 11:55 am: Z6 (Day sked if she knows why R1					

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