STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

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Z 000	COMMENTS Complaint Investigations: 1690989 / IL83573 & 1690994 / IL83580	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.760a) 350.760c)7) 350.1210 350.3240a) 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 350.760 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Depending on the services provided by the facility, each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as applicable (see Section 350.340): 7) Guidelines for Infection Control in Health Care Personnel Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. 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 followed as evidenced by: Per observation, record review and interview, nursing services failed to provide 78 of 78 clients(R1-R78) the necessary healthcare monitoring, preventative services and treatment services required to contain and control an outbreak of Scabies, when:	Z9999		

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Z9999	Continued From page 2 * Nursing services failed to develop and implement a protocol regarding communicable diseases and infections in accordance with IDPH and CDC requirements; * Nursing services failed to document and demonstrate that all staff having contact with infected individuals have been trained and monitored in the performance of standard infection control techniques; *Nursing services failed to ensure universal and contact isolation techniques were consistently implemented by staff; *Nursing services failed to implement a method to inform all clients, staff and visitors of a current communicable infectious disease (Scabies); *Nursing services failed to ensure clients diagnosed with Scabies are prevented from entering the common areas of the facility, including the dining room; *The Director of Nursing(E2) and Acting Administrator (E1) were unclear what preventative and treatment measures were required. The facility Medical Director was not initially available for consultation; *Nursing services failed to provide effective training to staff, to ensure all staff are aware of which clients presented with Scabies, and what isolation techniques are required; *Administrative and direct care staff provided varying and contradictory information regarding the implementation of isolation techniques and procedures.	Z9999		

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Z9999	Continued From page 3	Z9999		

Findings include:

According to the Annals of Long-Term Care, dated April 22, 2009, scabies is defined as a parasitic disease infestation of the skin that can infect residents of long-term care facilities. To prevent outbreaks, facilities should develop a written scabies outbreak control plan;train healthcare workers to recognize, document, and report resident's skin at the time of admission, and frequently thereafter, implement barrier precautions for residents with suspicious rashes or symptoms, and treat cases and their contacts with an effective scabicide. Transmission of the scabies mite is from person to person direct contact with the skin of the infested person. Atypical or crusted scabies may also be transmitted by wearing an infested person's clothing. Activities such as performing physical assessments and bathing are conducive to transmission because physical contact is often prolonged. Transmission may also occur between residents during social or recreational activities. Residents with atypical or crusted scabies can shed an estimated 7000 live mites into the environment every two days, increasing the risk of transmission from an environmental source.

Facilities should develop and periodically revise a written outbreak control plan. Healthcare workers should be trained to perform skin assessments on admission and periodically, and document and report verbal symptoms and visual changes in the condition of the skin. Until a diagnosis of scabies is ruled out, appropriate barriers including gowns and gloves to prevent transmission should be

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Z9999	Continued From page 4	Z9999		

implemented. The Centers for Disease Control and Prevention(CDC) currently recommend precautions until 24 hours after initiation of effective therapy. However, current treatment recommendations for atypical or crusted scabies may require several treatments, and severely infested residents may not be rendered non-contagious for several weeks. Therefore, residents with crusted scabies should be placed on contact precautions in a single-bed room until at least three consecutive skin scrapings are negative and symptoms have resolved. Precautions for recently exposed symptomatic residents and their contact should include gowns and gloves during treatment period. Personal clothes, wheelchair pads, pillows, and blankets can be either washed, sealed in a plastic bag for 5-7 days, placed in a hot dryer, or dry-cleaned. Environmental surfaces including wheelchairs, walkers, bed frames, tables, chairs, blood pressure cuffs, walking belts and other equipment should be cleaned and disinfected with an Environmental Protection Agency registered product approved for use in healthcare facilities.

The most common source of scabies outbreak is the resident who is undiagnosed and untreated. If not recognized promptly, within 3-6 weeks, new complaints of symptoms(rash, itching) are likely to occur sporadically throughout the facility in residents, healthcare workers, and staff including housekeepers, laundry personnel, administrative staff, visitors and volunteers. Permethrin 5% cream when applied as directed is approximately 90% effective. Currently the CDC recommends either Permethrin cream or Ivermectin cream. A second dose of either increases the cure rate to 95%.

A quick table quide for Contact prophylaxis is

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Z9999	Continued From page 5 defined as the following: - Place resident with suspicious skin lesions or symptoms in contact precautions(private room, gowns, and gloves). - Perform skin scrapings and if positive, obtain an order for scabicide. - Identify and treat within the same 24-48 hour period all potentially exposed residents and staff. - Maintain contact precautions until repeat skin scrapings, if performed, are negative and/or skin lesions and symptoms have resolved following treatment, or another diagnosis is confirmed. - Assess both exposed and unexposed residents, staff and visitors for new onset of skin lesions or symptoms at least 2 times per week for 6-8 weeks. E1 (Acting Administrator) was interviewed on 2/23/16 at 12:45pm. During this interview, E1 was asked if they currently have any clients who have a communicable disease. E1 stated that R1 and R10 are the two clients who are isolation for Scabies. E1 stated that 3 other individuals are being treated for suspected Scabies(R4,R8,R9), and until they can be seen, they are being treated as though they have Scabies. E1 stated that R1 and R8 are roommates, but R8 has not been officially diagnosed. E1 stated that they are planning on treating the whole facility, clients as well as staff. E1 stated that they became aware of the two confirmed cases on Monday night, 2/22/16 around 7 or 8pm. E1 stated that they do not have any internal policies regarding Scabies. E1 stated that E2(Director of Nursing) had a quick meeting last night, 2/22/16, and the staff that were working were made aware. E1 stated that all of the staff should be aware by now, because the day shift coming into work today was in-serviced.	Z9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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Z9999	Continued From page 6 During an environmental tour conducted on the same date, at approximately this same time, no signs or isolation carts, indicating contact isolation measures have been implemented for the above individuals, were observed. No signs were posted; no gowns or gloves were placed outside of the above mentioned clients rooms. During an interview with E2 on 2/23/16 at 2:30pm, E2 was asked if any of the above clients were in contact isolation for Scabies. E2 explained that on 2/22/16, both R10 and R1 had dermatology appointments. E2 stated that she was made aware that both clients had Scabies at approximately 2-3pm on 2/22/16. E2 explained that she is not sure if either of the two clients went out for a consult, or follow up. E2 stated that when she was made aware, she discussed it with the PM shift verbally that staff should wear gloves and gowns whenever they were to render personal close up care, when they would have the potential to have skin to skin contact. E2 stated that wearing just gloves would be the standard of care, so she would say these clients are in contact isolation. E2 stated that she followed that CDC guidelines, and that once the clients are treated, they are "good to go". E2 stated that they had an outbreak in December of 2014, and it came back in January, so they have had Scabies in their facility before. During this same interview, E1, who was also present, stated that he called a company to obtain all the appropriate garbage receptacles for each room, but that there was a miscommunication, and confirmed that to date, they do not have garbage cans in each isolation room that have red bags. E2 stated that she just told staff to carry their dirty gowns and gloves in a plastic bag and place it in the general trash. E1 was asked why there were	Z9999		

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Z9999	Continued From page 7	Z9999		

no isolation carts or signage outside of the isolated clients' rooms. E1 stated that if they put signs up or carts out, they have one resident here, R6, who would tear the signs down, and knock over the isolation carts, so that is why the gloves and gowns are not placed outside of their rooms, in the hallway.

During a second interview with E2 on 2/24/16 at 9:30am, E2 stated that they are still trying to obtain enough medication for all of the clients who reside in the facility, as well as staff, and the majority of the stock should arrive today. E2 stated that she will try to medicate all of the clients, and 50-60% of the staff. E2 stated that she realizes that she needs to treat everyone at once, and will probably start tomorrow(2/25/16). During a follow up interview with E2 on 2/25/15 at approximately 12:00pm, she confirmed that the remaining 73 clients and staff still have not been medicated preventatively, but that she plans on starting today around 1:00-1:30pm today.

1) R8's medical chart was reviewed. The Dermatology consult for R8 dated 1/12/16 was reviewed. The Impression/Plan states that R8 has linear burrows on his right hand, and a Scabies prep was performed on the right hand, which shows stool. R8 was prescribed Ivermectin for 1 dose, and to repeat again in 1 week, with a follow up to be scheduled in one month. The plan states that Scabies is an infestation of mites that is very contagious. Household contacts should be treated, and contaminated clothing should be isolated x 72 hours and washed and dried on high heat. This case of Scabies was not reported to IDPH upon entry into the facility.

During an interview with E2 on 2/25/16 at 9:30am, E2 was asked if R8 was placed in isolation in

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Z9999	Continued From page 8	Z9999		

January for a Diagnosed case of Scabies. E2 was made aware that this information was not presented to Public Health upon entering for this survey process. E2 stated that it was more of a preventative measure, because she was told that it was probably just the shedding, and not a new active case of Scabies. E2 stated that because she was told it was not active, they did not place R8 in isolation, did not wash his clothing separately, and for this reason, was not reported to Public Health. E2 was asked if R1 was R8's roommate at the time. E2 stated that they were and still are roommates. E2 confirmed that currently, R1 is being treated for Scabies, and R8 is going to see the physician as it is suspected that he has Scabies again. E2 stated that they just did not feel this was a case of Scabies. E2 was asked if R8 ever had his follow up appointment with the Dermatologist, Z1, in one month, as was ordered. E2 stated that E11(Assistant Director of Nursing) first made the appointment for R8 on 2/16/16, and is to be seen on 3/1/16., and therefore, is late for his follow up appointment.

During a phone interview with Z2 (RN at Z1's office) on 2/25/16 at 12:26pm, Z2 was asked if R8 was treated for Scabies on 1/12/16. Z2 confirmed that R8 was treated for Scabies, and should have been on Contact precautions while he was treated, by staff wearing gloves when they were in his room. Z2 stated that the facility is behind making an appointment to see R8 for his follow up. Z2 stated he should have been seen on 2/12/16, but has not yet been seen for his follow up. Z2 stated that she saw R8's roommate, R1, who is now positive for Scabies. Z2 stated that R8 and R1 could be bouncing the Scabies back and forth to each other. Z2 stated that R8's clothing should have been washed

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BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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Z9999	Continued From page 9	Z9999		

separately for the first 24 hours, back on 1/12/16. Z2 stated that R8 will now be seen this upcoming Tuesday, and that R8 should remain in contact precautions until he is seen on Tuesday, 3/1/16, as he now has a new rash, and the facility is suspecting that R8 could possibly have Scabies again.

2) R1's medical chart was reviewed. Nursing notes documentation states for the entry of 2/17/16, R1 was seen by his primary care physician on 2/17/16, and was assessed and noted to have dry skin to his arms/hands and elbows, and to follow up with Dermatology. An appointment is scheduled for 2/22/16. On 2/22/16, the entry at 10:15am states R1 went to his Dermatology appointment with staff via a medicar, and returned at 12:50pm. Orders were not faxed over to the facility until 5:00pm that evening, with the Diagnosis of Scabies, and to be treated with oral Ivermectin x one dose, with a repeated dose in one week. At 10:00pm, the nursing entry reads that R1 received his oral Ivermectin. There is no mention in the chart stating that R1 was placed on Contact Isolation/Precautions. The Dermatology Report for R1 dated 2/22/16 was reviewed. This report states that R1 is positive for Scabies that have scabetic nodules and linear burrows on his left hand. R1 is to be treated with oral Ivermectin, and to repeat in one week. R1 is to follow up in one month, and it is suggested that R1's roommate, R8 should be treated for Scabies as a precaution.

R1 was observed in his bedroom on 2/23/16. R1's bedroom door was closed, but there was no sign placed out on his door, indicating he was in isolation, nor was any personal protective equipment, such as gloves and gowns placed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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Z9999	Continued From page 10 outside of his door for staff to use. During an interview with E2 on 2/23/16 at 2:30pm, E2 explained that R1 had a doctor's appointment to see the Dermatologist on 2/22/16. E2 stated that she was not really sure why R1 was being seen, if it was a follow up, if he had a rash, she is not really sure. When R1 came back, he was diagnosed with Scabies, but the physician only ordered an oral treatment, not a lotion for treatment like was ordered for R10 for his Scabies. I have been trying to contact him, but they have not called me back, so for now, all he has received for treatment is oral medication (Ivermectin). E2 speculated that maybe R1's case is not as severe. E2 was asked if R1 should be in isolation. E1, who was also present for the interview, stated that R1 is not in contact isolation. E2 stated that personally, she thinks R1 should be in isolation, and that staff should use gloves and gowns to enter his room. E2 explained that she thought that once they receive treatment, they are good to go, but personally, to be most prudent, they should be in isolation for at least 24 hours. E2 confirmed that so far, R1 has not received the Elemite lotion. E2 stated that she has in-serviced all of the staff verbally on who has Scabies, who should be in isolation, and what staff should do. E2 stated that she in-serviced the department heads, and they went back and in-serviced their own individual staff. During a telephone interview with Z2 on 2/25/16 at 12:26pm, Z2 stated that R1 should be in contact precautions. Z2 stated that R1 does need to be treated with both oral Ivermectin, and topical Elemite. The following staff interviews were conducted to determine if staff understood who was in	Z9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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Z9999	Continued From page 11 isolation, and what precautions should be implemented: During an interview with E13 (Direct Care Staff) on 2/23/16 at 1:30pm, E4 was asked if she knew who was currently in isolation, and for what communicable disease. E4 stated that both R1 and R10 had Scabies. E4 stated that the nurse put cream on them she thinks, and we should change our gloves and wear personal equipment. E4 stated that they try to keep both clients in their room, but sometimes R10 doesn't listen, and leaves his room. We just direct him back into his room then. E4 was asked if there is a garbage receptacle in R1's or R10's room. E4 stated there was not, and she has been taught that you just place the gloves and gown in a plastic bag, carry it down the hall, and place it in the large trash can. E4 stated that they do not place the trash in a red garbage bag, they do not double bag the trash or linen of the above individuals, and they do not launder or keep the isolated clients' trash in a separate container. E4 was asked what type of in-service she received. E4 stated that it was not a formal meeting, nor did she sign anything, saying she attended. E4 stated that she feels pretty comfortable about the isolation. She would say that R1 should be in universal precautions, and contact isolation. During an interview with E4 (Qualified Intellectual Disability Professional) on 2/23/16 at 1:35pm, E4 was asked if she can tell me who the individuals are that are in isolation and for what communicable disease. E4 stated that she can only speak for R1 right now, but if I needed to know what other individuals might be in isolation, I would need to consult nursing for that. E4 stated that she was told in a meeting that R1 was formally diagnosed with Scabies, and that a few	Z9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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Z9999	Continued From page 12	Z9999		

others may have Scabies, but are not formally diagnosed. E4 stated that she thinks the others who are not formally diagnosed are R4, R9, R10 and R8. E2 was who informed E4. E4 stated that if they are going to come in direct contact with R1 she should wear gloves, but if its someone else, she should use universal precautions. E4 stated that the gloves and gowns go in the general trash bag. E4 stated that there is no special container for R1's trash to be placed into. The laundry staff will need to tell me how they wash R1's bed linen. She just lets them know that the linen she brings in is in the laundry room. E4 stated that she will need to be treated too, but she is still waiting to receive medication for herself.

During an interview with E12 (Housekeeping Supervisor) on 2/23/16 at 1:45pm, E4 stated that she was told that R1, R4, R8, R9 and R10 are the individuals with Scabies. E4 stated that they stripped all of the linen from everyone's bed. E4 stated that when they cleaned the individuals rooms of the above clients, they put the gloves and gowns that they wore in a plastic clear bag, and carried them out of the room, and placed them in the trash. E4 confirmed that neither the linen or trash was red bagged. E4 stated that she is not sure if they have isolation carts. E4 stated that she does not think they have red bags. E4 stated that this is a new thing for them (Scabies), and they are not really sure what to do.

During an interview with E10 (Medical Director) on 2/24/16 at 12:00pm, E10 was asked what type of isolation should be implemented for the confirmed and suspected cases of Scabies. E10 stated that they try to do the best that they can do. Nobody really knows this stuff. E10 stated that if he could isolate these clients, he would, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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		

it is hard to keep the individuals in their rooms. E10 stated that they have had Scabies at this facility in the past, and they had a very hard time eradicating it. E10 stated that he really is not a Scabies expert.

3) R10's medical record was reviewed. On 2/22/16, R10 was examined by Z1 (Dermatologist) for a follow up visit due to past diagnosis of Eczema on 9/15/15.
Z1 documented that an examination of the head (including face), neck, chest, abdomen, back, right and left upper extremities was performed.
Z1 diagnosed R10 with Norwegian Crusted Scabies - Erythematous eczematous patches with hyperkeratosis and crusting on the left hand.
Z1 documented a Scabies prep was performed on the left hand, showing mites.
Z1 ordered Permethrin cream 5% topical cream and oral Ivermectin for Week 1. Week 2 topical Permethrin cream. Week 3 topical Permethrin cream and oral Ivermectin.
Z1 also ordered Triamcinolone acetonide 0.1% topical cream to be applied twice daily to itchy areas as directed. A follow up appointment should occur in 3 weeks.

On 2/23/16 at 12:21pm, R10 was observed crawling out of his bedroom into the hallway. E5 (QIDP - Qualified Intellectual Disability Professional) was present when R10 crawled out of his bedroom and repeatedly asked R10 to go back into his bedroom to have his brief changed. R10 stood up and walked further down the hallway towards the facility's Great Room. R10 was observed standing in the hallway touching the walls. R10's pants fell down to his ankles, R10 as observed, was not wearing underwear. At 12:23pm, E5 assisted R10 back into his bedroom. E5 was not wearing a gown and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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	Z9999		

holding disposable gloves in his hand. E5 was not wearing the gloves.
E5 was asked why he was not wearing a gown (for contact isolation) and E5 stated that he could not wear a gown in the hallway. E5 also verified that he was not wearing the disposable gloves.
At approximately 12:25pm, E5 exited R10's bedroom and held the disposable gloves in one hand.
E5 was asked about the disposable gloves and why they were not disposed of in R10's bedroom. E5 stated, "I don't know what to do."
R10's bedroom door was open and there was no container for disposal of the gloves in R10's bedroom.

E6 (Lead Staff) was observed in the hallway by R10's bedroom on 2/23/16 at 12:27pm. E6 was asked if R10 was in Isolation or if any precautionary measures were in place due to R10's diagnosis of Scabies.
E6 stated that R10 was not in Isolation and that he could be in the common areas with his peers.

On 2/23/16 at 1:35pm, the door to R10's bedroom was observed to be closed. At 1:36pm, E11 (ADON) was observed to enter R10's bedroom wearing a disposable gown and disposable gloves. At the same time, E5 stated that he was also in R10's bedroom wearing a disposable gown and disposable gloves. E11 exited R10's bedroom at approximately 1:37pm and then re-entered R10's bedroom and was not wearing a disposable gown or gloves. E11 stated there was no container in R10's bedroom to dispose of the gown and gloves.

E2 (DON) and E1 (Administrator) were interviewed on 2/23/16 at 2:35pm. E2 and E1 were asked when the facility was notified that R10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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	Z9999		

was diagnosed with Scabies.
E2 stated that R10 had a Dermatology appointment on 2/22/16 and after the appointment R10's mother notified the facility that R10 was diagnosed with Scabies. E2 stated that R10's mother notified the facility on 2/22/16 around 2 or 3pm.
E2 stated she told staff that R10 should be in Contact Isolation and that yellow disposable gowns should be worn when providing close up skin to skin contact. Disposable gloves should also be worn for all personal care.
E2 stated that she talked to Pharmacy staff and was told that once R10 receives his first treatment he is good to go. E2 explained that meant after R10 receives his first treatment then he no longer needs Contact Isolation.
E2 stated that R10 received his first treatment of medication around 10pm on 2/22/16. E2 was asked if R10 was in Contact Isolation as soon as he returned from his Dermatology appointment where he was diagnosed with Norwegian Scabies. E2 stated that R10 was not immediately placed on Contact Isolation and he was out of his bedroom and in common areas. E2 stated, "What can I tell you?"
E2 stated, "How can I tell staff to keep R10 in his room when I know they can't"
E2 was asked why there were no supplies for Contact Isolation (gowns, gloves, bags, cart...) available outside of R10's bedroom. E2 stated because R6 would knock over any cart.

E6 (Lead Staff) was interviewed 2/23/16 at 1:36pm. E6 was asked what measure are in place for R10 due to his diagnosis of Scabies. E6 stated that R10 is in Isolation to a certain extent. E6 stated that R10 should be kept as close to his bedroom as possible. E6 stated that they (facility) don't want to put too many restrictions on R10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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	Z9999		

E6 stated that staff should stay with R10 "so he's not maliciously touching anything."

E10 (Medical Director) and E2 (DON) were interviewed on 2/24/16 at 12noon. E10 was asked what precautions (e.g. Isolation) should be in place when a client is diagnosed with Scabies. E10 stated, "I'd like to isolate. You do the best you can." E10 explained that it is difficult to have a client in Contact Isolation.
E10 was asked how long R10 would require Contact Isolation due to Scabies. E10 stated that he did not know.
E10 was asked if R10 is contagious due to Scabies. E10 stated that R10 can spread the Scabies. E10 stated, "I wouldn't shake his hand."

Z2 (Dermatology Nurse) was interviewed on 2/2516 at 12:26pm via telephone. Z2 was asked what precautions should be in place for R10 due to his diagnosis of Scabies. Z2 stated that R10 should be in Contact Isolation for a minimum of 3 weeks. Z2 stated that all staff having contact with R10 should be wearing gloves and disposable gowns can be used also. Z2 stated that there should be refuse container in R10's bedroom and that garbage should be double bagged. Used gloves and gowns should not leave R10's bedroom. Z2 stated that R10 should be in his bedroom for Contact Isolation to prevent contamination.

4) R4's medical record was reviewed. On 2/22/16, E2 (DON) documented, in R4's nursing progress notes, the following: "Spoke with Z1 (Dermatologist) regarding possible scabies infection. due to another resident with diagnosis. Advised treatment prophylactic. E10 (Medical Director) notified and agreed. Ordered Ivermectin 18mg PO (by mouth) 1 dose (repeat in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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	Z9999		

2 weeks) and Elimite 5% cream application 1 dose for total of 3 weeks. Orders transcribed and faxed to pharmacy."
Further review of R4's nursing progress notes identify that R4 has been treated for a rash since at least October 2015. Treatments have included over the counter lotion, hydrocortisone cream and oral steroids. R4's rash was noted on his trunk, arms and legs.

R4 was observed on 2/24/16 at 8:07am in his bedroom. At 8:15am R4 was observed quickly walking up and down the hallway.
E6 (Lead Staff) was interviewed on 2/24/16 at 8:07am regarding any precautions or Isolation for R4. E6 stated that R4 should stay in his bedroom due to a rash. E6 stated that R4 has Eczema. E6 stated that if staff provide any care to R4 then they should wear disposable gloves.
E6 was asked where R4 ate his breakfast this morning. E6 stated that R4 ate breakfast in the dining room (with other clients present). E6 stated that "should not have happened."

E2 was interviewed on 2/24/16 at 9:30am. E2 stated there are currently 5 clients on Contact Isolation (R1, R4, R8, R9 and R10). Contact Isolation means that staff should wear gloves and gowns when entering these 5 clients bedrooms. Surveyor told E2 that R4 was observed in the hallway, running up and down the hallway on 2/24/16 at 8:15am. R4 also ate breakfast in the dining room with other clients on 2/24/16. E2 stated that R4 should have been in Isolation and eating in the dining room and running in the hallway is not Isolation.
E2 stated that staff were told, last night, that if they run out of supplies (disposable gowns) then the remaining supplies should be divided up between R10 and R1. Staff were then instructed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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		

to use cloth gowns for R4, R9 and R8.

E10 (Medical Director) was interviewed on 2/24/16 at 12 noon. E10 was asked if a client (e.g. R4) is diagnosed with Scabies what precautions should be put in place.
E10 stated, "I'd like to Isolate. You saw (R4 in hallway), what are we going to do? You do the best you can."

5) R9's medical record was reviewed. On 2/22/16, E2 (DON) documented the following in R9's nursing progress notes: "Spoke with Z1 (Dermatologist) regarding possible scabies infection due to another resident diagnosed with scabies, stated to treat resident prophylactic. Notified E10 (Medical Director) who agreed. Ordered Ivermectin 18mg (by mouth) times 1 dose, repeat in 2 weeks, Elimite 5% cream - apply from neck to toes at night X 8 hours, wash off in AM, repeat in 1 week for next 2 weeks for total of 3 applications. ..."
Further review of R9's nursing progress notes identify that R9 has had a rash and has been observed to be scratching and restless since at least January 2016. R9's rash had been treated with different creams and oral medications (Benadryl).

E2 and E1 (Administrator) were interviewed on 2/23/16 at 2:35pm. E2 stated that 2 clients (R10 and R1) were diagnosed with Scabies on 2/22/16 and 3 additional clients (R8, R4 and R9) are being treated prophylactic for Scabies. E2 stated R8, R4 and R9 had previously been treated for Eczema.
E2 and E1 stated that R9 requires total staff assist for personal care and staff should take precautions when assisting R9.
E2 stated that staff should use disposable gowns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(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 and gloves when providing care to R9. E2 was interviewed on 2/24/16 at 9:30am. E2 stated that Contact Isolation procedures should be in place for R9. Observations were conducted on 2/23/16 and 2/24/16. There were no materials available (disposable gown and gloves) outside of R9's bedroom that staff would utilize to ensure Contact Isolation techniques are implemented by staff. The following DSP's (Direct Support Person) were interviewed regarding the status of any client's at the facility currently in Isolation and for what communicable disease: - E9 was interviewed on 2/23/16 at 1:28pm. E9 stated that he was not aware of any client currently is Isolation. - E8 was interviewed on 2/23/16 at 1:42pm. E8 stated that she was not aware of any client currently in Isolation. E8 stated that no employee or Supervisor discussed any client in Isolation. - E14 was interviewed on 2/23/16 at 1:45pm. E14 stated that she was not aware of any client currently in Isolation. E14 stated there has been no discussion, from Supervisory staff, of a need for a client to be in Isolation. - E15 was interviewed on 2/23/16 at 1:45pm. E15 stated that she was told by her Supervisor that 2 clients (R1 and R10) are currently in Isolation due to Scabies. - E7 was interviewed on 2/23/16 at 1:30pm. E7 stated that 3 clients (R1, R10 and R8) are currently in Isolation due to Scabies. E7 stated that Universal Precautions need to be taken such as wearing a gown and gloves before entering their bedrooms. E7 stated that these items (gowns and gloves) as well as laundry should be disposed of in the bedroom. E7 stated, however, the laundry of these clients, is currently being	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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Z9999	Continued From page 20 carried down the hallway to the laundry room. E7 stated this can cause contamination. (B)	Z9999		