STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013197	A. BUILDING: _____ B. WING _____	C 08/07/2025

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Z 000	COMMENTS Complaint survey 2546250/IL# 196087 Complaint survey 2546476/IL# 196390 Facility reported incident of 6-19-25/ IL#196678	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.610a) 350.1210a) 350.3240a) 350.3240b) 350.3240c) 350.3240d) 350.3240e) 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 350.1210 Health Services a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or resident's representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental health, psychosocial, and habilitation needs that are identified in the resident's comprehensive assessment that allows the resident to attain or maintain the highest practicable level of independent functioning and provide for discharge planning to the least	Z9999		

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restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or resident's representative, as applicable. (Section 3-202.2a of the Act)

Section 350.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 of the Act shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 of the Act shall immediately report the matter by telephone and in writing to the resident's representative, and to the Department. (Section 3-610(a) of the Act)

d) Any person may report a violation of Section 2-107 of the Act to the Department. (Section 3-610(a) of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that

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employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These requirements were not met as evidenced by:

1.) Based on interview and record review the facility failed to identify two occurrences of abuse for one of three (R1) individuals reviewed for abuse, failed to verbally notify administrator of abuse allegations per policy, failed to investigate abuse allegations and failed to protect individuals from alleged perpetrator in a sample of four. This failure resulted in R1 feeling targeted and anxious.

2.) Based on interview and record review the facility failed to prevent elopement for one individual with known history of elopement and allergy to bee venom without epi pen. This failure resulted in one of two individuals (R2) reviewed for elopement in the sample of four to walk out the door unsupervised, being found by local EMS on the asphalt in a parking lot playing in a puddle of water approximately 0.4 miles from facility without lifesaving epi pen. This failure has the potential to affect all individuals who are at risk for elopement R2, R3.

Findings include:

1.)
R1's Individual Service Plan dated 11/2024 includes diagnosis of mild intellectual disability, seizures, and anxiety.

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R1's Individual Risk Assessment dated 10/8/24 includes, R1 doesn't understand that everyone doesn't have her best interest in mind, so she would be an easy target for solicitation, negative for history of false allegations/report.

Facility provided handwritten note dated 6/19/25 with R1's name on it includes the following: around 11:45pm R1 asked E7 (Direct Support Person) to put R1 to bed. E7 got mad and said: "you all got me f****d up tonight." E7 Followed E10 (Direct Support Person) and started yelling. R1 asked and asked, "can I please go to bed?" E7 took R1 to bathroom then proceeded to ask R1 why R1 was not in bed. When R1 asked E7 to give R1's phone to her, E7 told R1, E7 will find it in the morning, that R1 didn't need her phone. On 6/20/2025 at 8:45am R1 asked can I go to bathroom and E7 said its okay if you pee the bed.

Facility provided handwritten note dated 6/28/25 with R1's name on it includes the following: at 3:42am R1 woke up to R4 yelling "I fell out of bed". R1 waited a few mins to see if E7 would respond, R1 even called E7's name because R4 yelling. E7 did not even respond to me so I called E6 (Direct Support Person) to let E6 know what R1 was hearing. R4 was still yelling "I need help, I have fallen out of bed" E6 said if R1 feels comfortable call Z2 (R1's mother/guardian). So, R1 did. R1 told (Z2) what R1 was hearing, so Z2 called the facility phone. E7 told Z2 R4 was fine, R4 finally stopped yelling after Z2 called the house phone. The next morning E7 told R1 "to keep what happened between R1 and E7, so R1 would not get R1's phone taken away."

Facility provided statement from E14 (Direct Support Person) includes the following: E7 came in on Friday yelling at E10 (Direct Support

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Person) because R1 wasn't put to bed. E7 stated how "f****d up" he was since R1 was not put to bed, saying second shift always makes him do stuff, nobody doing this shit all the time, how they always expect him to put individuals to bed and get them up in the morning. Even after being told to stop yelling and cussing E7 kept going on about it and how lazy second shift is and how messed up E7 was. E7 continued yelling and screaming until we (E10) got in our car and left.

On 7/23/25 at 1:30pm E2 (Qualified Intellectual Disabilities Professional) stated that Z2 had called and stated R1 felt targeted, mistreated, picked on and Z2 was tired of it. E2 stated Z2 had stated she was not happy with the way E7 had treated R1 over the weekend, that R4 was yelling that he had fallen and was on the floor. E2 stated that E6 had helped R1 write a note on 6/20/25 and had left the note on E2's desk. E2 stated R1 wrote a second note on 6/28/25 and E6 put it on E2s desk also. E2 stated both notes were scanned into the computer and sent to E1 and E13. E2 stated she didn't look into these because she sent it to E1 and E13 via email.

Facility provided email notification dated 6/25/25 at 8:37pm from E2 to E13 (Administrator in Training) with attachments of R1 statement (dated 6/19/25) and E14 (Direct Support Person) statement.

Facility provided email notification dated 7/1/2025 at 2:50pm from E2 to E1 and E13 with R1's handwritten statement (dated 6/28/25) attached. E2's body of the email includes "R1 gave this to me yesterday. I just received a call from R1's guardian (Z2).

On 7/24/25 at 11:35am E1 (Administrator) stated

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that she was not aware of any allegations from R1. E1 stated she has not had any allegations of mistreatment, individuals feeling targeted or R1 being picked on. E1 was provided handwritten note dated 6/19/25 from R1 and E1 stated this was the first time E1 had seen this handwritten statement from R1, and this was not reported, investigated or a final report completed. E1 was provided handwritten note from R1 dated 6/28/25. E1 stated she was not aware of this note, it had not been reported, investigated, or taken care of.

On 7/28/25 at 10:05am E1 stated the allegations on the handwritten notes dated 6/19/25 and 6/28/25 from R1 have not been reported, investigated of taken care of. E1 stated she must not have seen the attachment on the email dated 7/1/25.

Review of staff schedules and time sheets for the dates of 6/19/25- 7/28/25 include E7 worked 6/19/25 11:15pm-9:15am on 6/20/25, 6/22/25 11:40pm-9:45am 6/23/25, 6/25/25 12:30am-8am, 6/27/25-11:30pm-9:30am 6/28/25, 6/26/25 11:40pm-9am 6/29/25, 7/1/25 11:30pm-9:30am 7/2/25, 7/2/25 11:30pm-9:30am 7/3/25, 7/3/25 11:30pm-9:30am 7/4/25, 7/6/25 11:30pm-9:30am 7/7/25, 7/7/25 11:30pm-9:30am 7/8/25, 7/11/25 11:30pm-9:30am 7/12/25, 7/12/25 11:30pm-9:30am 7/13/25, 7/15/25 11:30pm-9:30am 7/16/25, 7/16/25 11:30pm-9:30am 7/17/25, 7/17/25 11:30pm-9:30am 7/18/25, 7/20/25 11:30pm-9:30am 7/21/25, 7/21/25 11:30pm-9:30am 7/22/25, 7/25/25 11:30pm-9:30am 7/26/25, 7/26/25 11:30pm-9:30am 7/27/25.

On 7/23/25 at 11:25am R1 stated she had written up notes and gave them to E2 about E7.R1

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stated E7 came into work one night and was mad because R1 wasn't in bed. R1 stated E7 said "you got me all F****d up." And E7 started cursing at E10 (DSP). R1 stated E7 was the only staff member on duty that night and R1 was afraid E7 was so mad E7 was going to leave and there wouldn't be anyone to take care of them. R1 stated she was in the living room when E7 started cursing at E10 and E7 followed E10 outside. R1 stated she had to ask E7 to put her to bed after this because he was the only staff member there. R1 stated she feels targeted by him. R1 stated E7 did put her to bed that night but did not give R1 her phone when she asked for it. R1 told E7 it was at the foot of the bed, and she needed her phone, E7 told her she didn't need it. A second issue with E7 was when R4 was yelling for help and R1 had to call Z2 about it. R1 stated E7 told me not to tell anyone about it because I will get my phone taken away. R1 stated this made me anxious, I have anxiety, and no one is allowed to take my phone away not even my mom. It makes me feel targeted. R1 stated she uses her phone to call for help and if she doesn't have her phone, she can't call anyone for help.

On 7/24/25 at 1:45pm E7 stated there was a situation in June when E7 came into work on night shift and R1 was still up in the living room. E7 stated "when I get to work everyone should be in bed I shouldn't have to put them in bed, because I have to get them up in the morning. I'm not putting them to bed and getting them up. The second shift is being lazy, and I shouldn't have to do their work." E7 stated he was cursing at E10 telling E10 he wasn't going to keep doing this. E7 stated R1 may have heard the cursing because R1 was still up. E7 stated Z2 called the facility one night around 4am cause R1 had called Z2 saying R4 had fallen and was yelling. E7 stated

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R4 did not fall. E7 stated R1 is not to be on her phone at 4am. E7 stated I told R1 "she could not do that, you are going to get me in trouble, that R1 was not to be on her phone at 4am."

On 7/24/25 at 2:30pm E10 (Direct Support Person) stated E7 came in one night when R1 was in the living room and E7 stated oh R1 is still up? E10 stated E7 flipped out saying "I am all f****d up". R1 witnessed E7 cursing at E10. E10 stated she told E7 that R1 has the right to stay up and doesn't have to go to bed because E7 wants R1 in bed when E7 comes into work.

On 7/29/25 at 11:45am E14 (Direct Support Person) stated that E7 clocked in one night and started cussing saying "you got me all f****d up" when he saw that R1 was still up. E14 stated E7 was mad because we did not force R1 to go to bed. E14 stated E7 was mad because management said that R1 has the right to stay up and that R1 doesn't have to go to bed before second shift leaves. E14 stated E7 basically wanted us to force R1 to go to bed. E14 stated R1 heard E7 cussing about making R1 go to bed. E14 stated she went to check on R1 before she left and R1 stated that E7's behavior was typical. E14 stated she called E6 that night about it and E6 told E14 to write a statement about it. E14 stated she wrote a statement the next day.

2.)
R2's Individual Service Plan dated 2/2/2025 includes diagnosis of profound intellectual disability, seizures and R2 is deathly allergic to bee venom, R2 has an epi pen that R2 wears when R2 leaves the home. R2 is nonverbal and not able to make wants and needs known. R2 has a history of walking out the door without staff knowledge. R2 has been found wandering in the

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neighborhood and has been returned to home, due to this there are alarms on all the doors in Curtiss court. Staff must go to the door and enter a code in order for the alarm to be reset. While R2 is outside of the facility R2 must remain in visual sight of staff. R2 needs constant supervision because R2 has a tendency to wander off and think everyone is R2's friend. R2 has the potential to be vulnerable in relationships, R2 could be convinced to do something unsafe by someone with bad intentions. R2's identified risks of community safety include traffic safety and inability to navigate self, R2 is unable to independently navigate unfamiliar environments or use public transportation.

R2's physician order sheet dated 7/2025 includes epinephrine 0.3ml inject intramuscularly as needed for severe allergen reaction (Anaphylaxis). R2's allergies include bee venom, Zonegran and Chocolate.

R2's Individual Risk Assessment includes seizure disorder, history of choking, allergy to bee stings, inability to report pain/discomfort/medical distress accurately and accurately identify area of body affected. R2 does not understand public/private spaces with inability to read social cues, lacks personal protection, basic first aid skills, and physical or psychological danger pose by another person.

R2's Behavior Plan dated 2/2/2025 includes according to assessment, historical information, and recent events R2 has a tendency to leave the indoor portion of the facility without supervision and potentially from the facility outdoor property. With a recent increase in incidents documented the facility feels R2 would benefit from a behavior program.

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R2's consent for restrictive measures includes, it is in R2's best interest to have the following restrictive measures applied, door alarms to all exterior doors for the safety of the individual in the home. The negative outcomes expected if the restrictive measures are not applied are as follows: R2 may exit the home without staff aware. R2 has limited safety awareness. The positive outcomes expected if the restrictive measure is applied are as follows: R2 will have increased safety and supervision.

R3's Individual Risk Assessment dated includes seizure disorder, profound intellectual disability, inability to report pain/discomfort/medical distress accurately and accurately identify area of body affected, PICA, history of eating nonfood items, aggressive, yes for elopement, reluctant or inability to report abuse, difficulty with boundaries, lacks understanding of private vs public, difficulty distinguishing types of relationships, R3 is unable to safely navigate the community alone and is unable to communicate his needs appropriately. Acks basic first aid skills, lacks physical or psychological danger posed by another person and community supervision in line of sight. Facility provided education sheet dated 5/28/25 includes when R2 is at the home under no circumstances are the exterior doors to be propped open signed by E11 (DSP) and E9 (DSP).

Facility provided General Event Report dated 6/20/25 includes staff had door propped open, one staff member (E9 Direct Support Person) reported that another staff member (E11 Direct Support Person) had left without telling anyone and leaving E9 alone in the facility.

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On 7/17/2025 at 9:00am E1 (Administrator) stated that E11 had propped door open and went to sit in her car and that's how R2 got out, E11 was terminated because of it. E1 stated E11 had propped door open while E9 was in the shower with R1.

On 7/17/25 at 10:30am E9 stated E11 had propped the door open, and she was getting R1 ready for her shower. E9 stated the door alarms when you open it then you enter the code, and the door can be propped open without the alarm sounding. E9 stated while she was trying to get R1 in the shower she noticed E11 went out to her car. E9 stated this made me nervous cause E9 knows R2 likes to walk out the door. E9 stated she couldn't stay in the shower with R1 and watch R2. E9 stated she stepped out of the shower room quickly to check on E11 and see if she had come back in yet and E11's car was gone. E9 stated she started looking for R2 but couldn't find R2 and tend to R1 in the shower. E9 stated R1 called E11 on her cell phone and E11 stated she was in the drive through at McDonalds. E9 stated she told E11 that she couldn't find R2. E9 stated she got R1 safe and started looking more for R2 when E9 noticed the police lights and EMS vehicles down the street. E9 stated the vehicles were on the opposite side of the street and in the parking lot over a block away. E9 stated it was around noon on 6/20/25 that this occurred and R2 had on leggings and a t-shirt but no shoes. E9 stated she was afraid for R2 because R2 is deathly allergic to bee stings and R2's epi pen was inside the facility not on R2. E9 stated E11 and E6 (DSP-House Manager) returned with R2.

On 7/17/2025 at 11:15am E6 stated that E11 had called her and stated R2 had gotten out and that the police will not release R2 to E11. E6 stated

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she went to the site where the police had R2 (about a block away in the parking lot on the opposite side of the street) E6 stated the police released R2 back to the facility and E11 drove R2 back to the facility. E6 stated when she arrived at the facility the door on the back side of the building by the parking lot was still propped open. E6 stated the door alarm sounds then the staff enter a code then the staff are able to prop the door open without the alarm sounding. E6 stated the staff prop the door open and E2 (QIDP) is aware of it and has told them not to do it. E6 stated R2 did not have shoes on and was dressed in pants and t-shirt.

On 7/17/2025 at 2:54pm R1 stated she was in the shower and E9 was in there also. R1 stated E9 said she couldn't find R2, so R1 called E11 with her cell phone and put E11 on speaker so E9 could hear. R1 stated E11 said she was at the McDonalds drive through. R1 stated that E9 got her dressed and R1 saw the door propped open. R1 stated the door is propped open a lot.

On 7/22/2025 at 12:54pm Z1 (EMS) stated when EMS arrived R2, was on the asphalt in a parking lot playing in a puddle of water around noon. Z1 stated it was hot that day and R2 had long pants and sweatshirt on without shoes. Z1 stated R2 was nonverbal, covered in dirt but appeared to not be in distress. Z1 stated two staff members showed up in their cars to take R2 back to the facility.

On 7/23/25 at 12:00pm E12 (Occupational Therapy) stated she often sees doors propped open when at the facility.

On 7/23/25 at 12:15pm E2 stated she is aware that staff have been propping doors open so she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013197	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURTISS COURT	2883 SOUTH TAYLOR AVENUE SPRINGFIELD, IL 62703

(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	Z9999		

told them that they could only prop doors open when R2 isn't home.

Observations include facility is located on the corner of a busy intersection with a stop light. R2 was located on opposite side of street approximately 0.4 miles from facility.

Facility provided policy titled Investigative committee dated 4/24 includes the following definitions: Abuse- The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Neglect-Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The Investigative Committee shall be responsible for the following: Identify, review, and determine if alleged violations of any individual's rights, including abuse and neglect, have occurred between the employee and an individual. And investigate allegations in a professional and impartial manner and to protect individuals from further harm. In order for the incident to be considered reported, the employee or agent must speak directly to one of the following managers: a) Administrator, b) Executive Director or c) Chief Executive Officer (CEO). The Administrator shall call a meeting of the Investigative Committee. The Administrator will designate a chair and the committee members. The committee members shall meet to review the allegations, conduct interviews and examine the information available that is pertinent to the incident. Upon completion of the committee investigation, a report containing the findings shall be presented. The Administrator shall make the final decision as to the appropriate action required, taking into consideration the findings and recommendations of the committee. If the allegation is that an employee committed an

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Z9999	Continued From page 13 act of abuse or neglect, the employee shall be suspended from duty until such time as the: Investigation is complete, and The Administrator considers the report and takes administrative action. Facility provided policy titled individual rights dated 12/15 includes Each individual shall be encouraged to submit complaints or recommendations concerning the policies and services of the home to staff or to outside representatives of the individual's choice, or both, free from restraint, interference, coercion, discrimination, or reprisal. Each individual shall be free from mental and physical abuse. (B)	Z9999		