		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
	14G116		B. WING _		R <b>05/21/2015</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HAMMO	ND HOUSE			6701 SOUTH MORGAN CHICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	ſS	w oo	00		
	ANNUAL LICENSU	JRE SURVEY				
W 125	INSPECTION OF C 483.420(a)(3) PRO RIGHTS	CARE TECTION OF CLIENTS	W 12	25		5/28/15
	Therefore, the facili individual clients to of the facility, and a	sure the rights of all clients. ty must allow and encourage exercise their rights as clients s citizens of the United States, o file complaints, and the right				
	Based on observat failed to maintain pr R1, R2, R3 and R4 sample including R	s not met as evidenced by: ion and interview, the facility rivacy for 4 of 4 in the sample, , and for 9 of 9 outside the 5, R6, R7, R8, R9, R10, R11, sting individuals first and last nformation.				
	Findings include:					
	at 7:55am a posting Diets and Allergies R2, R3 and R4,R5, R12 and R13 first a Mechanical soft die allergy: Tetracycline known allergies. Fo and double portions Mechanical soft die No known allergies information regardin	it was observed on 5/21/2015 g titled, The name of the facility List 3/15. This list include R1, R6, R7, R8, R9, R10, R11, and last name. For R1 it listed, t; milkshake with dinner; e. For R2, Regular diet, No r R3, Regular diet; milkshake s; No known allergies. For R4, t (No seeds, nuts, caffeine); . Subsequent personal ng diet and allergies was listed R9, R10, R11, R12 and R13.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 06/04/2015

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/04/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED	
		14G116	B. WING _			R 21/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
НАММО	ND HOUSE			6701 SOUTH MORGAN CHICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 125	Continued From pa	ge 1	W 12	5		
	area titled, Residen plates and \or cloth It noted for R6, R1,	as observed in the kitchen ts that require high - sided ing protector during mealtime. R10 and R4 a high - sided protector. For R2 and R3 it plate.				
	surveyor observed there laundry room	on 5/21/2015 at 7:55am a posting visible to anyone in titled, The facility's weekly hair isted the time\day and the first 2, R10 and R11.				
W 227	Disability Profession were an oversight a	D0am E3, Qualified Intellectual nal, stated these postings and they would be corrected. VIDUAL PROGRAM PLAN	W 22	7		5/28/15
	objectives necessal as identified by the	ram plan states the specific ry to meet the client's needs, comprehensive assessment uph (c)(3) of this section.				
	Based on observat review, the facility fa objectives are provi individuals when; 1 were kept in the loc of 12 individuals ins and 9 individuals ou and; 2) A bilateral the medication roor of an adaptive device	s not met as evidenced by: ion, interview and record ailed to ensure specific ided to meet the needs of the ) Personal grooming items ked electrical room affecting 4 side of the sample (R1-R4) utside of the sample (R5-R13) hearing aid is kept locked in n for R3 who requires the use ce. Individuals affected do not ey. This affected 1 of 1				

Facility ID: IL6003990

If continuation sheet Page 2 of 7

		AND HUMAN SERVICES				FORM	06/04/2015 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G116	B. WING				२ 21/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
НАММО	ND HOUSE				701 SOUTH MORGAN HICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 227	Continued From pa individuals inside of	-	W 2	27			
	Findings include:						
	5/19/15 at 1:50pm. garment size bag w containing grooming	ere conducted in the home on Surveyor observed a hanging vith individual pockets g items consisting of combs -R13 hanging inside of the om of the facility.					
	5/20/15 at 1:45pm i home. E1 confirmed	eld with E1 (Director) on in the dining room area of the d that the residents do not ve to ask staff to gain entry into					
	Notes/Medical/Nurs that R3 requires the and agreed to their hearing aids since 1 at night before bath Review of R3's Indir show that R3 has a	f facility "Integrated Progress sing" dated 10/14/14 stated e use of bilateral hearing aids use. R3 has been wearing her 10/14/14 and takes them out sing and gives them to staff. vidual Program Plan does not in objective to teach her how devices correctly without					
	5/21/15 at 11:00am home. E1 confirmed are kept in the lock R3 will misplace the misplaced her hear not have a key to ac E1 stated that R3 h	eld with E1 (Director) on in the dining room area of the d that the hearing aids for R3 ed medication room because em, however R3 has not ring aids in the home. R3 does ccess the medication room. as misplaced her hearing two re visit. The facility failed to ithout losing them.					

Facility ID: IL6003990

If continuation sheet Page 3 of 7

		AND HUMAN SERVICES				FORM	06/04/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		14G116	B. WING	i			R <b>21/2015</b>
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMOND HOUSE					701 SOUTH MORGAN CHICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 227	An interview was he 5/21/15 at 11:00am home. E1 confirmed are kept in the locke R3 will misplace the misplaced her hear not have a key to ad E1 stated that R3 h times while on hom ensure specific obje the needs of individ 483.440(f)(3)(i) PRC CHANGE The committee sho monitor individual p inappropriate behav in the opinion of the client protection and This STANDARD is Based on record re failed to ensure that Committee /Human reviewed , monitore techniques prior to Personal grooming electrical room affec of the sample (R1-F of the sample (R5-F hearing aid is kept I for R3 who requires device. Individuals a	eld with E1 (Director) on in the dining room area of the d that the hearing aids for R3 ed medication room because em, however R3 has not ring aids in the home. R3 does ccess the medication room. has misplaced her hearing two he visit. The facility failed to ectives are provided to meet duals served. OGRAM MONITORING & build review, approve, and programs designed to manage vior and other programs that, e committee, involve risks to	W 2				5/28/15

If continuation sheet Page 4 of 7

		AND HUMAN SERVICES				FORM	06/04/2015 APPROVED 0938-0391
STATEMENT					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		14G116	B. WING				⊣ 21/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
НАММО	ND HOUSE				701 SOUTH MORGAN HICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 262	Continued From pa	ige 4	W 2	262			
	5/19/15 at 1:50pm. garment size bag w containing grooming	ere conducted in the home on Surveyor observed a hanging vith individual pockets g items consisting of combs -R13 hanging inside of the om of the facility.					
	5/20/15 at 1:45pm i home. E1 confirme	eld with E1 (Director) on in the dining room area of the d that the residents do not ve to ask staff to gain entry into					
	Notes/Medical/Nurs that R3 requires the and agreed to their hearing aids since at night before bath Review of R3's reco	f facility "Integrated Progress sing" dated 10/14/14 stated e use of bilateral hearing aids use. R3 has been wearing her 10/14/14 and takes them out ning and gives them to staff. ord does not show HRC olementation of the restrictive					
	5/21/15 at 11:00am home. E1 confirmed are kept in the locke R3 will misplace the misplaced her hear not have a key to access the medicat has misplaced her h home visit. The faci Specially Constitute Committee (HRC) r	eld with E1 (Director) on in the dining room area of the d that the hearing aids for R3 ed medication room because em, however R3 has not ring aids in the home. R3 does tion room. E1 stated that R3 hearing two times while on ility failed to ensure that the ed Committee /Human Rights reviewed , monitored and e techniques prior to					

If continuation sheet Page 5 of 7

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
			B. WING _		05	R 05/21/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		/21/2013	
HAMMO	ND HOUSE			6701 SOUTH MORGAN CHICAGO, IL 60621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
W 263	Continued From pa	ge 5	W 26	53			
W 263	483.440(f)(3)(ii) PR CHANGE	OGRAM MONITORING &	W 26	53		5/28/15	
	are conducted only	uld insure that these programs with the written informed t, parents (if the client is a rdian.					
	Based on record refailed to ensure that obtained from the grestrictive technique when 1) Personal g the locked electrical individuals inside of individuals outside 2) A bilateral hearin medication room fo an adaptive device. have access to a ke individuals inside of	s not met as evidenced by: eview and interview, the facility t written informed consent was juardian for the use of es prior to their implementation grooming items were kept in I room affecting 4 of 12 i the sample (R1-R4) and 9 of the sample (R5-R13) and; ng aid is kept locked in the r R3 who requires the use of Individuals affected do not ey. This affected 1 of 1 i the sample.					
	5/19/15 at 1:50pm. garment size bag w containing grooming	ere conducted in the home on Surveyor observed a hanging rith individual pockets g items consisting of combs -R13 hanging inside of the om of the facility.					
	5/20/15 at 1:45pm i home. E1 confirme	eld with E1 (Director) on n the dining room area of the d that the residents do not re to ask staff to gain entry into					

If continuation sheet Page 6 of 7

		AND HUMAN SERVICES				FORM	: 06/04/2015 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		14G116	B. WING				R <b>21/2015</b>
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
НАММО	ND HOUSE				701 SOUTH MORGAN CHICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 263	2) Record review of Notes/Medical/Nurs that R3 requires the and agreed to their hearing aids since at night before bath Review of R3's reco guardian consent w implementation of t An interview was he 5/21/15 at 11:00am home. E1 confirmed are kept in the lock R3 will misplace the misplaced her hear not have a key to access the medicat has misplaced her home visit. The fact written informed co	age 6 f facility "Integrated Progress sing" dated 10/14/14 stated e use of bilateral hearing aids use. R3 has been wearing her 10/14/14 and takes them out sing and gives them to staff. ord does not show that vas obtained prior to he restrictive technique. eld with E1 (Director) on in the dining room area of the d that the hearing aids for R3 ed medication room because em, however R3 has not ing aids in the home. R3 does tion room. E1 stated that R3 hearing two times while on ility failed to ensure that nsent was obtained from the e of restrictive techniques prior	W	263			

If continuation sheet Page 7 of 7