

Statement of Deficiencies

1507-A: Daily Attendance Records - Children

Not Met

1507-A: A daily attendance record for children shall be maintained that shall:

1. include the child's first and last name, arrival and departure times, and first and last name of person or entity to whom the child is released;
2. accurately reflect children on the center premises at any given time; and
3. be used to sign in and out if a child leaves and returns to the center during the day.

Finding:

1507-A Based on record review: A daily attendance record for children to include the time of departure was not documented for 3 of 16 children present on 12/11/17 and for 6 of 16 children present at the center on 12/22/17, per documentation on the children's attendance logs dated 12/11/17 and 12/22/17.

1715-A.5: State Central Registry

Not Met

1715-A.5: Personnel files for each staff member shall be maintained at the center and shall include the following:

documentation of a current, completed state central registry disclosure form indicating no justified (valid) finding of abuse or neglect by the DCFS, or a current determination from the DCFS indicating that the individual does not pose a risk to children.

Finding:

1715-A.5 Based on record review: S1 did not have documentation of a current state central registry disclosure form available for review, prior to the previous form dated 1/17/17, and expiring on 1/17/18. S1 updated the form during the licensing inspection.

1915-B.&C: Health Services - Parental Notification

Not Met

1915-B.&C:

B. Reporting. Incidents, injuries, accidents, illnesses, and unusual behavior shall be documented and reported to the parent no later than when the child is released to the parent or authorized representative on the day of the occurrence.

C. Immediate Notification. The parent shall be immediately notified in the following circumstances:

1. blood not contained in an adhesive strip;
2. head or neck or eye injury;
3. human bite that breaks the skin;
4. animal bite;
5. impaled object;
6. broken or dislodged teeth;
7. allergic reaction skin changes (e.g. rash, spots, swelling, etc.);
8. unusual breathing;
9. symptoms of dehydration;
10. temperature reading over 101° oral, 102° rectal, or 100° axillary; or
11. injury or illness requiring professional medical attention.

Finding:

1915-B.&C Based on interview: S1 did not document when C1 was coughing at the center, and O1 did not bring his asthma medication on 12/15/17 as evidenced by a text message between S1 and O1 in which O1 stated the child needed to be given his asthma medication when coughing or wheezing.

1917-A: Medication Authorization

Not Met

1917-A: Written Authorization. No medication or special medical procedure shall be administered to a child unless authorized in writing by the parent. Such authorization shall include:

1. name of child;
2. drug name and strength;
3. date(s) to be administered;
4. directions for use, including the route (oral, topical), dosage, frequency, time and schedule and special instructions, if any. It is not acceptable to note "as indicated on bottle"; and
5. signature of parent and date of signature.

Finding:

1917-A Based on record review: The medication authorization form observed in C1's file for the child to receive medication at the center, did not include the following information: name of the child and strength of the medication.

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1917-H: Medication Administration Records

Not Met

1917-H: Records. Medication administration records shall be maintained for all children regardless of who administers the medication. Records shall include the following:

1. name of the child and medication name and dosage administered;
2. date and time medication administered;
3. documentation of telephone contact with parent prior to giving "as needed" medication;
4. signature of person administering medication or witnessing the child administering own medication;
5. signature of person completing the form; and
6. when a parent administers medication to his/her own child on center premises, the medication administration record shall be documented by either the parent or a staff member.

Finding:

1917-H Based on record review and interview: The medication administration record on C1, which S1 stated she completed when administering asthma medication to C1 twice at the center on 12/11/17, did not include the following information: name of the child, name of the medication, date the medication was administered and documentation of telephone contact with the parent prior to giving as needed medication. Specialist observed S1's documentation of giving two puffs at 9:30am and 2:30pm on the back of the emergency contact form from C1's file.
