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Z 000	COMMENTS Complaint Investigations: 2541732/IL187367 2541985/IL187706 2542577/IL188770	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 1 of 4: 350.620a) 350.1010 350.1020e)1) 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 350.1010 Service Programs The facility shall provide, either directly or through arrangements with an outside resource, as needed by the individual resident, all resident living services, training and guidance necessary in the activities of daily living and in the development of self-help skills for maximum independence. Section 350.1020 Psychological Services e) The facility shall employ sufficient, appropriately qualified staff, and necessary supporting personnel, to carry out the various	Z9999		

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psychological service activities in accordance with the needs of the following functions:

1) Psychological services to residents including evaluation, consultation, therapy, and program development

These Regulations are not met as evidenced by:

Based on observation, record review and interview the facility failed to ensure a Qualified Intellectual Disability Professional developed, implemented and/or revised Behavioral Management Plans/BMP's for residents (R4, R14), provided residents access to their money (R8, R11, R14), and to order food for meals to be prepared consistent with current menus. These failures have the potential to affect 14 of 14 residents living in the facility. (R1-R14)

Job Description of a Qualified Intellectual Disability Professional (QIDP) last revised 04/24 documents the job function of the QIDP is the "Development and implementation of individual program plan in accordance with applicable state and federal regulations. Coordinate all habilitation of direct care services as defined by state and federal regulations provided to individuals within the home." Primary duties include, "1. Ensure that the home is in compliance with all active treatment regulations in providing habilitation services. 2. Coordinate efforts of the Interdisciplinary Team and program staff to ensure that each individual is receiving optimum services, which must meet his/her individual needs. 3. Develop, implement, review, and document the individuals' individual program plans." Additionally, "9. Maintain each individual's finances and fund accounts, including balancing checkbooks."

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On 03/11/25 at 10:55 AM, E8 (Maintenance Person) stated E1 was the float QIDP as the facility does not have a current QIDP. E8 stated E1 was not in the building but he would contact her.

1) An undated resident roster documents R1 functions at the level of Profound Intellectual Disability. R1's Programmatic Reports dated October and November 2024 document under a section titled progress comments, "Needs more data. Staff need to document in (computerized charting system) so that we can see if (R1) is making progress towards completing this outcome." R1's Self Medication, Budgeting and Personal Hygiene had zero documentation. There were no reports completed for December 2024, January or February 2025.

An undated resident roster documents R2 functions at the level of Severe Intellectual Disability. R2's Programmatic Reports dated October and November 2024 have zero documentation for R2's Exercise Eating, Community, Financial or Self Medication programs. A section titled progress comments documents, "Needs more data. Staff need to document in (computerized charting system) so that we can see if (R2) is making progress towards completing this outcome." There were no reports completed for December 2024, January or February 2025.

An undated resident roster documents R3 functions at the level of Profound Intellectual Disability. R3's Programmatic Reports dated October and November 2024 have zero documentation for R3's Community Orientation, Eating, Self-Medication, or Coin Identification

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programs. A section titled progress comments documents, "Needs more data. Staff need to document in (computerized charting system) so that we can see if (R3) is making progress towards completing this outcome." There were no reports completed for December 2024, January or February 2025.

On 03/12/25 at 10:52 AM, E1 confirmed she cannot provide QIDP summaries for December 2024, January or February 2025 for R1, R2, or R3 and cannot provide documentation of behaviors or active treatment programs since October 2024.

A Clinician Report listing R4's behaviors between 01/01/25 through 03/10/25 documents on 01/16/25 at 1:31 PM, R4 broke an ornament and cut her arm with it. On 01/17/25 at 8:00 AM, R4 was woken up for breakfast and once she got in the dining room, she proceeded to swipe a glass plate and break (it) up. R4 then attempted to cut herself but staff grabbed the glass before she could. On 01/20/25 at 9:00 AM, R4 "did a good amount of property damage from the (medication) room to her room and the bathroom. (R4) swiped a couple of things off counters and tables and attempted to snap things in half and grab things off (of the) wall." On 01/22/25 at 7:50 AM, R4 went into the kitchen during breakfast and smashed a plate on the floor. On 02/18/25 at 8:31 AM, R4 broke a glass item in the dining area, pushed, hit and punched, refused to get down from the dining room table and ran out the front door. On 02/18/25 at 11:00 AM, R4 tore pictures off of the wall, was hitting and punching, also hit a peer. On 02/19/25 at 8:50 AM, R4 broke glass and tore pictures from the wall, pushed, punched, spit, broke glass and attempted to self-harm, banging head on the wall and scratching herself, then ran out the front door trying to check the mail

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without permission. On 02/20/25 at 8:30 AM R4 pulled a fire alarm, broke her dresser drawers and things on her dresser, pushed, spit and punched, refused to leave the dining room while other residents were in there, and refused to get down from standing on the table in the dining area. On 02/24/25 at 11:00 AM, R4 stood on the dining room table and refused to get down saying she "wanted to die".

On 03/11/25 at 12:00 PM, E1 (QIDP/float) was asked for R4's current BMP and copies of all BMPs for the facility. E1 stated, "I haven't been here in a couple of weeks. I can call (E3, a QIDP from a sister facility) for information. (E3) knows the residents better as he fills in with direct care a lot. I'm not sure." E1 could not provide BMPs in a manner that was readily available to staff.

On 03/13/25 at 1:45 PM, E1 confirmed R4's most current Maladaptive Behavior Program has not been revised or re-written since 01/01/25. E1 confirmed R4 had six psychiatric hospital visits since 01/01/25 and has had no changes to her programming.

R14's Physician's Orders for March 1, 2025, through March 31, 2025, document R14 was admitted to the facility on 09/04/24. R14's Individual Risk Assessment dated 10/15/24 documents a section titled "Behavioral" that are marked "Yes" to the following behaviors: Aggression, verbal or physical threats to self, self-injury, history of false allegations/reports and manipulating of others. R14 had an undated Support Service Team (SST) Recommendation. This documents R14 has diagnoses of Mild Intellectual Disability, Attention Deficit Hyperactive Syndrome, Mood Disorder and Depression. This recommendation states the reason for referral

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includes R14 being verbally aggressive which includes threatening housemates or manipulating others and pressuring them into submission "which is causing a major concern for the rest of the individuals who live in the home". SST provided recommendations include detailed ways to building rapport, coping, identifying emotions, boundaries, communication and positive interactions. The undated SST recommendations conclude with "*This document contains recommendations for teams to choose to implement." And "Any recommendations the team chooses to implement should be integrated into the individual's programming."

On 03/12/25 at 10:52 AM, E1 stated, "I don't have an Individual Service Plan/ISP or BMP for (R14). I have five houses and I'm behind." E1 confirmed that due to R14 not having ISP or BMP programming, there has been no documentation to review or programs to revise.

2) On 03/12/25 at 6:17 AM, R8 stated he didn't have any access to his money, "because (E1) won't sign our checks". R8 and R11 were sitting next to each other in the living room and agreed Christmas was the last time they went shopping. R8 stated he needs money for minutes on his phone.

On 03/12/25 at 8:15 AM, R14 was sitting outdoors smoking. R14 stated his mom puts money on his card because he doesn't have access to his money at the facility. R14 stated he hasn't been shopping since Halloween 2024. R14 stated (E1) won't sign residents' checks and budget sheets should be done every two weeks.

(B)

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Z9999	Continued From page 6 Statement of Licensure Violations 2 of 4: 350.1070 Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. These Regulations are not met as evidenced by: Based on observation, record review and interview the facility failed to provide sufficient support staff to allow the direct support staff to perform tasks and duties to meet the individuals needs and implement facility policy of 14 of 14 residents living in the facility (R1-R14) impacting 14 of 14 residents living in the facility (R1-R14). This failure led to one direct care staff with a lack of training for fire emergency, left in the facility to provide care, services and monitoring for 14 residents until or if different staff members arrive from other facilities. As a result, residents were not provided timely assistance during activities of daily living, mealtime and escort service to the hospital (R1, R2, R3, R5, R7, R10, R12), residents are utilize to perform housekeeping and kitchen tasks not a part of their individual service plan/ISP (R5, R8, R10), delayed interventions or constant addressing of residents (R3, R4, R12) with either disruptive or elopement behaviors which directly related to other residents not being provide care and service throughout the day (R1, R14), and the delay of the resident meal service due to the lack of a cook, residents not provided with funds	Z9999		

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in order to attend activities outside the facility (R8, R11) and the lack of enough staff to help prepare residents in the morning to be ready for the transportation to the day program.

Findings include:

An undated resident roster documents there are 14 residents in the facility of which five function at the level of Mild Intellectual Disability (R8, R11-R14), four function at the level of Moderate Intellectual Disability (R4, R5, R7, R10), two at the level of Severe Intellectual Disability (R2, R9) and three at the level of Profound Intellectual Disability (R1, R3, R6). Nine of 14 residents require behavior management plans. (R2-R8, R11, R14)

On 03/12/25 at 2:00 PM, E1 stated only three individuals have received money since January 2025. Shopping worksheets document money being dispersed to R12 on 02/12/25, to R13 on 02/06/25 and to R14 on 01/17/25, 01/31/25 and 02/19/25. E1 stated no outings have been taken place since November 2024.

On 03/11/25 at 5:09 PM, a menu on the freezer documented the resident's main course was chicken and dumplings for supper on 03/11/25.

On 03/11/25 at 5:09 PM, E2, Direct Support Person (DSP), was preparing spaghetti as the main dish for supper. E2 stated staff frequently have to change the menu to items they have in the facility. E2 stated she chose to make spaghetti because dumplings were not available.

On 03/11/25 at 5:29 PM, E1 stated it is the Cooks responsibility to fill out a shopping sheet. E1 confirmed the facility does not currently have a

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cook.

Policy 5.16 titled Staff Schedules and last revised 05/23 documents, "It is the policy of the home to employee sufficient qualified staff and to schedule them in a manner which meets the needs of the individuals served."
An Employee schedule for March 2025, updated 02/24/25, documents on 03/08/25 and 03/09/25 there was one Direct Support Person (DSP) scheduled from 9:30 AM until 5:30 PM, one DSP scheduled from 3:30 PM until 11:30 PM and one DSP scheduled from 11:30 PM until 9:30 AM.
Timecard Editors printed on 03/11/25 document time punches for the following: 03/08/25 E6, DSP, worked from 6:37 AM until 6:39 PM, E12, DSP from a sister facility, worked 5:42 PM until 9:31 PM and E13, DSP, worked from 9:33 PM until 11:16 AM on 03/09/25. On 03/09/25 E6 worked from 10:05 AM until 6:09 PM, E14, DSP, worked from 2:42 PM until 10:31 PM and E13 worked from 10:31 PM until 10:27 AM on 03/10/25.

On 03/11/25 at 3:24 PM, E8, Maintenance, was removing wooden slats which were broken from the dining room blinds. E8 stated, "(R4)" when asked how the blinds had been broken.

On 03/11/25 at 3:36 PM, the day training bus arrived home.

On 03/11/25 at 3:48 PM, E2, DSP, was the only scheduled direct care staff working. E2 was putting away food items from a morning delivery which were stacked from the floor to the counter, in the hallway and covering the top of the kitchen countertop. E3, Qualified Intellectual Disability Professional (QIDP), from a sister facility stated he came to administer medications.

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On 03/11/25 at 3:52 PM, a resident told E2 that R7 had an accident in her bathroom and was changing herself. E2 left the kitchen to assist R7.

On 03/11/25 at 4:05 PM, E2 took a mop bucket to clean R7's bathroom.

On 03/11/25 at 4:11 PM, E7, house manager from a sister facility, arrived. E7 stated she had never been to the facility before but was asked to come and help out.

On 03/11/25 at 4:15 PM, E3 pushed R1 down the hall in his wheelchair and into his bedroom to assist R1 with incontinence care.

On 03/11/25 at 4:28 PM, E2 asked E7 to begin cooking supper. E7 went to the kitchen and started to put away food boxes from an earlier delivery to clear workspace for the meal. R5 and R10 assisted E7 by opening and breaking down food boxes and taking outside to the dumpster.

On 03/11/25 at 4:36 PM, E2 finished cleaning R7's room and assisting R7 with a shower and dressing in clean clothing. E2 returned to the kitchen to continue unloading food boxes and start supper.

On 03/11/25 at 4:44 PM, E3 started to administer evening medications which were scheduled for 4:00 PM.

On 03/11/25 at 4:48 PM, E2 asked R5 to change the trash. R5 proceeded to pull the trash liner, replace it with a clean liner, and take the trash to the dumpster outside.

On 03/11/25 at 4:53 PM, R12 was heard yelling in the living room. R12 was observed standing

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leaned over R4 and yelling near R4's face. R4 was sitting on a couch near a window. R4 was breaking the wooden slats on the window blinds. R12 was repeatedly telling R4 to "leave it alone" and "you'll get in trouble." R4 continued to break the blinds and throw them on the floor. R12 was visibly upset while he was yelling. R1 and R9 were also sitting in the living room.

On 03/11/25 at 4:56 PM, R12 took a piece of the broken blind into the kitchen to tell E2 that R4 was having a behavior. E2 left the kitchen and came into the living room to address R4's behavior.

On 03/11/25 at 5:07 PM, E2 advises E7 what needs to be done for R7's linen change after her accident while E2 continued cooking the meal. E2 stated they try to eat between 5:00 PM and 5:30 PM.

On 03/11/25 at 5:09 PM, E2 confirmed the menu documented residents were supposed to be served chicken and dumplings for supper. E2 stated there were no dumplings so she "made spaghetti because it was the quickest since I'm here alone." E2 stated that is difficult for one person to cook and do dishes for 14 residents plus putting away the truck items, laundry, etc. E2 was asked if residents participated in active treatment programs. E2 stated there is no time to do programming with one staff.

On 03/11/25 at 5:29 PM, E1 confirmed the facility does not currently have a cook.

On 03/11/25 at 5:59 PM, E3 left the facility, leaving E2 and E7 with 14 residents.

On 03/11/25 at 6:03 PM, E2 was looking for

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spaghetti sauce for the evening meal. E2 asked E7 to go to the store and buy spaghetti sauce as there was none in the facility.

On 03/11/25 at 6:45 PM, supper was served by E2 and E7.

A March Sign Up sheet documents E5, DSP from a sister facility, signed up to work 11:30 PM on 03/11/25 until 9:30 AM on 03/12/25. E5's Timecard Editor documents he punched in at 11:13 PM on 03/11/25 and punched out at 8:55 AM on 03/12/25.

On 03/12/25 at 5:51 AM, E5 was the only employee in the building with 14 residents from 11:13 PM 03/11/25 until 7:05 AM when E3 arrived... E5 stated prior to the shift worked last night, E5 had never been in the facility. E5 stated he had not been trained on or participated in a fire drill at this facility. E5 could not identify where the facility mustering station was located. E5 confirmed he did not have keys to the closet where the medical records including individual service plans or behavior management plans were kept. E5 began preparing lunches for day training.

On 03/12/25 at 5:58 AM, E5 began preparing breakfast.

On 03/12/25 at 6:03 AM, R5 appeared frustrated and looking for his lunch box stating he leaves for a community job at 7:30 AM.

On 03/12/25 at 6:05 AM, E5 stated he didn't know where anything was in the kitchen and stated, "This is ridiculous."

On 03/12/25 at 6:11 AM, R2 was walking in the

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hallway with soap and a towel. R2 stated she wanted a shower but, "didn't get one." R2's Individual Service Plan dated 04/02/24 documents R2 needs assistance with bathing.

On 03/12/25 at 6:17 AM, R8 and R11 were sitting in the living room. R8 stated he doesn't have any money because E1, QIDP, will not sign his checks. R11 stated the last time anyone got to go shopping was around Christmas. R8 stated no one has any money for anything and that they haven't been on a dine-out or shopping for a long time because there isn't enough staff. R8 began talking about R4's behaviors which were described as yelling, hitting, breaking things and running off down the road where staff have to chase R4. R8 also stated that sometimes the facility has supper early but sometimes it's late, depending on how R4 is acting. R8 stated, "I help the staff out a lot because they are short." R8 described helping as, "wash dishes, take trash out, sweep, and washing tables."

On 03/12/25 at 6:39 AM, R3 and R12 were in an altercation in the dining room. E5 came out of the kitchen to stop the behavior. R12 was standing between the table and a wall while R3 was sitting across the table. R12 proceeded to reach across the table and hit R3.

On 03/12/25 at 6:42 AM, R12 began yelling again and hitting the table. E5 returned from the kitchen, calmed R12 down and removed R12 from the dining area.

On 03/12/25 at 6:43 AM, R10 was sitting at the dining room table asking for milk, a bowl and a knife. R10 had cold cereal, sausage and a piece of toast.

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On 03/12/25 at 6:44 AM, R12 was upset and yelling in the living room.

On 03/12/25 at 6:48 AM, R5 was sitting at the table and stated he was waiting on eggs to eat with the other breakfast items.

On 03/12/25 at 6:59 AM, R5 stated, "Eggs take too long to make".

On 03/12/25 at 6:52 AM, R12 came back into the dining room to eat breakfast. R10 apologized for R12 yelling. R5 asked for eggs again. E5 stated he will cook them if he can find them.

On 03/12/25 at 6:55 AM, E5 told R5 he did not see any eggs and offered R12 another bowl of cereal. R5 went into the kitchen to look for eggs but returned with another box of cereal. R5 appeared frustrated and stated, "eggs tomorrow." R10 finished breakfast, picked up a lunch box and offered to help E5 in the kitchen.

On 03/12/25 at 7:00 AM, R2 was visibly upset in the kitchen and asking for breakfast.

On 03/12/25 at 7:04 AM, R2, R5 and R10 were in the kitchen yelling.

On 03/12/25 at 7:05 AM, E3 arrived to help E5, one hour and 14 minutes after observations began.

On 03/12/25 at 7:06 AM, R2 wanted breakfast and was yelling.

On 03/12/25 at 7:16 AM, R5 was upset because he still could not find a lunch box, one hour and thirteen minutes after he was frustrated and heard saying he could not find his lunchbox

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before.

On 03/12/25 at 7:31 AM, the bus arrived to take residents to day training. The bus left without picking up any residents due to them not being ready or having consumed breakfast. R3 was upset residents did not get on the bus. E15, Licensed Practical Nurse, advised R3 that E3 would take them to day training in the facility bus.

On 03/12/25 at 8:05 AM, E3 stated the plan was to take R1, R4 and R13 to a sister facility, R5 to a community job and the rest would go to day training once everyone was ready. E3 explained E16, DSP, was on the schedule but didn't come in. E3 stated there was a backup plan for a DSP from another facility to come in, but that DSP didn't come in either.

On 03/12/25 at 8:15 AM, R14 was sitting outdoors smoking. R14 stated R4's behaviors are a problem and getting worse. R14 stated, "One staff is not enough because they can't handle (R4). What if (R1) tried to get up and fell? No one else can be helped when (R4) is having a behavior." R1's ISP dated 06/10/25 documents he is a 97-year-old man who requires support needs including dressing, medications, bathing, and oral care. On 03/12/25 at 9:03 AM, R1 was being changed in a bathroom due to incontinence. R1 utilizes a manual wheelchair with staff assist.

On 03/12/25 at 8:30 AM, E3 was getting R1 out of bed and dressed.

On 03/12/25 at 8:49 AM, R2 was sitting at the dining room table upset and talking about missing the bus for day training. R2 now refused breakfast stating she's "not hungry because I'm

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Z9999	Continued From page 15 upset". On 03/12/25 at 8:50 AM, E1, QIDP, took R5 to his community job which started at 8:30 AM according to R5's Individual Service Plan dated 11/11/24. On 03/12/25 at 9:11 AM, R8 stated, "We're going to be really late for workshop today, our bus usually comes at 7:30 AM." On 03/12/25 at 9:21 AM, R2 was crying and upset because she misses her friends at workshop and needs a hug. On 03/12/25 at 9:31 AM, R6 was upset about his shirt and hitting a wall in the dining room. On 03/12/25 at 9:42 AM, E3, QIDP, left with residents to take them to workshop. On 03/11/25 at 4:18 PM, E3, confirmed staff worked alone over the past weekend (03/08/25 and 03/09/25) which left the staff to resident ratio 1:14. On 03/11/25 at 5:29 PM, E1, QIDP, stated the facility does not currently have a cook. On 03/11/25 at 5:09 PM, E2 stated that is difficult for one person to cook and do dishes for 14 residents plus putting away the truck items, laundry, etc. On 03/11/25 at 6:13 PM E2, DSP, stated R4's behaviors often require one to one attention and it's not fair to other residents like (R1). E2 stated she works alone more often than not. E2 stated there is no time to run active treatment programs when working alone.	Z9999		

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Z9999	Continued From page 16 On 03/12/25 at 10:50 AM, E4, DSP, stated the facility needs more direct care staff and administration. E4 stated when she works alone, she is responsible for resident's cares, laundry, medication pass, breakfast and lunch along with clean up and dishes and resident safety. E4 stated there is not time to do active treatment programs with residents. E4 stated R4 often requires one to one attention due to her behaviors which include biting, scratching, punching, kicking, spitting, breaking plates, standing on the table, cutting herself and eloping. On 03/12/25 at 1:28 PM, E6 stated she worked alone on 03/08/25 and 03/09/25 during first shift. E6 stated those dates were the past weekend and all residents were home. E6 stated R4's behaviors last weekend included breaking blinds, eloping and spitting. E6 stated it isn't fair to other residents, especially R1 and R6 who require assistance. E6 stated there is no opportunity to complete active treatment programs when there is no other DSP's and no cook. R3's Behavior Programs dated 4/25/24 document behaviors including aggression and self-injurious behavior. R3's Individual Risk Assessment dated 4/4/24 includes, "Medical: Health-related risks; Follow-Up: (R3) has a history of refusing or being uncooperative for medical procedures if (R3) does not understand the purpose. (R3) does not communicate (R3's) pain levels or injuries accurately. Interpersonal and Support Risks: Relationship and service-related risks: (R3) has difficulty understanding communication and is not easily understood by those who do not know (R3). (R3) also struggles with 'stranger' danger	Z9999		

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and should be assisted and accompanied by staff when accessing the community. (R3) does not respond well when being told no."

Facility Incident Report dated 3/20/25 includes, "On the evening of 3/19/25 (R3) slipped in some water (R3) had spilled in the restroom and fell, landing on (R3's) right side. The facility nurse was contacted. (R3) complained of pain in (R3's) right leg and was transported to local hospital for evaluation. (R3) sustained a fracture to (R3's) right hip and was admitted for treatment."

R3's Hospital History and Physical dated 3/19/25 includes, "The patient is a 52 y.o (year old) man w/ (with) hx (history) of impulse control disorder, intellectual disability, anxiety disorder, and obsessive-compulsive disorder who presented to the ED (emergency department) with right hip pain after an unwitnessed fall d/t (due to) slipping on wet floor in the bathroom. (R3) was found to have a displaced right femoral neck fracture. Ortho (Orthopedic) was consulted from the ED and are planning surgical intervention tomorrow 3/20 (3/20/25)."

Facility Staff Schedule for 3/19/25 documents E2 worked from 3:45 pm until 10:00 pm. E17 (DSP) worked from 3:30 pm until 11:30 pm. E13 worked from 11:30 pm until the following morning on 3/20/25.

On 4/4/25 at 2:17 pm, E3 confirmed the facility staff schedule provided for 3/19/25 was accurate.

Z1 (Guardian) email dated 3/21/25 includes, "(Z1) was contacted, by the hospital. The nurse who called was concerned that (R3) arrived at the ER (emergency room) without a staff. When the nurse contacted the facility, he was assured

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someone would be coming to be with (R3). What is the facility policy when an individual goes to the hospital?" E-mail response back from E10 (Administrator) includes, "Normally someone would be with (R3) until (R3) is admitted, however we could not get a staff member to go sit with (R3). It is very hard to find a staff member to sit with individuals on 3rd shift."

On 4/3/25 at 12:31 pm, E2 stated on 3/19/25 R3 was in R3's room. R3 has a behavior of rectal digging and tries to wash R3's hand. E2 heard water and went to R3's room. When E2 opened the door R3 asked for help. R3 was on the bed and couldn't move. E2 noticed water on the bathroom floor and R3 said he (R3) fell. E2 called the nurse and R3 was sent to the hospital. E17 was working at the time but was on break. E2 then stated no staff could go to the hospital with R3 because E2 was close to getting off work and E17 was the only other staff at the facility.

On 4/3/25 at 10:45 am, E11 (Administrator in Training) stated no staff went to the hospital with R3 on 3/19/25 because there was no staff available. E11 confirmed a staff member should have gone with R3.

On 4/3/25 at 11:08 am, Z1 stated a hospital nurse had called the facility requesting a staff member to come to the hospital to be with R3 and the facility had told the nurse they would send someone, but never did. Z1 e-mailed E10 with the concern and E10 told Z1 normally someone would go until an individual is admitted, but the facility couldn't get a staff member, and it is hard to find someone to go on third shift.

Facility Physical Injury and Illness/Individual Medical Emergencies Policy revised 4/24

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Z9999	Continued From page 19 includes, "B. In case of a medical emergency: 6. Ensure that an employee of the agency is with the individual throughout the emergency room visit." (B) Statement of Licensure Violations 3 of 4: 350.1070 Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. These Regulations are not met as evidenced by: Based on observation and interview the facility failed to ensure employees had ongoing training to ensure residents were treated with dignity and respect. This failure has the potential to affect 14 of 14 residents in the facility (R1-R14). On 03/11/25 at 5:29 PM, E1 QIDP (Qualified Intellectual Disability Professional) was in an office when R6 approached the doorway. E1 refused to let R6 into the office and shut the door while he was standing just outside of the doorway. On 03/11/25 at 6:26 PM, E1 was in the kitchen when R6 approached E1. E1 stated to R6, "(R6), I don't have time to mess with you right now." On 03/12/25 at 8:41 AM, E1 arrived at the facility. R4 asked E1 to call her guardian. E1 stated, "Not right now, we're trying to get everybody breakfast and stuff."	Z9999		

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Z9999	Continued From page 20 On 03/12/25 at 3:53 PM, E1 was in an office with the door closed. This surveyor knocked on E1's door and received no response. On 03/12/25 at 3:54 PM, this surveyor knocked on E1's door again. E1 loudly yelled, "I'm on a phone call!" On 03/12/25 at 3:55 PM, this surveyor knocked on E1's office door with no response. On 03/12/25 at 3:56 PM, this surveyor knocked on E1's office door. E1 shouted loudly, "Go away!" On 03/12/25 at 3:56 PM, E3, QIDP noted this surveyor had been waiting several minutes for E1 to answer the door. E3 stated, "She probably thinks you're (R6) asking for a picture." On 03/12/25 at 3:57 PM, this surveyor knocked on E1's office door with no response. On 03/12/25 at 3:59 PM, this surveyor knocked on E1's door. E1 responded loudly, "Nobody's home!" On 03/12/25 at 4:00 PM, this surveyor knocked on E1's door with no response. On 03/12/25 at 4:01 PM, this surveyor knocked on E1's door. E1 partially opened the door and said, "Oh, I thought you left." On 03/11/25 at 3:00 PM, E2 Direct Service Person stated if residents have behaviors, E1 will not help and will typically just shuts the office door. (B)	Z9999		

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Statement of Licensure Violations 4 of 4:
350.620a)
350.1010
350.1020e)1)

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 350.1010 Service Programs

The facility shall provide, either directly or through arrangements with an outside resource, as needed by the individual resident, all resident living services, training and guidance necessary in the activities of daily living and in the development of self-help skills for maximum independence.

Section 350.1020 Psychological Services

e) The facility shall employ sufficient, appropriately qualified staff, and necessary supporting personnel, to carry out the various psychological service activities in accordance with the needs of the following functions:

1) Psychological services to residents including evaluation, consultation, therapy, and program development

These Regulations are not met as evidenced by:

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Based on observation, record review and interview the facility failed to ensure Active Treatment Programs were completed for 3 of 3 (R1-R3) in the sample with the potential to affect the other 11 residents in the facility (R4-R14) when they failed to Implement Active Treatment Programs as developed, review and revise programs based on data documentation, review and revise treatment goals to address individual needs. The facility also failed to ensure an Individual Service Plan (ISP) and a Behavior Management Plan was developed for one of four individuals outside of the sample (R14) reviewed for service plans based off of a comprehensive functional assessment. The facility failed to make Individual Service Plans (ISP) and Behavioral Management Plans (BMP) available to Direct Support Persons (DSP) working in the facility alone. This has the potential to affect 14 of 14 residents living in the facility. (R1-R14)

Observations were made in the facility when residents were present between 3/11/25 from 3:36 PM until 6:45 PM and on 03/12/25 from 5:51 AM until 9:12 AM. No active treatment was observed during medication administration or daily routines throughout the facility.

R1's Programmatic Report for October and November 2024 document R1 has Active Treatment Programs including a self-medication program to be ran and documented daily in the afternoon, budgeting to be ran and documented on Friday evenings, and personal hygiene to be ran and documented daily. R1 has no Programmatic Report to evaluate progress or regression for December 2024, January or February 2025. R1's October and November 2024 Programmatic Reports document "Needs more data. Staff need to document in (a

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computerized charting system) so that we can see if (R1) is making progress toward completing this outcome" for all programs.

R2's Programmatic Report for October and November, 2024 document R2 has Active Treatment Programs including an exercise program to be ran and documented three times per week, an appropriate eating program to be ran daily with each meal, a community program to be ran and documented Tuesday and Thursday evenings, a self-medication program to be ran daily at 7:00 PM medication pass a financial program to be ran and documented on Friday evenings and behavior management program to be followed and documented anytime R2 has a behavior. R2 has no Programmatic Report to evaluate progress or regression for December 2024, January or February 2025. R2's October and November 2024 Programmatic Reports document "Needs more data. Staff need to document in (a computerized charting system) so that we can see if (R2) is making progress toward completing this outcome" for all programs.

R3's Programmatic Report for October and November, 2024 document R3 has Active Treatment Programs including a community orientation program to be ran and documented on Tuesday and Thursday at 4:00-5:00 PM, an appropriate eating program where R3 is to slow his eating pace so that R3 is safe during meals to be ran and documented, a self-medication program to be ran and documented daily at 7:00 AM, a coin identification program to be ran and documented Monday and Wednesday at 3:00 -5:00 PM, an aggression program to be documented daily, a self-injurious behavior program to be as behaviors occur and a water temperature regulation program to be ran and

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documented daily. R3 has no Programmatic Report to evaluate progress or regression for December 2024, January or February 2025. R3's October and November 2024 Programmatic Reports document "Needs more data. Staff need to document in (a computerized charting system) so that we can see if (R3) is making progress toward completing this outcome" for all programs.

On 03/11/25 at 6:13 PM, E2, DSP, stated E2 works alone more often than not. E2 stated there is no time to run active treatment programs when working alone.

A Physician Order Sheet for March 1 through March 31 documents R14 was admitted to the facility on 09/04/24 and has diagnoses which include Cognitive Impairment, Attention Deficit Hyperactivity Disorder and Bipolar Disorder.

R14's Individual Risk Assessment dated 10/15/24 documents he has difficulty with boundaries, being told no and is vulnerable to solicitation. R14 has financial risks including vulnerability to exploitation and incurring excessive charges. R14's community deficits include route planning, navigating streets, using public transportation and approaching strangers. R14 lacks basic first aid skills or safely utilizing appliances. R14 currently displays or has a history of inappropriate sexual behaviors.

R14's Individual Risk Assessment dated 10/15/24 documents under a section titled, "Behavioral": Behaviors of lifestyle choices that are considered dangerous or potentially dangerous to self and/or pose a risk to others." These behaviors are listed as aggression, verbal or physical threats to self, self-injury, history of false allegations and manipulating of others.

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	IL6010474	A. BUILDING: _____ B. WING _____	C 04/07/2025

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GLENWOOD TERRACE-SPRINGFIELD	2724 GLENWOOD AVENUE SPRINGFIELD, IL 62704

(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 On 03/12/25 at 5:51 AM, E5, DSP from a sister facility was in the kitchen preparing resident lunches. On 03/12/25 at 6:08 AM, E5 was knocking on resident doors and waking residents for the day. On 03/12/25 at 10:52 AM, E1, Qualified Intellectual Disability Professional, stated she cannot provide an ISP for R14. E1 stated, "I have five houses and I'm behind." E1 confirmed R14 does not currently have an ISP or active treatment programs. R14 had an undated Support Service Team (SST) Recommendation. This recommendation states the reason for referral includes R14 being verbally aggressing which includes threatening housemates or manipulating others and pressuring them into submission "which is causing a major concern for the rest of the individuals who live in the home." SST provided recommendations include detailed ways to building rapport, coping, identifying emotions, boundaries, communication and positive interactions. The undated SST recommendations conclude with "*This document contains recommendations for teams to choose to implement." And "Any recommendations the team chooses to implement should be integrated into the individual's programming." On 03/12/25 at 10:52 AM, E1, Qualified Intellectual Disability Professional, stated she cannot provide a BMP for R14. E1 stated, "I have five houses and I'm behind." E4, Direct Service Person, stated when she works alone, she is responsible for resident's	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 26 cares, laundry, medication pass, breakfast and lunch along with clean up and dishes and resident safety. E4 stated there is not time to do active treatment programs with residents. E1, Qualified Intellectual Disability Professional confirmed at the time of survey Clinician Reports for R1, R2 and R3 for the months of December 2024 and January/February 2025 had not been completed. E1 confirmed there is no active treatment documentation to monitor for needed changes due to progression or regression for R1, R2 and R3 between October 2024 and February 28, 2025. (B)	Z9999		