Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013957	A. BUILDING: _____ B. WING _____	04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINTON TERRACE	330 LINTON AVENUE WOOD RIVER, IL 62095

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Z 000	COMMENTS ANNUAL LICENSURE SURVEY	Z 000		
Z9999	FINDINGS Statement of Licensure Violation: 350.610a) 350.670f)3) 350.1060a) 350.1086b) 350.1610e) Section 350.610 Management Policies a)The facility's governing body shall exercise general direction of the facility, and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served. Section 350.670 Personnel Policies f)3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. Section 350.1060 Training and Habilitation Services a)The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. Section 350.1086 Unnecessary, Psychotropic,	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 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. (Section 2-106.1(b) of the Act) Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome. Side effects of the medications shall be described. Section 350.1610 Resident Record Requirements e) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. These requirements were not met as evidenced by: Based on observation, record review and interview the facility failed to ensure: 1a) infection control measures were followed, potentially affecting 3 of 3 individuals who are currently residing at the facility (R1, R2, and R4), 1b) the recommended modifications to the diet were provided for 1 of 1 individuals inside the sample (R1), 2) staff were trained efficiently on when to use a gait belt that is ordered as needed, affecting 1	Z9999		

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Z9999	Continued From page 2 individual outside the sample (R4), 3) implementation of the behavior program is followed for 1 of 2 individuals inside the sample with Self Injurious Behavior (R1), 4) complete and accurate guardian consents were obtained for 1 of 2 (R2) in the sample who receive behavior modifying medication, 5) ensure program data was documented accurately for 2 of 2 individuals in the sample of 3 (R1,R2) who requires an active treatment training program. Findings include: The 1/22/21 Individual Service Plan identifies R1 as a 53 year old male who functions within the Profound Range for Individuals with Intellectual Disabilities. R1 has additional diagnosis of Epilepsy, Psychosis NOS (not otherwise specified) due to dementia of mixed origin, legally blind, cerebral palsy, and spastic dysplagia. Review of R2's ISP (Individual Service Plan) of 1/22/21, R2 is a 76 year old ambulatory verbal female who functions in the Profound Range of Intellectual Disabilities. Facility Roster, undated, identifies R3 and R4 as individuals who function within the Profound Range for Individuals with Intellectual Disabilities. 1a) Facility Infection Control Policy and Procedure 5.26 documents, "The Infection Control Committee: 1. Shall be responsible for surveillance of any suspected or known potential infection, the review and analysis of actual infections, the promotion of a preventative and	Z9999		

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Z9999	Continued From page 3 corrective program to minimize infection hazards. Also surveillance and correction of infection potentials." Observation on 4/26/21 at 10:00 am: R1 sitting at dining room table with two plastic bins on table. Observation on 4/26/21 at 11:31 am: R1, R2 and R3 sitting at table for lunch. Staff did not sanitize table before meal. Observation on 4/26/21 at 2:49pm, R1 was observed playing with his container of blocks at the dining room table. R2 was sitting in her recliner in the living room. E5 (DSP) announced it was time for the individuals afternoon snack. E5 was not observed to sanitized the table before she place a cup of liquid and processed cheese snacks next to R1 and R2. R1 and R2 were not prompted to wash hands before the snack. Interview on 4/26/21 at 2:42 pm: E2 (Administrator) was asked if tables are to be washed off before each meal? E2 stated, "Yes." E2 was asked if individuals are to wash their hands before snacks/meals? E2 stated, "Yes." 1b) Facility Food Service Policy 8.02 documents, "1. Seasonal menus will be planned, modified, and reviewed by a qualified dietician at the central office. 2. Medically prescribed diets shall be recorded in the individual's medical record by the QIDP 3. The QIDP shall give the diet order information to the cook/Direct Support Professional (DSP) by completing a Diet Order Form (GP-38). The Diet Order shall have mane of physician and the signature of the QIDP. 7. All diet orders will be followed, as planned or approved by a physician and a qualified dietitian."	Z9999		

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Z9999	Continued From page 4 R1 Nutritional Assessment dated 2/9/21 documents, "Weight: 86 pounds. R1 weight loss noted. Goal: Achieve weight gain over year. Monitor weight, labs and appetite. Diet Order: General Diet with Fortified Whole Milk and 8 oz (ounces) of nutritional supplement." Observation on 4/26/21 at 11:31 am: R1 eating shredded chicken, green beans, applesauce, and pudding. R1 given water to drink. Observation on 4/26/21 at 2:30 pm: R1 given processed cheese snack and tea to drink. Observation on 4/27/21 at 12:01 pm: R1 sitting at dining room table. R1 was eating chopped turkey and cheese, chopped crackers, mixed fruit, and brownie. R1 was given water to drink. Observation on 4/27/21 at 2:30 pm: R1 was given processed cheese snack and tea to drink. Interview on 4/27/21 at 11:03 am: Z1 (Dietician) was asked for clarification on R1's diet order on his Nutritional Assessment that was filled out on 2/9/21. Z1 stated, "R1 is suppose to get milk with each meal and a nutritional supplement daily." Interview on 4/27/21 at 11:08 am: E9 (DSP) was asked if there were any nutritional supplement's at the facility? E9 stated, "No, we use to, we've been out for a couple weeks." E9 was asked if anyone gets a supplement on a routine basis? E9 stated, "R1 does sometimes." E9 was asked if It was on a routine basis? E9 stated, "No, we weren't instructed anything about a routine thing." Interview on 4/27/21 at 11:25 am: E1 (Administrator) was asked who's responsibility is it to ensure the Nutritional Assessment is	Z9999		

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Z9999	Continued From page 5	Z9999		

overseen and the dietary recommendations are followed? E1 stated, "It's the QIDP's responsibility to make sure the dietary recommendations are followed and that it is sent to the doctor."

2) Review of R4's ISP (Individual Support Plan), R4's motor skills are fair due to legal blindness. R4 requires adaptive equipment including a gait belt, a built up spoon and an inner lipid plate with a guard.

Continuous Observation on 4/26/21 from 8:00am-3:50pm, R4 was observed sitting on the couch all and the gait belt was buckled around R4's waist.

At 3:50pm. E7 (Direct Support Person) prompted R4 to stand up by pulling her right arm and R4 walked to the dining by herself. E7 did not assist R4 by holding on to her gait belt.

Observation on 4/27/21 at 6:00am, E8 (DSP) escorted R4 into the dining room but holding her right arm. The gait belt was not observed to be utilized by E8 to assist R4 with ambulation.

Interview with E4 (House Manager) on 4/27/21, E4 stated the facility has not received any specific training on the proper usage of R4's gait belt.

3a) Review of R1 and R2's program objectives: R1 has a self medication program to punch his medication out hand over hand. R2 also has a medication program to punch out her medication with verbal prompts.

Observation on 4/27/21, E8 (DSP) started the medication pass at 6:00am. E8 was to punch R1 and R2's medication from the cards one at a time

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Z9999	Continued From page 6 and hand it to the individual to administer. E8 was not observed to prompt R1 and R2 to punch out their own medication. 3b) The Behavior Program dated 3/1/21 documents, "R1 has been displaying agitation in the form of self-injurious behavior which includes hitting self, and face against objects, pinching self or scratching self or in hitting others, throwing things, pinching others. R1 usually does this when he is frustrated that he cannot do the things he wants to do or has difficulty communicating his wants and needs to others. Adaptive Behavior: When R1 gets agitated and lashes out at himself or others, staff should instruct R1 to stop and redirect him to a quiet area. Programming Methods and Instruction: Staff will provide adequate monitoring of R1's general mood. If staff senses that he is becoming agitated by either his physical activity or vocal patterns they will immediately attempt to interrupt the pattern. Typically, R1 has difficulty switching from one set of requests to a new set. Staff should be aware of these difficult periods and should attempt to make R1 feel comfortable with the request. Staff should always talk to him in a calm voice. If R1 is hitting himself with an object, the object shall be removed until R1 calms down. Staff will need to be aware that R1 will not stop unless the request is made in a steady voice. Do not indicate any emotions, and take adequate precaution with regard to positioning as R1 may hit DSP. Staff are to attempt to redirect him to an appropriate activity but should be aware that this may further the behavior. If R1 persists in his behavior, staff should attempt to remove him to a quiet area such as his bedroom or an unoccupied program area." Observation on 4/26/21 at 10:00 am: R1 sitting at	Z9999		

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Z9999	Continued From page 7 dining room table. R1 hitting himself on top of his head. Z2 (day training staff) standing next to table. No staff intervention done. R1 continued to hit himself on top of his head. E4 (House Manager) walked by, no staff intervention done. Observation on 4/26/21 at 10:03 am: R1 hitting himself on top of the head. E5 (DSP) at the table and stated, "I hate it when he does that." No staff intervention done. Observation on 4/26/21 at 10:07 am: Z2 walking back inside with R1. R1 hitting himself on top of his head five times. No staff intervention done. Observation on 4/26/21 at 10:19 am: R1 sitting at dining room table, hitting himself on top of his head. Z2 standing next to him with no intervention done. R1 stood up, placed his hand on the table and began banging his head on his hand. Z2 standing next to him and no intervention done. Observation on 4/27/21 at 10:42 am: R1 hitting himself on top of his head. Z2 standing next to him. No intervention done. Interview on 4/26/21 at 10:06 am: E5 was asked what are you suppose to do when R1 hits himself? E5 stated, "I'm not sure. I can ask E4." E5 was asked if R1 his himself often? E5 stated, "Yes." Interview on 4/27/21 at 10:42 am: Z2 was asked if R1 hits himself while at workshop? Z2 stated, "Yes." 4) Review of a Physician Order (dated 1/11/21), R2 is to receive Ativan 3mg, 1 and a half hour	Z9999		

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Z9999	Continued From page 8	Z9999		

before her dental appointment on 1/13/21. Review of MAR (Medication Administration Review) Sheet, R2 did receive Ativan 3mg on 1/13/21.

Interview with E2 (Administrator) on 4/26/21, E2 was unable to produce a consent from R2's guardian approving the Ativan.

5a) R2's ISP identifies R2 to have physical aggression and self-injurious behavior. R2 also has a history of tantrum behaviors, rectal digging, urinating on the floor and feces smearing. R2 can be physically aggressive toward others. When these episodes occur, her behaviors include: hitting, biting, kicking and throwing things.

Interview with E2 (Administrator) on 4/26/21 at 10:00am, E2 stated the facility was unable to locate R2's behavior program that addresses her maladaptive behaviors. At this time there is no current Qualified Intellectual Disabilities Professional employed at the facility. E2 was unsure whether a behavior program was implemented for R2.

b) R2 has the following program objectives: To punch out her medication with verbal prompts, exercise for 5 minute with verbal prompts, turn on the cold water handle and feel the cold water with verbal prompts, select 5 wash cloths.

c) R1 has the following program objectives: To punch out his medication with hand over hand, select one poker chip hand over hand.

Review of the program documentation completed by the staff, all the steps of the program are documented. The staff are documenting on steps with starts dates of 11/1/21 and completion dates

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Z9999	Continued From page 9 of 1/31/22. Interview with E7 (Direct Support Person) on 4/26/21, E7 stated "it just a habit to document on all the steps of the program. The client don't like to do the program anyway". "B"	Z9999		