alc.general.9.1.
issued 6/26/07; revised 2/26/10

State of Illinois
Department of Human Services
Accreditation, Licensure and Certification
SURVEY REPORT FORM

SECTION I. AGENCY INFORMATION

NAME	ALC SECTION
Streator Unlimited In	Spfld

ADDRESS	CITY/STATE/ZIP
305 North Sterling Street	Streator, IL. 61364

SECTION II. PROGRAM INFORMATION

DATE(S) OF SURVEY	SUEVEYOR NAME(S)
6/16-18/2015	J. Vincent

PROGRAM(S) SURVEYED (CHECK ALL APPROPRIATE) SURVEY REVIEW X COMPLAINT REVIEW ______

☒ COMMUNITY INTEGRATED LIVING ARRANGEMENTS (115) – CONTACT PERSON ______

Level Award II % Compliance 99%

Site(s) Visited

602 E. Kent St.
1 Eagle Dr.
2 Eagle Dr.
315 S. Sterling

☒ DEVELOPMENTAL TRAINING (119) – CONTACT PERSON ______

Level Award II % Compliance 97%

Site(s) Visited

305 N. Sterling St.

☐ MEDICAID COMMUNITY MENTAL HEALTH SERVICES (132) – CONTACT PERSON ______

Level Award ______ % Compliance ______

Site(s) Visited

AGENCY NAME: Streator Unlimited

DATE OF INSPECTION 6-16/18/2015

RULE: 115.200 d)

COMMENT/EXPLANATION:

CILA's shall be designed to promote optimal independence in daily living, economic self-sufficiency, and integration into the community. All plans must have a goal in economic self-sufficiency.
(1/4 charts - TK)

RULE: 115.300 c) 8) D)

COMMENT/EXPLANATION:

Insufficiency or problems identified during an evacuation drill shall result in specific corrective action
(Fitzsimmons home TB bed alarms non-operational 7+ months.)

RULE: 119.230 d)

COMMENT/EXPLANATION:

The plan shall be signed by the QIDP and the individual/guardian.

(1/4 charts deficient - AB - not signed by QIDP)

RULE: 119.230 e)

COMMENT/EXPLANATION:

The individual/guardian shall be offered a copy of the plan.

(1/4 charts deficient - EB - box not marked to indicate offering)

RULE: 119.230 g) 2)

COMMENT/EXPLANATION:

At least monthly, the QIDP shall review the plan and document in the record that the services continue to meet the individuals needs or require modification.
(1/4 charts deficient EB - goal not revised after months (6) of 100% accuracy)

AGENCY NAME: Streator Unlimited

DATE OF INSPECTION: 6/16-18/2015

SURVEYOR NOTES

(1) All staff extremely helpful with expediting the survey process.

(2) All staff very knowledgeable regarding individual consumer needs and overall CILA service delivery processes.

(3) All records thorough and well organized.

(4) Facilities appear well maintained and personalized.

(5) Agency poised to promote optimal independence for all consumers.

(6) Vocational programs all age appropriate and engaging.

(7) Thank you for your assistance & cooperation!

AGENCY NAME: Streator Unlimited

DATE OF INSPECTION 6/16-18/2015

RULE: ______________

COMMENT/EXPLANATION:

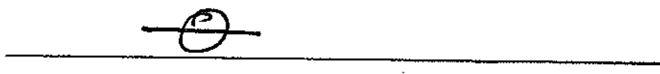
RULE: ______________

COMMENT/EXPLANATION:

RULE: ______________

COMMENT/EXPLANATION:

All violations must be corrected. A written Plan of Correction compliant with the Criteria for Submission of a Plan of Correction must be submitted to this Department on or before:

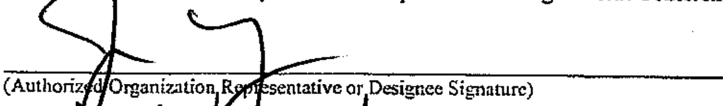


Failure to submit the required Plan of Correction by that date is grounds for revocation or non-renewal of your agency's license/certificate.

Please submit the Plan of Correction to:

Derek Bradshaw
Department of Human Services
Bureau of Accreditation, Licensure and Certification
401 South Clinton, 7th Floor
Chicago, Illinois 60607

All citations in the above report have been presented during the Exit Conference on ____________ at which I was present.



(Authorized Organization Representative or Designee Signature) (Date) 6-18-15

(Lead Surveyor Signature) (Date) 6·18·2015