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 IL6002398 08/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1817 CRESENT DRIVE** DAVIES SQUARE **PEKIN, IL 61554** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) Z 000 Z 000 COMMENTS **COMPLAINT SURVEY:** 2226087/IL149710 Z9999 **FINDINGS** Z9999 Statement of licensure Violations: 350.620a) 350,700c) 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. Section 350.700 Incidents and Accidents The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These Regulations were not met as evidenced Attachment A Statement of Licensure Violations Based on observation, record review and

Illinois Department of Public Health

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

TITLE

(X6) DATE

Illinois Department of Public Health

(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	
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		IL6002398	B. WING		08/25/2022	_
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Z9999	Continued From page 1		Z9999			
	interview, the facility failed to:					
	*Follow their abuse and neglect policy for 1 of 1 individual in the sample (R1) who alleged facility staff caused a bruise,  *Report an injury caused by staff to IDPH for 1 of 1 individual in the sample (R1) who had a bruise,					
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		igate an injury for 1 of 1 nple (R1) who presented with aused by staff.				
		e the potential to affect the residing in the facility				
	Findings include:					
	documents, "A. Any who witnesses or s individual rights, pe reasonable suspicioneglect as well as in shall immediately re	rative Committee Revised 4/19 y home employee or agent uspects a violation of er-to-peer incidents, on of a crime, abuse, or njuries of unknown source eport the matter to home the following protocol:				
	reported the emplo directs to one of the *Administrator *Executive Director *Chief Executive O 4. The employee of factual statement re Progress Note prio B. If the allegation committed an act of					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: \_ B. WING IL6002398 08/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1817 CRESENT DRIVE** DAVIES SQUARE **PEKIN, IL 61554** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) Z9999 Continued From page 2 Z9999 such a time as the 1. Investigation is complete and 2. The Administrator considers the report and takes administrative action. C. The home administrator shall report the matter within 2 hours if the event that caused reasonable suspicion resulted in bodily injury to a individual or within 24 hours if the event that cased reasonable suspicion did not result in bodily injury to an individual and send a written report within five (5) working days to the individual's representative and to the Illinois Department of Public Health." ISP/Individual Support Plan dated 5/11/22 identifies R1 as a 57 year old female with diagnoses including Hypertension and Hyperlipidemia who functions at the Moderate Level of Intellectual Disability. R1's ISP documents R1 is independent in many aspects in her daily life. Resident Roster (undated) identifies 12 additional residents residing in the facility (R2-R13). R6. R9. R10. R11 and R13 function at the Mild Level of Intellectual Disability. R2 and R4 function at the Moderate Level of Intellectual Disability. R3, R5. R8 and R12 function at the Severe Level of Intellectual Disability, R7 function at the Profound Level of Intellectual Disability. A General Event Report from day service provider provided by the facility dated 8/1/22 documents, "(R1) came in to (Day Service Provider) this morning saying her staff at home left a bruise on her arm." General Event documents the home staff was identified as E2/DSP (Direct Support Person). The General Event Report also

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notified on 8/1/22 at 9:59 AM.

documents, E1/Executive Director of facility was

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6002398 08/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1817 CRESENT DRIVE DAVIES SQUARE PEKIN, IL 61554** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 3 On 8/4/22 at 12:14 PM, Z1/Day Service Provider Direct Support Person was asked about R1's bruise. Z1 stated, "(I) noticed the bruise on (R1's) arm on Monday (August 1, 2022). (R1) was upset-said staff had grabbed her arm, left a bruise. (R1) said staff named (E2) was helping her off of bus. (R1) is independent and does not need help. (I) told her Case Manager (Z5)." On 8/4/22 at 12:18 PM, R1 is observed to have a bruise on her left forearm measuring approximately 1/2 inch by 1 1/2 inches. The bruise is blue and purple with yellowing around the edges. R1 was asked about the bruise on her left forearm. R1 stated, "I was getting off the bus, going home from work. Staff, (E2) grabbed my arm. (E2) is tall and black hair. She (E2) grabbed my arm. It hurt and it did this (Pointed to bruise on arm). I told her to stop, I didn't need help." R1 was asked where the incident happened. R1 responded, "Getting off the bus at my house." R1 was also asked if she had told anyone. R1 responded, "(I) told (E4/Regional Trainer) and (E5/Regional Manager). I told (E3/DSP) the other day and he was busy so told me to tell (E4)." R1 was asked if she had told E4. R1 responded, "Yes. He said okay." On 8/4/22 at 12:25 PM, R2 stated, "(R1) was getting off bus after work. Staff grabbed her arm. (R1) yelled, 'Stop that. Ouch.' R2 was asked if he saw the staff who grabbed R1's arm. R2 responded, "Yes. (E2)." R2 then asked surveyor if surveyor had seen the bruise and stated, "It was a big bruise." R2 was asked what day the incident happened. R2 responded, "One day last

On 8/4/22 at 2:45 PM, E1/Administrator was

week."

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ C IL6002398 08/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1817 CRESENT DRIVE** DAVIES SQUARE **PEKIN. IL 61554** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **TAG DEFICIENCY**) Z9999 Continued From page 4 Z9999 asked if R1's bruise had been investigated. E1 responded, "No, because day training staff said caused by staff grabbing her arm getting off bus." On 8/4/22 at 3:18 PM, E3/DSP (Direct Support Person) was asked about his knowledge of the bruise on R1's forearm. E3 stated, (R1) got off the bus and pointed to bruise and said (E2-DSP) did it." E3 was asked what date R1 reported the bruise. E3 responded, "August 1 or 2." E3 stated, "I told (R1) to go show (E4/Regional Trainer) because I was helping others off of bus. (R1) went over and I saw her showing (E4) her arm." E3 was asked if he reported the bruise to anyone. E3 responded, "Supposed to call administrator, told (E4) instead." E3 was asked if he filled out a Progress Note. E3 responded, "Assumed (E4) took care of it." On 8/4/22 at 3:18 PM, E3/DSP (Direct Support Person) confirmed he was aware of R1's bruise and was asked if anyone from the facility had asked him about his knowledge of R1's bruise. E3 responded, "No one has asked me about it." On 8/8/22 at 11:36 AM, E2/DSP was asked if anyone from the facility had asked about her knowledge of R1's bruise. E2 responded, "I know nothing about any bruise on individuals. I have not been talked to by anyone about injuries or bruises." On 8/8/22 at 3:42 PM, E3 was asked if R1 had told him when incident occurred. E3 responded, "No. Didn't tell me how or why." On 8/4/22 at 2:45 PM, E1/Administrator was asked if R1's bruise had been reported to

Illinois Department of Public Health STATE FORM

IDPH/Illinois Department of Public Health. E1

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