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 _____	C 10/11/2007

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

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W9999	Continued From page 17 LICENSURE VIOLATIONS 350.620a) 350.700a)1)2) 350.750a)1)2) 350.750b)3) 350.750c)1) 350.750d)e) 350.1210a)b) 350.1230b)3) 350.1230c) 350.1230d)2) 350.3240a)c)d) 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 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number.	W9999		

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W9999	Continued From page 18	W9999		

2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence.
b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurses' notes for each resident involved.

Section 350.750 Contacting Local Law Enforcement
a) For the purpose of this Section, the following definitions shall apply:
3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).
b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:
3) Sexual abuse of a resident by a staff member, another resident, or a visitor;
c) The facility shall develop and implement a policy concerning local law enforcement notification, including:
1) Ensuring the safety of residents in situations requiring local law enforcement notification;
d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c).
e) The facility shall also comply with other reporting requirements of this Part.

Section 350.1210 Health Services
The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:
a) Physician services including a complete physical examination at least annually and formal arrangements to provide for medical emergencies on a 24 hour, seven day-a-week basis.

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W9999	Continued From page 19	W9999		

b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

Section 350.1230 Nursing Services
b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:
The DON shall participate in:
3) Periodic reevaluation of the type, extent, and quality of services and programming.
c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.
d) Direct care personnel shall be trained in, but are not limited to, the following:
2) Basic skills required to meet the health needs and problems of the residents.

Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.
d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department.

These Requirements were not met as evidenced by:

Based on record review and interview, it was determined the Facility failed to ensure one client's safety (R1) following an allegation of sexual abuse and a newly diagnosed sexually

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W9999	Continued From page 20	W9999		

transmitted disease, when the Facility failed to implement their written policies and procedures which protect clients from mistreatment, neglect and abuse.

Findings include:

Facility policy "Incident Policy and Procedures" includes the following, "II. Definitions: Unusual Incident: is an occurrence which... involves a threat to a client's health or safety. Unusual incidents include but are not limited to: Abuse, Neglect, Exploitation, Sexual assault. IV. All incidents and unusual incidents are to reported, investigated and acted upon...Within 24 hrs. of becoming aware of an unusual incident, [facility] shall report to the appropriate law enforcement agencies... V. Procedures: Without delay, the Center Director or designee will investigate the incident and obtain statements from all staff and clients involved. VI. An Incident report form must be completed within 24 hrs."

R1's record was reviewed on 10/4 and 10/5/07. According to the residential information sheet, R1's date of birth is 12/18/51, she has a diagnosis of Severe Mental Retardation and one of her sisters is her guardian. Her ICAP, dated 1/8/07, documents that she functions at a level of 1 year, 8 months. Her IQ, according to an evaluation dated 4/07, is 22. The annual individual program plan, dated 1/9/07, documented that she is ambulatory, verbal and is on general supervision in the home. R1's Human Sexuality Evaluation, dated 1/8/07, included documentation that R1 does not understand the following; 1) what to do if a person gets uncomfortably close, 2) informed consent for sexual activity, 3) how to avoid a sexually transmitted disease (STD), and 3) what

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W9999	Continued From page 21	W9999		

should be done for genital sores/itching.

Progress notes indicated that on 9/10/07 R1 went for an annual gynecological exam. The gynecologist documented, "Attempts to insert speculum were unsuccessful secondary to patient's non-compliance. Scarring from vulvar ulcers evident" and "vulvar lesions (healed)...serological (blood work) evaluation." On 9/20/07, the gynecologist wrote, "Discussed results of serological evaluation...which was positive for genital herpes."

E1, the Residential Service Director/QMRP, was interviewed on 10/5/07, at 12:30 PM. She stated that the facility became aware of R1's diagnosis after R1 returned from the follow up gynecological appointment on 9/20/07. She said that R1 was admitted to this facility in 1987 and that she has worked with R1 for many years, but was not aware of a prior diagnosis of genital herpes. She confirmed that R1 has been refusing gynecological exams and that she does not know, nor has documentation, of the last time R1 had a complete female exam, including a PAP smear.

According to E1, the only staff member interviewed was the one male working in the home as the cook. She stated that she notified the day training (DT) program, but had not gone to the site to ensure a safe level of supervision. She had not interviewed anyone at DT because she did not think R1 had prolonged contact with any male staff. However during the investigation, it was identified that the site is co-ed and that R1's training counselor at DT, for approximately 5 hours per day, is male. E1 said that R1's level of supervision in the home remains general, she can move about without close monitoring. She stated

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W9999	Continued From page 22	W9999		

there are no reports of sexual activity occurring at the facility or at the day training (DT) site.

E1 stated that none of the residents had been interviewed, but confirmed that the majority are verbal, ambulatory, and 3 of the 15 are male. She said she had not interviewed R1, but that one of the direct care staff (DCS) had done so. The interview by the DCS was in the progress notes and contained the following documentation dated 9/21/07, "Upon my arrival, read shift log, it stated to read R1's correspondence about medical condition. After reading I asked R1 who hurt you in your private area. She stated, 'Boy momma.' I asked what boy. Kept saying, 'that boy'." There was no documentation of additional questioning of R1. This was confirmed by E1.

R1 was interviewed at DT by the surveyor, on 10/4/07 at 1:10 PM. She stated that she was fine and had gone to the doctor. When asked if she liked home visits, she first said yes, then no. When asked if anyone touches her inappropriately at home, she said no.

E1 stated that no outside agencies, including the Illinois Department of Public Health had not been notified and that an incident report had not been initiated.

E1's file note, dated 9/20/07, regarding guardian notification, contained the following documentation, "[Guardian] was informed of R1's diagnosis...of genital herpes. We discussed the possibilities of how she could have contracted the disease. [Guardian] stated that her sister takes R1 out of the program for long periods of time... [Guardian] speculated that it may have been a suspicious male she's seen at her sister's house.

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W9999	Continued From page 23 That also, R1 had been raped years ago by her stepfather. It was requested that everyone be taken off the list of people who can take R1 out of the facility. This will be done as soon as possible." Z1 was interviewed on 10/4/07 at 2:50 PM. She stated that she has had concerns with bruises and a blackeye and that R1 may have been raped when those occured and until someone investigates this, visits to her sister's house have stopped. However, she then stated that her sister does not have male friends and that mostly R1 plays with the kids. She said that male staff have worked at the facility in the past. R1's record lacked documentation of suspicious bruising or a black eye. E1 was interviewed on 10/11/07 at 10:15 AM. She stated she does not recall R1 having suspicious bruises or a black eye and that that there were no related incident reports within the last year. On 9/21/07, the list of visitors who could take R1 out of the facility was limited to the guardian and her husband. The record lacked documentation of a special team meeting or an investigation to address the new diagnosis and the guardian's statement. It lacked documentation of a Human Rights Committee review for the new visitor-escort restrictions. The above findings were confirmed by E1, during interview on 10/5/07 at 2:15 PM. (A)	W9999		