STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G124	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANFORTH HOUSE	4540 SOUTH MICHIGAN AVENUE CHICAGO, IL 60653

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W 000	INITIAL COMMENTS Annual Certification Survey - Fundamental Licensure Survey Inspection Of Care	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure for 1 of 1 individual in the sample who was in need of a successor guardian (R3) did not pay to obtain successor guardianship which is a violation of the 89 Illinois Administrative Code Chapter I, Section 140.515. Findings include: R3 is an individual whose level of function is Severe Intellectual Disability per the 12/10/14 Individual Service Plan. R3's diagnoses include Intermittent Explosive Disorder per the June 2015 Physician's Order Sheets. R3's Quarterly Trust Fund Report date 01/14/15 for quarter ending 6/30/14 validates a withdrawal entry of "7/24/14 Successor Guardianship Fee $250.00" Facility Procedure on Resident Funds Revised 7/2013 includes: "The facility shall at the time of admission, provide each resident, or his/her representative, with a written statement	W 104		8/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/01/2015

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W 104	Continued From page 1 explaining the resident's rights regarding personal funds and listing the services for which the resident will be charged,..." Administrator E8 validated on 6/24/15 at 10:30 AM that E8 was unaware that successor guardianship fee could not be taken out of the individual's Trust Fund. In review of the 89 Illinois Administrative Code Chapter I, Section 140.515b). It states: "The monthly personal allowance of each recipient is that individual's personal property. The personal allowance may be used or accumulate as the recipient or correspondent wishes."	W 104		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Illinois Department Of Public Health was notified of a peer to peer incident of aggression between two individuals in the past year (R3 and R5). Findings include: R3 is an individual with diagnoses including Severe Intellectual Disability and Intermittent Explosive Disorder per the 12/10/14 Individual Service Plan. R3 has identified behaviors	W 153		8/30/15

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W 153	Continued From page 2 including verbal aggression and non-compliance. R5 is an individual whose level of function is Severe Intellectual Disability per Facility Roster provided on 6/22/15. R5 has identified target behaviors including physical aggression, non-compliance and health risk behavior per the Target Behavior Log Sheet for June 2015. On 6/23/15 from 7:09 AM through 7:30 AM, R3 and R5 were observed with the following: R3 gave back blows to R5 using her hand. R3 taps R5 on the head. R3 grabs R5's arm and shakes his arm. Review of the Target Behavior Log Sheets for R3 and R5 from June 2014 through June 2015 include R5 displaying physical aggression on 9/8/15 from 6:00 PM through 5:30 AM shift. No entry for R3 in June 2015. Daily Observation/Progress Notes on 9/8/14 include report that R5 displayed target behavior and the note of "R5 was involved in a struggle with R3. Both clients were being aggressive with each other by squeezing and holding each other by the arms." R3's target behavior Log sheet for 9/8/14 validated that R3 displayed property destruction. Interview with Residential Service Director E1 on 6/23/15 at 2:05 PM include "R5's 9/8/14 incident not reported to IDPH because E1 was not notified (by staff). (When) staff tell me (of incident) E1 writes the IDPH reportable incident."	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154		8/30/15

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W 154	Continued From page 3 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct a thorough investigation into the sudden unexpected death related to seizure of 1 individual outside of the sample (R6) with the potential to impact 3 other individuals with a history of seizure (R2, R7 and R8). Findings include: Facility Investigation Report dated 7/18/14 by Administrator E8 includes "R6 was found unresponsive in her bed when staff went to awaken her for the day. CPR (cardio pulmonary resuscitation) was immediately performed and 911 were called. R6 was taken to the (closest) hospital emergency room and later she expired. The incident is being investigated." Facility Investigative Report on R6's 7/18/14 event includes "At this time, we do not know the cause of death, we are awaiting the ambulance run report and the autopsy report before a completed investigation report can be submitted." Facility Policy and Procedure on Bed Check Effective 1/2012 and Revised 7/2013 reads "The facility will ensure that residents are monitored during sleeping hours. Staff will monitor each resident at least every thirty minutes or more often if needed. Staff will complete the bed check log after each bed check." Facility Bed Check Log for 7/18/14 validates there is a column every thirty minutes from 9:00 PM	W 154		

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W 154	Continued From page 4 through 6:00 AM for each individual in the facility. Interview with Program Assistant E5 on 6/24/15 at 9:00 AM include "we check individuals every 30 minutes unless they have a seizure and they are checked every 15 minutes. We have no place to write the bed check we did, we just do it." Residential Service Director E1 validated on 6/24/15 that staff were instructed to do every 15 minute checks on individuals with seizure history (R2, R7 and R8) since the passing of R6. Administrator E8 was interviewed on 6/25/15 at 11:30 AM regarding the facility policy on bed checks and the facility form for bed check log. E8 validated that the bed check log form (set at every 30 minutes) is not set in stone and can be changed (to indicate more frequent checks).	W 154		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to demonstrate safe technique during a needle stick procedure for 1 individual outside of the sample (R5). Findings include: R5 is an individual whose level of function is Severe Intellectual Disability per Resident Roster provided on 6/22/15.	W 192		8/30/15

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W 192	Continued From page 5 Facility Policy on Glucose Finger Stick Revised 6/2012 include "3. Follow universal precautions and infection control procedures." Program Assistant E2 was attempting to check R5's blood glucose level via stick on his arms on 6/22/15 at 4:05 PM. R5 refused to have needlestick of his fingers. E2 had to change the lancet twice as E2 was unable to obtain enough blood sample. E2 removed the cover of the lancet before inserting the lancet (with needle visible as tip already removed) into the single-lancet device. E2 applied the cover/tip of the lancet device and stuck R5 two times the 1st time and was unable to get enough blood sample. E5 removed the lancet from the lancet-device and was observed cleaning her fingers with several alcohol pads by the waste basket. E5 was asked by surveyor if she had been stuck by the needle and stated she did. Surveyor informed E1 and E2 to follow inform their nurse and seek guidance per their needles protocol. Surveyor asked if she was going to attempt to prick R5 again and stated she was. Surveyor informed E2 to apply the lancet into the lancet device with the tip on R5 was pricked twice and enough sample was obtained. (PA) Program Assistant E2 validated on 6/22/15 at 4:15 PM that she had trained to do this (blood glucose/finger stick test). E2 added that R5 recently started the blood glucose test but another resident in the facility has been on blood glucose testing before. PA E5 validated on 6/24/15 at 9:00 AM that he trained on blood glucose testing a long time ago, he inserts the lancet into the lancet device with the cover on.	W 192		

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W 192	Continued From page 6 PA E17 validated on 6/23/15 at 12:33 PM that she inserts the lancet into the lancet device with the cover on. Nurse E9 validated on 6/23/15 at 3:50 PM that training on blood glucose testing was provided to PA E18 as E18 was the only staff who had not yet received training on blood glucose testing since E9 was assigned this facility. (Other staff received training in the past as one other resident is already on blood glucose monitoring/testing). E9 validated that the correct procedure is to insert the lancet with the tip cover into the lancet-device. Facility employees must safely perform blood glucose/finger stick testing each time it is done.	W 192		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure there is a current assessment of the behavioral needs of 1 of 4 individuals in the sample on a behavior program (R4). Findings include: R4 is an individual with diagnoses including Profound (Intellectual Disabilities), Autistic Disorder and Intermittent Explosive Disorder per the 10/14/2003 Individual Behavior Plan Face Sheet continued and approved by Human Rights Committee (HRC) on 12/9/2014.	W 214		8/30/15

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W 214	Continued From page 7 R4's Behavior Plan lists target behaviors of "Disruptive/dangerous behaviors: occasionally walks around the house very fast, flails his arms, sometimes colliding with other people or objects, especially it seems when he appears excited. R4 is therefore a danger to others and himself." R4's Psychiatric Consultation Forms of visits with physician E10 include the following findings/recommendations: 2/11/15 - shows some improvement with decrease in episodes of agitation however continues ritualistic behaviors/OCD (obsessive compulsive disorder) behaviors. Continue Valproic Acid, Haloperidol, Benzatropine, Add Citalopram. 11/12/14 - exhibits increase in agitation and self injurious behaviors since Haloperidol dose decrease. Increase Haloperidol, continue Valproic Acid. 8/11/14 -shows improvement since restarted on Valproic Acid. No physical aggression, episodes of self mutilation behavior. Continue Haloperidol, Benztropine, Valproic Acid. 6/20/14 - exhibiting agitation, increase in impulsive behavior. Continue Haloperidol, restart Valproic Acid. R4's Target Behavior Log Sheets from May 2014 through June 2015 were reviewed. This Log Sheet identifies R4's target behavior as Depressive Behaviors (walking fast around the house, flails arms, sometimes colliding with other people or objects, especially, it seems when he appears excited. R4 is therefore a danger to others and himself." There are only four documented entries on the behavior Log sheet for R4. These were on 6/23/15 during 5:30 AM through 8:30 AM shift, on 7/12/14 during 8:30 AM	W 214		

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W 214	Continued From page 8 through 2:45 PM shift, on 5/15/14 during 8:30 AM through 2:45 PM shift and on 5/16/14 during the 8:30 AM through 2:45 PM shift. Qualified Intellectual Disabilities Professional E6 validated on 6/23/15 at 1:45 PM that there are no documented residential data on target behaviors of R4. E6 validated the renewed Behavior Plan from 2003 for R4 is the current Behavior plan. Administrator E8 validated on 6/24/15 at 10:30 AM that when individuals are escorted to the physician's (E10) office, E10 document how individuals present at the office and make their recommendations. Since June 2014 through June 2015, R4 had two occurrences of displaying target behavior of depressive/dangerous behavior. R4's Behavior plan does not identify any issue related to self-injurious or ritualistic behaviors. R4 had an increase, re-start and addition of medications for behaviors that are not identified to be an issue per R4's records. Behavioral needs have to be identified.	W 214		
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.	W 261		8/30/15

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W 261	Continued From page 9 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the human rights committee has membership to one who has no ownership or controlling interest in the facility. Findings include: Facility Procedure on Human Rights Committee Revised 7/2013 reads "III. Procedures A. Composition. 2. The HRC (Human Rights Committee) shall be composed of 6 to 8 member of which at least one half shall not be program employees..." Review of the June, May and April 2015 Human Rights Committee (HRC) Minutes validate that all the participants during the HRC meetings are all employees of the facility. HRC members are E9, E12, E13, E14 and E15. Interview with Residential Services Director E1 on 6/23/15 at 1:00 PM validate that there was a community member in the past but that person is no longer there.	W 261		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review the facility human rights committee failed to ensure: 1. there is a valid, written consent for 1 of 1	W 263		8/30/15

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W 263	Continued From page 10	W 263		

individual in the sample admitted in the past year who takes medication for behavior reasons (R1) and
2. that there are no blanket medication consents for 3 of 4 individuals in the sample (R1, R3 and R4).

Findings include:

1. R1's level of function is Severe Intellectual Disability per Facility Roster provided on 6/22/15. R1's 2/11/15 Individual Behavior Plan identifies Sertraline, Valproic Acid and Quetiapine as medications utilized for behavior reasons.

R1's June 2015 Physician's Order Sheet (POS) validates the orders for Sertraline, Valproic Acid and Quetiapine.

R1's 12/15/14 Written Informed Consents for Psychiatric Medications include those for Valproic Acid, Fluoxetine and Quetiapine.

There is no consent for the use of Sertraline. Per R1's June 2015 POS, R1's Sertraline order was given on 2/04/15. R1 has been taking Sertraline since March 2015, per review of March through June 2015 Medication Administration Records, without a valid written consent.

2. Review of R1, R3 and R4's records include signed Medication Consent Forms that did not identify which medication is prescribed and for what diagnosis it is prescribed for.

R1 has a 12/3/14 signed, written blanket Medication Consent in the record.

R3 has a 12/9/14 signed, written blanket

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W 263	Continued From page 11 Medication Consent in the record. R4 has a 12/1/14 signed, written blanket Medication Consent in the record. Interview with Residential Service Director E1 on 6/23/15 at 1:00 PM validated that a former Qualified Intellectual Disability Professional (E16) took care of consents. Interview with Administrator E8 on 6/24/15 at 10:30 AM regarding the blanket consent forms include "those forms are used for a different residential setting."	W 263		
W 341	483.460(c)(5)(ii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to demonstrate preventive and safe technique during a needle stick procedure for 1 individual outside of the sample (R5). Findings include: R5 is an individual whose level of function is Severe Intellectual Disability per Resident Roster provided on 6/22/15.	W 341		8/30/15

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W 341	Continued From page 12 Facility Policy on Glucose Finger Stick Revised 6/2012 include "3. Follow universal precautions and infection control procedures." Program Assistant E2 was attempting to check R5's blood glucose level via stick on his arms on 6/22/15 at 4:05 PM. R5 refused to have needlestick of his fingers. E2 had to change the lancet twice as E2 was unable to obtain enough blood sample. E2 removed the cover of the lancet before inserting the lancet (with needle visible as tip already removed) into the single-lancet device. E2 applied the cover/tip of the lancet device and stuck R5 two times the 1st time and was unable to get enough blood sample. E5 removed the lancet from the lancet-device and was observed cleaning her fingers with several alcohol pads by the waste basket. E5 was asked by surveyor if she had been stuck by the needle and stated she did. Surveyor informed E1 and E2 to follow inform their nurse and seek guidance per their needles protocol. Surveyor asked if she was going to attempt to prick R5 again and stated she was. Surveyor informed E2 to apply the lancet into the lancet device with the tip on R5 was pricked twice and enough sample was obtained. (PA) Program Assistant E2 validated on 6/22/15 at 4:15 PM that she had trained to do this (blood glucose/finger stick test). E2 added that R5 recently started the blood glucose test but another resident in the facility has been on blood glucose testing before. PA E5 validated on 6/24/15 at 9:00 AM that he trained on blood glucose testing a long time ago, he inserts the lancet into the lancet device with the cover on.	W 341		

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W 341	Continued From page 13 PA E17 validated on 6/23/15 at 12:33 PM that she inserts the lancet into the lancet device with the cover on. Nurse E9 validated on 6/23/15 at 3:50 PM that training on blood glucose testing was provided to PA E18 as E18 was the only staff who had not yet received training on blood glucose testing since E9 was assigned this facility. (Other staff received training in the past as one other resident is already on blood glucose monitoring/testing). E9 validated that the correct procedure is to insert the lancet with the tip cover into the lancet-device. Facility employees must safely perform blood glucose/finger stick testing each time it is done.	W 341		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all drugs are administered according to the physician's orders impacting 1 of 1 individual admitted in the past year (R1). Findings include: Facility Policy/Procedure on Discontinued Medication revised 7/12/11 reads "The MD (medical doctor) must write an order on the physician order sheet, consultation sheet, and/or prescription when a change is to be made in the resident's plan of care regardless of whether it is a change in medication, diet or activity level."	W 368		8/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G124	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANFORTH HOUSE	4540 SOUTH MICHIGAN AVENUE CHICAGO, IL 60653

(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) COMPLETION DATE
W 368	Continued From page 14 R1's March 2015 Medication Administration Records (MAR) and Physician's Order Sheets (POS) include the drug order for Fluoxetine 20 mg take 1 capsule every morning. The March 2015 POS' validate the order for Fluoxetine 20 mg take 1 capsule every morning. The March 2015 MARs contain the handwritten entry that reads "D/C (discontinue)" and a blue sticker that reads "STOP, DRUG DISCONTINUED." Nurse E9 validated on 6/24/15 at 1:05 PM that E9 applied the sticker and wrote the entry on the March 2015 MAR. R1 did not receive the Fluoxetine in the month of March 2015. Interview with Nurse E9 on 6/24/15 at 1:05 PM validate the following: R1 was admitted to the facility with list of medications from home. Facility physicians E10 and E11 did not want R1 to continue taking Fluoxetine. Pharmacy provider will not discontinue printing the Fluoxetine on the MAR and POS until a physician order is received. E9 placed the stop sticker and discontinue entries on the March and April 2015 MARs. E9 documented communication with E10 and E 11 on 2/25/15 to request stop order. A stop order for the Fluoxetine is in the record dated 3/27/15. R1 did not receive Fluoxetine in March 2015 but R1's March 2015 POS validate an order for Fluoxetine. There was discontinue entry in the MAR but there was no corresponding physician's order for this discontinuation.	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the door to the med room was locked when not used for med administration. Findings include: Observation on 6/22/15 include residents arriving from workshop at 3:00 PM. Residents went to the dining area for their snacks. Residential Service Director E1 and Program Assistant E2 were in the dining area and kitchen. E2 was preparing for med pass. E1 was interacting with E2 and other residents. The med room is adjacent to the dining room. Inside the med room are unlocked rolling plastic carts with individual's medications and shelves with unlocked plastic containers with individual's medications. At 3:28 PM, the door to the med room was wide open with a door stopper while five residents were in the dining room eating their snacks. E1 and E2 were in the kitchen and the hallway. E1 returned to the dining room from the kitchen at 3:29 PM. All medications have to be locked at all times unless being used during med administration.	W 382		8/30/15