STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 CERTIFICATION SURVEY-FULL ANNUAL LICENSURE SURVEY	Z 000		
Z9999	FINDINGS #1 Statement of Licensure Violations: 350.1010e) 350.1060a) 350.1060b)2) 350.1060c)2) 350.1060d) 350.1060e) 350.1060f) 350.1060j) 350.3240a) 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. These services shall consist of at a minimum the following: e) Training and Habilitation Services (as defined in Section 350.1060) Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensor motor, and effective development of each	Z9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 1 resident in the facility. b) Each resident shall have individual evaluations which shall: 2) Provide the basis for prescribing an appropriate program of training experiences for the resident. c) There shall be written training and habilitation objectives for each resident that are: 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. f) There shall be a functional training and habilitation record for each resident, maintained by and available to the training and habilitation staff. j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 2 Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure active treatment was provided when the facility failed to: 1) develop an Active Treatment Plan for 3 individuals who are not attending Day Training for 3 of 4 in the sample (R1, R2 and R4). 2) develop program objective for 1 of 4 in the sample (R2). 3) ensure the Qualified Intellectual Disabilities Professional) developed and implemented an active treatment plan for 3 individuals the sample (R1, R2 and R4) and 1 outside (R17) 4) develop a behavior program for 1 individual who was observed exhibiting SIB (Self Injurious Behaviors (R17). 5) ensure programs were implemented for 2 in the sample (R1 and R3) and 1 outside R5 Findings include: The 8/24/21 Individualized Habilitation Plan (IHP) identifies R4 as an individual who functions within the Moderate Range for Individuals with Intellectual Disabilities with diagnosis of Bipolar	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 3 Affective Disorder and Depression. R4 has the following formal programs: -R4 will decrease the number of times R4 is incontinent to 43 incidents or less per month for 3 consecutive months. -With 2 verbal prompts, R4 will scoop bite size portions of food onto spoon, 50% of trials per month for 6 consecutive months. -Using picture board of shapes, R4 will match the triangle with 2 verbal prompts 50% of trials per month for 3 consecutive months. -With 2 verbal prompts, R4 will match a dime when asked to do so by a teacher/trainer 50% of trials per month for 3 consecutive months. -Behavior: R4 will exhibit no more than 5 incidents of agitation leading to physical aggression per month for 6 consecutive months. Review of R1's IHP (Individualized Habilitation Plan) of 11/23/21, R1 is a 61 year old non-ambulatory non-verbal female who functions in the Profound Range of Intellectual Disabilities with Autism Spectrum Disorder, Bi-polar and Manic with psychotic features. R1 has the following formal programs: With 1 or less verbal prompt R1 will scoop up "bite size" portions of food in spoon or fork and place in mouth for 75% of trails per mouth for 3 consecutive months. R1 was observed on 3/7/22 at the lunch meal shoving food in her mouth with no intervention from staff. R1 was also observed at the evening	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 4 meal on that day. R1's plate was placed in front of her with no prompting from staff Interview with E5 (Direct Support Person) in the dining room at 4:45pm, E5 was asked if there any clients in this area on a formal eating program. E5 responded, "I think R7 might be on one to take a drink in between bites." -Behavior program to exhibit no more then 15 episodes of agitation which may lead to SIB (Self-Injurious Behavior), PA (Physical Aggression) and /or PD (Property Destruction) per month. R1 will communicate that she feels an environment is too noisy by screaming and yelling. She may hit herself in the face when she is angry about participating in an activity. R1's interventions include when she displays loud vocalization it is usually due to elevated noise levels or others being loud. Allow me to move to a quiet/less disruptive area with staff until the disruption has stopped. Observation on 3/7/22, R1 was brought into the dining area around 4:30pm along with the other clients, as the noise level increased in the dining room R1 continuously screamed until 4:45pm, when her dinner arrived. Staff was not observed to remove her from the area. -R1 has a money program to identify a penny, identify colors on a picture board and to sleep 6 hours through the night. Observation on 3/7 and 3/8 throughout the day, R1 was observed to be either sitting in front of the television in the activity room on the wing or sleeping in her bed.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 Interview with E3 (Qualified Intellectual Disabilities Professional) on 3/8/22, R1 has been to the Day Training since 3/20. The facility has not developed a specific Active Treatment Schedule throughout the day for the individuals who do not attent day training. Review of R2's IHP (Individualizes Habilitation Plan) of 6/22/21, R2 is a 57 year old non-ambulatory female who functions in the Moderate Range of Intellectual Disabilities with Schizoaffective Disorder, Seizure Disorder, and Bilateral Aspiration Pneumonia. R2 has a history of verbal aggression, socially offensive behaviors, hallucinations, sleep disturbance, depressed mood, manic speech and hyperactive behaviors. R2 has a behavior program to exhibit no more than 10 incidents per month. R2's IHP indicates: R2 is total care in all ADL's All her programming should be done as tolerated. R2 is on comfort care measures and staff should make sure not to make R2 participate in programming if she chooses not to. R2 's health is her priority. There are no formal programs for R2. Interview with E3 on 3/8/22 at 1:10pm, E3 was asked if R2 have any program objectives. E3 stated, "R2 has no classroom program." E3 was asked if there are any intervention in place to assist staff in providing care for R2. E3 stated, "No, staff are to interact with R2 throughout the day." E3 was asked how do you know they are doing this. Is there documentation. E3 responded, "No."	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 6 Review of R3's ISP (Individual Support Plan) dated 12-28-21, documents R3 functions in the Mild Range of Intellectual Disabilities. Review of R3's POS (Physician Order Sheet) dated 3-2022, documents R3 functions in the Mild Range of Intellectual Disabilities. Review of R3's self-medication program dated 3-2022: R3 will obtain the correct medication card with 2 verbal prompts. Observation of the morning medication pass on 3-8-22 at 6:37 AM, E4/LPN (licensed Practical Nurse) was observed to be assisting R3 with his medications. E4 did not informally implement R3's medication program. Review of R3's program data collection sheets to be implemented every Tuesday, Wednesday and Thursday include: Communication-with 3 verbal prompts, R3 will identify and sign letters for 3 consecutive months. Money-with 3 verbal prompts, R3 will indicate the number of dollar bills that are equivalent to a $20 dollar bill for 3 consecutive months. Interview with E3 (Qualified Intellectual Disabilities Professional) on 3/8/22 at 12:35pm, E3 was asked how do you train your staff on individuals formal/behavior programs? E3 replied, "The programs are placed in a binder on the wing and staff are to read the programs." E3 was asked do you complete any training with staff and verification that the staff read the programs? E3 responded, "No." On 3/7/22 at 10:55 am, R4 was sitting in a recliner in the day room off B Wing.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 7 On 3/7/22 at 3:51 pm, R4 was sitting in a recliner in the day room off B Wing. On 3/7/22 at 4:31 pm, R4 was sitting in a recliner in the day room off B Wing. No staff present. On 3/8/22 at 7:32 am, R4 was sitting in a recliner in the day room off B Wing. No staff present. On 3/8/22 at 8:41 am, R4 was sitting in a recliner in the day room off B Wing. On 3/8/22 at 10:14 am, R4 was sitting in a recliner in the day room off B Wing. On 3/8/22 at 12:40 pm, R4 lying in bed. On 3/8/22 at 1:28 pm, R4 lying in bed. On 3/8/22 at 2:30 pm, R4 was sitting in a recliner in the day room off B Wing. No staff present. On 3/8/22 at 3:07 pm, R4 was sitting in a recliner in the day room off B Wing. On 3/9/22 at 8:42 am, R4 was sitting in a recliner in the day room off B Wing. No staff present. On 3/9/22 at 9:53 am, R4 was sitting in a recliner in the day room off B Wing. No staff present. On 3/9/22 at 11:20 am, R4 was sitting in a recliner in the day room off B Wing. No staff present. Observation on 3/7 and 3/8 throughout the day, R1 was observed to be either sitting in front of the television in the activity room on the wing or sleeping in her bed.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 8 Interview with E3 (Qualified Intellectual Disabilities Professional) on 3/8/22, R1 has been to the Day Training since 3/20. The facility has not developed a specific Active Treatment Schedule throughout the day for the individuals who do not attent day training . R2's IHP indicates: R2 is total care in all ADL's All her programming should be done as tolerated. R2 is on comfort care measures and staff should make sure not to make R2 participate in programming if she chooses not to. R2 's health is her priority. There are no formal programs for R2. Interview with E3 on 3/8/22 at 1:10pm, E3 was asked if R2 have any program objectives. E3 stated, "R2 has no classroom program." E3 was asked if there are any intervention in place to assist staff in providing care for R2. E3 stated, "No, staff are to interact with R2 throughout the day." E3 was asked how do you know they are doing this. Is there documentation. E3 responded, "No." Review of E3's (Qualified Intellectual Disabilities Professional) Monthly Notes from 11/21-2/22, "R2 doesn't participate in programming due to decline in mental and physical health. R2 will refuse to do goals and will become agitated if staff continue to bother her." The 30 Day Review dated 8/24/21 identifies R17 as an individual who functions within the Severe Range for Individuals with Intellectual Disabilities. R17 has additional diagnosis of Autism, Hydrocephalus, Bardet-Bardet-Biedl Syndrome, and VP (Ventriculoperitoneal) shunt at birth. On 3/8/22 at 8:22 am, R17 was sitting at the	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 9 dining room table hit herself on the back of the neck three times. Four staff present and no intervention. On 3/8/22 at 8:29 am, R17 was sitting at the dining room table hit herself on the back of the neck two times. Five staff present and no intervention. On 3/8/22 at 8:30 am, R17 was sitting at the dining room table hit herself on the back of the neck. Four staff present and no intervention. On 3/8/22 at 8:34 am, R17 was sitting at the dining room table hit herself on the back of the neck two times. Two staff present and no intervention. On 3/8/22 at 8:35 am, R17 was sitting at the dining room table hit herself on the back of the neck two times. Two staff present and no intervention. On 3/8/22 at 8:37 am, R17 was sitting at the dining room table hit herself on the back of the neck three times. Three staff present and no intervention. On 3/8/22 at 8:38 am, R17 was sitting at the dining room table hit herself on the back of the neck seven times. Two staff present and no intervention. On 3/8/22 at 8:39 am, R17 was sitting at the dining room table hit herself on the back of the neck five times. Six staff present and no intervention. On 3/8/22 at 8:40 am, R17 was sitting at the dining room table hit herself on the back of the	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 10 neck five times and top of head three times. Four staff present and no intervention. On 3/8/22 at 12:35 pm, E3 (Qualified Intellectual Disabilities Professional/QIDP) verified R17 has no behavior program for SIB because she is not on medications. E3 stated, "We don't consider R17 hitting herself SIB because she doesn't cause injuries to herself." Review of R5's POS dated 3-2022, documents R5 functions in the Moderate Range of Intellectual Disabilities. Review of R5's self-medication program dated 3-2022: R5 will state what medications she takes, Insulin to control her Diabetes Mellitus with 2 verbal prompts. Observation of the morning medication pass on 3-8-22 at 6:26 AM, E4/LPN was observed to be assisting R5 with her medications. E4 did not informally implement R5's medication program. (B) #2 Statement of Licensure Violations: 350.620a) 350.1040a)1) 350.1040b)1)4) 350.1210 350.1430e) 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	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 11 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 350.1040 Speech Pathology and Audiology Services a) Speech pathology and audiology services shall be provided to meet the needs of the residents through the following: 1) Direct contact between speech pathologists, audiologists and residents. b) Speech pathology and audiology services available to the facility shall include the following: 1) Screening and evaluation of residents with respect to speech and hearing functions. 4) Provision for procurement, maintenance, and replacement of hearing aids, as specified by a qualified audiologist. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1430 Administration of Medication e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record,	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 12 and the error or reaction shall also be described in an incident report. These Regulations were not met as evidenced by: Based on observation, record review and interview, the facility's nursing staff failed to: 1. Ensure all medication was given and documented without error, affecting 1 individual outside the sample who receives Insulin, (R5). 2. Ensure the physician was notified in a timely manner when a resident received the wrong dose of Insulin affecting 1 individual outside the sample, (R5). 3. Notify the day training service provider when a resident received the wrong dose of Insulin affecting 1 individual outside the sample, (R5). 3. Prepare medication for administration with the individual present affecting 2 of 2 individuals in the sample, (R1, R2) and 7 of 7 individuals outside the sample, (R7, R11, R20, R22, R25, R26, R31), 4. Ensure privacy was provided during medication pass affecting 2 of 2 individuals outside the sample, (R2, R16) and 5. Ensure a follow-up appointment for an otolaryngology recommendation affecting 1 of 1 individuals in the sample, (R3). Findings include: The facility's policy titled, "Insulin Administration" dated 12-18-19, documents in part, "Purpose: To	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 13	Z9999		

safely administer insulin to adult patients, optimize glycemic control, and ensure appropriate documentation of insulin administration. Procedure: Prior to subcutaneous insulin administration, the nurse confirms that there is an appropriate indication. Assesses the patient's most current blood glucose value. Assesses the patient for symptoms of hypoglycemia. Informs the patient of their most current blood glucose level. Informs the patient of their dose, the full name of the product, and the insulin's intended action. Documentation: Record blood glucose result and insulin dosage. Record exact time insulin administered and location of administration site on the medication administration record."

The facility's policy titled, "Administration of Medication" dated 6-2-17, documents in part, "2. Medications will be administered as soon as possible after doses are prepared at the facility..."

The facility's policy titled, "Medication Errors" dated 11-7-07, documents in part, "Policy: Significant medication errors and adverse drug reactions are assessed, documented, and reported to the resident's attending physician, the pharmacy. Definition: The administration of medication other than as prescribed resulting in the wrong medication being taken, or medication being taken at the wrong time, or in the wrong dosage, or via the wrong route, or by the wrong person, or omitted entirely. It is meant to include a lack of documentation of medication administration or any error in that documentation. In the event a medication error, the nurse on duty will immediately report the error to the Director of Nurses (DON) to receive direction on any action to be taken.
Medication errors and drug reactions shall be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 14 immediately reported to the individual's physician, licensed prescriber if other than a physician, the consulting pharmacist/dispensing pharmacist. Adverse drug reaction: An undesirable or unintended harmful effect occurring as a result of a medication. Significant: Medication errors and adverse drug reactions that: Require discontinuing a medication or modifying the dose, Require hospitalization, Result in disability, Require treatment with a prescription medication, Result in cognitive deterioration or impairment, Are life threatening, Result in death." Review of R5's POS (Physician Order Sheet) dated 3-2022, documents R5 functions in the Moderate Range of Intellectual Disabilities with additional diagnoses of Diabetes Mellitus Type 2 (Insulin Dependent), Hyperglycemia and History of Chronic Pain/Muscle weakness/Difficulty Walking. Review of R5's POS, documents R5 receives Insulin Lispro 100units/ml (milliliters) per sliding scale at 7:00 AM as followed: 61-150=0 units; 151-200=4 units; 201-250=6 units; 251-300=8 units; 301-350=12 units; 351-400=16 units; 400 and above= 20 units and notify the MD (Medical Doctor). Further review of R5's POS documents R5 also receives a fixed dose of Insulin Lispro 100units/ml: Inject 4 units subcutaneously 3 times daily before meals, chart site. Observation on 3-8-22 at 6:26 AM-6:30 AM: E4/LPN (Licensed Practical Nurse) obtained a blood glucose reading from R5, which was 285. E4 then began to prepare R5's Insulin vial to be drawn from by a syringe. E4 then withdrew Insulin from the vial with the syringe to the 24 unit mark.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 15 As E4 prepared to administer R5's Insulin dose, surveyor reviewed the label on the Insulin vial box, which read: Insulin Lispro sub-q 3x/daily before meals, per ss (sliding scale): 61-150=0 units; 151-200=4 units; 201-250=6 units; 251-300=8 units; 301-350=12 units. Just beneath these instructions, a portion of the label was removed. E4 was then informed R5's Insulin label documents to administer 8 units and the syringe contained 24 units. E4 then stated, "Yes, but she is on a sliding scale." E4 was then asked are you sure? E4 then stated, "Yes." E4 then administered 24 units to the left side of R5's abdomen. Interview with E2/DON on 3-8-22 between 10:15 AM-10:26 AM: E2 was informed that E4/LPN administered 24 units of Insulin to R5. E2 stated, "R5 is on a sliding scale" and further stated she would have to review R5's orders. Review of R5's 3-2022 MAR at 10:28 AM for 3-8-22, E4/LPN documented her initials for the 7:00 AM time slot for R5's sliding scale Insulin and for R5's 4 units of Insulin. The box to document the amount of Insulin administered and the site of injection were left blank. Further review of R5's MAR from 3-1-22 through 3-7-22, has only staff initials and does not document amount of Insulin administered or the site of injection. On 3/8/22 at 10:40 am, R5 was sitting at the table at day training. Z1 (Day Training LPN) was standing next to R5 and stated, "At 10:25 am The staff noticed R5 acting different and contacted me. R5 was exhibiting signs of low blood sugar so I checked her blood sugar and it was 49. I gave R5 glucose gel and a glass of orange juice. I just rechecked it and it is 65. I'm going to recheck her blood sugar in a little bit." Z1 was	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 16 asked if the faility had notified her regarding anything about R5. Z1 stated, "No." On 3/8/22 at 10:48 am, Z1 was asked if R5's blood sugar drops often. Z1 stated, "It happens 1-2 times a month." On 3/8/22 at 10:50 am, Z1 rechecked R5's blood sugar and blood sugar was 68. Z1 gave R5 a glass of orange juice. On 3/8/22 at 10:58 am, Z2 (Day Training Executive Director) was asked if the facility had notified her anything regarding R5. Z2 stated, "No, but if it's a nursing issue they would have spoke to the nurse." Interview with E2/DON on 3-8-22 at 10:41 AM: E2 was informed of R5's blood glucose of 49 that was obtained at the day training service provider location. E2 stated, "This is her normal, she bottoms out all the time." E2 was asked if the day training service provider was notified of R5 receiving 24 units of Insulin from the morning medication pass? E2 stated, "I'm just finding out about R5's blood glucose and I was not aware of her receiving too much Insulin until now." E2 was then asked if R5's physician was aware R5 received 24 units of Insulin? E2 stated, "I am notifying him now." R1's POS dated 3-2022, documents R1 functions in the Profound Range of Intellectual Disabilities. R1's POS documents R1 receives Clearlax powder 17 grams at 7:00 AM. R2's POS dated 3-2022, documents R2 functions in the Moderate Range of Intellectual Disabilities. R2's POS documents R2 receives Valproic Acid 250mg (milligrams)/5ml (15ml) at 7:00 AM.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 17 R7's POS dated 3-2022, documents R7 functions in the Moderate Range of Intellectual Disabilities. R7's POS documents R7 receives Polyethylene Glycol powder 17 grams at 7:00 AM. R11's POS dated 3-2022, documents R11 functions in the Mild Range of Intellectual Disabilities. R11's POS documents R11 receives Polyethylene Glycol powder 17 grams at 7:00 AM. R20's POS dated 3-2022, documents R20 functions in the Profound Range of Intellectual Disabilities. R20's POS documents R20 receives Clearlax powder 17 grams at 7:00 AM. R22's POS dated 3-2022, documents R22 functions in the Severe Range of Intellectual Disabilities. R22's POS documents R22 receives Polyethylene Glycol powder 17 grams at 7:00 AM. R25's POS dated 3-2022, documents R25 functions in the Severe Range of Intellectual Disabilities. R25's POS documents R25 receives Potassium Chloride 20 mEq (milliequivalent) packet at 7:00 AM. R26's POS dated 3-2022, documents R26 functions in the Severe Range of Intellectual Disabilities. R26's POS documents R26 receives Clearlax powder 17 grams at 7:00 AM. R31's POS dated 3-2022, documents R31 functions in the Profound Range of Intellectual Disabilities. R31's POS documents R31 receives Polyethylene Glycol powder 17 grams at 7:00 AM. Observation on 3-8-22 at 6:19 AM: Surveyor entered the medication room with E4/LPN who was awaiting residents to enter the med room for	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 18	Z9999		

their morning medication. Resting on a wall shelf were 9 cups, each of them liquid filled with resident names wrote on each cup, those include: R1, R2, R7, R11, R20, R22, R25, R26, R31. E4 was asked what are these cups? E4 stated, "I have prepared meds for some of the residents. R1, R7, R11, R20, R22, R26 and R31 get Clearlax, R2 gets her Valproic Acid and R25 gets his Potassium."

Observation on 3-8-22 at 6:50 AM: E4/LPN was assisting R2 with her morning medication which included administering to R2 the premixed medication cup of the resident's Valproic Acid that was observed to be sitting on top of the wall shelf. In the same observation, E4 was assisting R2 with her Docusate Sodium Liquid. E4 was observed to pour 15ml of the medication in a medication cup and administer it to R2.

3a. Observation on 3-8-22 at 6:50 AM: E4/LPN was assisting R2 with her morning medications. During R2's medication pass, residents R11 and R16 were observed to be standing behind R2. E4 was not observed to redirect R11 or R16 away from the medication room area to ensure privacy for R2.

Review of R16's POS dated 3-2022, documents R16 functions in the Severe Range of Intellectual Disabilities.

Observation on 3-8-22 at 6:54 AM: E4/LPN was assisting R16 with her morning medications. During R16's medication pass, Resident R11 was observed to be standing behind R16. E4 was not observed to redirect R11 away from the medication room area to ensure privacy for R16.

R16's received the following medications by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 19 mouth at the 7:00 AM medication pass on 3-8-22: Hydrochlorothiazide 25mg (milligrams) 1 tablet, Loratadine 10mg 1 tablet, Potassium Chloride ER (extended release) 20 mEq (milliequivalent) 1 tablet, Buspirone HCL (Hydrochloride) 30mg 1 tablet, Glipizide 10mg 2 tablets, Metformin HCL 1,000mg 1 tablet, Lorazepam 1mg 1 tablet, Acetazolamide 250mg 1 tablet. During the same observation of the medication pass on 3-8-22, E4/LPN administered to R16 all of her medication except for the following: Atropine 1% drops 1 drop both eyes, Prednisolone 1% 1 drop both eyes, Brimonidine 0.2% 1 drop both eyes (wait 10 minutes between Brimonidine and Timolol), Timolol 0.5% 1 drop both eyes. Interview with E2/DON (Director of Nursing) on 3-8-22 at 10:26 AM, E2 confirmed privacy should be provided to residents during med pass. Review of R3's POS dated 3-2022, documents R3 functions in the Mild Range of Intellectual Disabilities. Review of R3's audiology consult report dated 6-23-21, documents R3 was evaluated for as a potential candidate for a cochlear implant. Further review of R3's report documents a recommendation for R3 to follow-up with the provider after a 30 day hearing aid trial. Interview with E2/DON on 3-8-22 at 3:42 PM: E2 was asked if R3 had a follow-up consult with the audiologist per the recommendation? E2 confirmed R3 has not followed up with his provider since the 6-23-21 appointment.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006472	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

(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 20 (B)	Z9999		