

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CURTISS COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	COMMENTS  annual Licensure- 350.625e.)f.), 350.1420a.) and 350.1086b.)	Z 000		
Z9999	FINDINGS  Statement of Licensure Violations:  ONE OF THREE  350.1086b  Section 350.1086 Unnecessary, Psychotropic, and Antipsychotic Drugs b) Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interviews the facility failed to ensure current guardian consent of behavior modifying medications was obtained for one of three individuals (R2) reviewed for restrictive measures in the sample of three.  Findings include:  Facility Roster, undated, identifies R2 resides at the facility.  R2's Prescription Summary dated 9/6/24 includes, "Lorazepam 0.5 mg 2 tablets one hour prior to procedure."  R2's Team Meeting Note dated 9/18/24 includes,	Z9999		

Illinois Department of Public Health

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

TITLE

(X6) DATE

11/14/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CURTISS COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z9999	<p>Continued From page 1</p> <p>"R2 has an upcoming well women's checkup on 9/19, with a pap smear. R2 has been prescribed Lorazepam 0.5 mg: 2 tabs 1 hour before appointment to decrease R2's anxiety and relax R2's legs enough for the examination."</p> <p>R2's 9/24 Medication Administration Record documents R2 received Lorazepam 0.5 mg 2 tablets on 9/19/24.</p> <p>Facility unable to produce evidence of R2's guardian consent for Lorazepam 0.5 mg 2 tablets one hour prior to procedure.</p> <p>On 11/4/24 at 10:03 am, E2 (Qualified Intellectual Disabilities Professional/QIDP) confirmed the facility does not have a signed guardian consent for R2's Lorazepam 0.5 mg 2 tablets one hour prior to procedure.</p> <p>(C)</p> <p>TWO OF THREE 350.625e) f)</p> <p>Section 350.625 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CURTISS COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z9999	<p>Continued From page 2</p> <p>name on the Illinois Sex Offender Registration website at <a href="http://www.isp.state.il.us">www.isp.state.il.us</a> and the Illinois Department of Corrections sex registrant search page at <a href="http://www.illinois.gov/idoc/Pages/default.aspx">www.illinois.gov/idoc/Pages/default.aspx</a> to determine if the individual is listed as a registered sex offender.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review and interviews the facility failed to perform a criminal history background check for one of two individuals reviewed for criminal history background check within 24hours after admission and failed to check individuals on the sex offender registry within 24 hours after admission for two of two individuals reviewed for background checks.</p> <p>Findings include:</p> <p>Resident roster provided from facility on 10/31/2024 identifies R1 and R9 as an individual who resides at the facility. R1's admission date is documented as 4/4/2024 and R9's admission date is documented as 12/19/2023.</p> <p>R1's Criminal History information Response Process is dated 4/15/2024.</p> <p>R1 and R9's Illinois Sex offender registry search document are both dated 10/18/2024.</p> <p>On 11/6/2024 at 2:05pm E1 (Administrator) stated that the sex offender search for both R1 and R9 were completed on 10/18/2024. E1 stated the Criminal history information response process was not completed within 24 hours of R1's admission.</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CURTISS COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z9999	<p>Continued From page 3</p> <p>Facility provided policy titled Identified Criminal/Sex Offender dated 6/24 that includes; A.) The home screens all current and prospective individuals against the Illinois Department of Corrections and Illinois State Police Registered Sex Offender databases, according to Illinois Department of Public Health regulations prior to admission. D.) The home performs a criminal history check pursuant to the Uniform Conviction Information Act on all current and prospective individuals prior to admission.</p> <p>(C)</p> <p>THREE OF THREE 350.1420a)</p> <p>Section 350.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review and interviews the facility failed to administer medications at the correct time as prescribed by the physician for all one of three (R2) individuals</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CURTISS COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z9999	<p>Continued From page 4</p> <p>reviewed for medication administration.</p> <p>Findings include:</p> <p>Resident roster provided from facility on 10/31/2024 identifies R2 as an individual who resides at the facility.</p> <p>Facility provided policy titled Medication Administration Record and Required Documentation dated 8/23 includes the following: All medications shall be given only upon the written order of a physician; all orders shall be given as prescribed by the physician and at the designated time.</p> <p>R2's POS (Physician Order Sheet) dated 10/2024 identifies R2 as an individual with diagnoses including: Mild Intellectual disability, visual problems, seizures and general anxiety.</p> <p>R2's POS documents the following meds be administered daily at 7am; Zolof 100mg daily, Baclofen 20mg, Gabapentin 100mg, Claritin 10mg, Carabamexipne 200mg, Norvasc 5mg, Vitamin D3 25mcg, tenoritic 50mg/25mg, kdur 40meq and icy hot and arthritis cream.</p> <p>On 10/31/2024 at 8:25am E3 (Direct Support Person) was observed administering the following medications to R2: Zolof 100mg daily, Baclofen 20mg, Gabapentin 100mg, Claritin 10mg, Carabamexipne 200mg, Norvasc 5mg, Vitamin D3 25mcg, tenoritic 50mg/25mg, kdur 40meq and icy hot and arthritis cream.</p> <p>10/31/2024 at 8:30am E3 stated that R2's meds are ordered at 7am and that the meds should be given by 8am. E3 stated that R2's meds were administered at 8:25am.</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CURTISS COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703</b>		
(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 5  10/31/2024 at 8:30am E4 (Registered Nurse Trainer) stated that meds are to be given an hour before or an hour after the scheduled time to be given.  (C)	Z9999			