STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	4237 SOUTH INDIANA 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 186	Continued From page 15 R7, R8, R9, R10, and R11). E3 stated, "Normally there are 2 staff. If I can't find someone, I come in, but I didn't that day. It was a holiday and there were people going home. I had scheduled E1 to come in at 2:00pm instead of at 4:00pm." E3 on 5/9/07 at 4:20pm stated regarding staffing, "We have 2 staff on the 12:00am to 8:00am shift, 3 staff on the 4:00pm to 12:00am shift, and 2 staff on the 8:00am to 4:00pm shift. On 4/6/07 there were 2 staff until 10:45am and E1 came in at 2:00pm. On 4/6/07 there was 1 staff present from 10:45am thru 2:00pm and 11 residents. Sometime between 1:00pm and 1:30pm per E4, R2 heated a towel in the microwave, placed it in a bag and applied it to R1's leg resulting in a thermal burn. E4 was unaware of R2's actions.	W 186		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.810a) 350.1060e)h)k) 350.1070 350.1230e) 350.3240a)b) Section 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. Section 350.1060 Training and Habilitation Services	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	**4237 SOUTH INDIANA 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
W9999	Continued From page 16 e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. k) Residents shall not be used to replace employed staff. Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. Section 350.1230 Nursing Services e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. These REGULATIONS are not met as evidenced by:	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	4237 SOUTH INDIANA 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
W9999	Continued From page 17 Based on record review and staff interview, the facility failed to implement their policy to prevent neglect when R2 placed a hot compress on R1's leg causing thermal burns. The facility failed to: 1) Provide sufficient staffing to ensure supervision of the 11 individuals (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11) in the facility when only 1 staff was present at the time of the incident. 2) Supervise R2 who is known to do staff's responsibilities. 3) Take corrective action following the incident by evaluating staffing needs and programmatically addressing R2's inappropriate actions of doing staff responsibilities. 4) Ensure that staff immediately report the incident of R1's thermal burns to the administrator. Findings include: The facility's policy on Abuse/Neglect/Injury Definitions defines Neglect as the failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental state. R1, per the Physician's Orders Sheet (POS) dated 4/25/07, is a 63 year old male whose diagnosis includes Severe Mental Retardation, Personality Disorder, Conduct Disturbance Not Specified, and General Convulsive Epilepsy. R1,	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	**4237 SOUTH INDIANA 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
W9999	Continued From page 18 per the Nurse Note dated 4/3/07, was receiving hot compresses on his left leg 3 times a day due to cellulitis prior to sustaining a thermal burn to his leg on 4/6/07. R2, per the POS dated 4/25/07, is a 40 year old female whose diagnosis includes Moderate Mental Retardation and Diabetes. E7, Administrator, stated on 5/7/07 at 2:25pm that R2 has a history of trying to help staff. Per an Incident Report dated 4/6/07 R2 placed a "too hot compress" on R1's leg. The report notes R2 did this without being told by staff, resulting in several blisters. R1 was taken to the the hospital on 4/7/07 where he was diagnosed with a thermal burn. The report notes, "At that time only one staff was working." The report also notes 11 residents were present at the time of R1's injury. 1) The facility failed to provide sufficient staff to supervise clients in the facility at the time of the incident on 4/6/07. On 5/8/07 at 3:10pm E4, Program Aide, was interviewed. E4 stated when asked how did R1's leg get burned, "On Saturday after lunch I gave R1 a bath and brought him into the living room and elevated his legs. I went back to check on the others and it was at that time R2 used the microwave to heat up a towel. I went to the dining room to start on books. R2 yelled out to come look at R1's leg. This was sometime between 1:00pm and 1:30pm. I saw a bag (towel had been placed in it) and it was very hot. I got an ice pack and it began to drain. I called E2 (Nurse). E2 told me to apply antibiotic cream to R1's leg." Per nursing notes, on 4/7/07, R1 went to the hospital where he was diagnosed with a thermal burn. On	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	**4237 SOUTH INDIANA 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
W9999	Continued From page 19 4/10/07 R1's primary Doctor admitted R1 to the hospital to monitor the healing process of R1's leg. R1 returned to the facility on 4/13/07. On 5/7/07 at 8:47am E1, Program Aide, was interviewed. E1 stated, "I arrived for work (4/6/07) around 2:00pm. Staff E4 informed me R1 had blisters on his left leg. She told me R2 had put a hot towel on his leg without her knowledge. She told me she had talked to the nurse and she was applying cold towels and ice on it and the nurse told her that was fine. When I looked it was still forming. The next day I came in 8:00am - 9:00am and the blisters had burst and then I saw bleeding and pus coming out. It didn't look right. I called the nurse and E3, Residential Services Director/Qualified Mental Retardation Professional (RSD/QMRP). I informed them I was taking R1 to the hospital." On 5/7/06 at 1:25pm E3, RSD/QMRP, was interviewed. E3 was asked about there being 1 staff person in the facility at the time of the injury to R1. E3 stated, "Normally there are 2 staff. If I can't find someone, I come in, but I didn't that day. It was a holiday and there were people going home. I had scheduled E1 to come in at 2:00pm instead of at 4:00pm." E3, on 5/9/07 at 4:20pm, stated regarding staffing, "We have 2 staff on the 12:00am to 8:00am shift, 3 staff on the 4:00pm to 12:00am shift, and 2 staff on the 8:00am to 4:00pm shift. On 4/6/07 there were 2 staff until 10:45am, and E1 came in at 2:00pm." Regarding R2's known history of helping staff and taking on staff's responsibilities, E3 stated "R2 just naturally wants to help. She does not mean any harm. We are having a meeting on 5/10/07 to address R2's	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	4237 SOUTH INDIANA 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
W9999	Continued From page 20 role and not being a 2nd staff person. I don't know if staff are, but if they are, we will put a stop to it." Per review the facility's investigation dated 4/9/07, R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11 were present in the facility on 4/6/07 during the hours of 10:45am to 2:00pm when E4 was the only staff on duty. 2) The facility failed to evaluate staffing needs and programmatic needs for R2 following the incident of 4/6/07. Per review of the investigative report of R1's injuries of 4/6/07, there is no evidence that the facility identified and took corrective action to ensure staffing levels to ensure supervision as per the needs of the individuals served. There is no evidence that the facility identified and took corrective action regarding the supervision requirement for R2 to ensure that she does not do staff responsibilities. The injury to R1 as a result of R2's placing a hot compress on his leg occurred on 4/6/07. Corrective action addressing R2's need to assist staff and staff understanding of R2's role in the facility did not occur until 5/10/07. The facility has not addressed staffing to ensure sufficient staff are present to meet the needs of the clients. 3) The facility failed to ensure the incident of 4/6/07 was immediately reported to the administrator. Record review of the facility's policy on	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	**4237 SOUTH INDIANA 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
W9999	Continued From page 21 Incidents/Accidents includes, "Any incident which affects a client shall be reported and an incident report completed. A client reporting/sustaining a physical injury shall be given first aid and the client's physician contacted. The physician's instructions are to be followed and documented...." Under the policy of Reporting Allegations of Abuse, Neglect and Death/Assignment of Investigation, "If an employee witnesses, is told of, or has reason to believe an incident of abuse or neglect or a death has occurred, the employee shall report the allegation to the immediate supervisor." In reviewing records there is no documentation that E4 contacted the Administrator or her designee when R1 first sustained the burn on 4/06/07 per facility policy. E3, Residential Services Director/Qualified Mental Retardation Professional (RSD/QMRP), was interviewed on 5/7/07 at 1:25pm. E3 stated she received a telephone call from E1, Program Aide, on 4/7/07 informing her she was taking R1 to the hospital due to the condition of his leg. E3 stated this was the first that she had heard of R1's burn. The Investigative Report dated 4/9/07 conducted by E3, RSD/QMRP, in her interview with E4, Program Aide, asked E4, "Why was the RSD not informed. E4 stated she panicked and was not thinking at that time. She just wanted to speak to the nurse to find out what to do for the blisters on R1's leg." On 5/8/07 at 3:10pm E4, Program Aide staff, was interviewed. E4 stated when asked did you notify the administrator or her designee of the burn to	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G125	A. BUILDING _____ B. WING _____	C 05/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	**4237 SOUTH INDIANA 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
W9999	Continued From page 22 R1's leg stated, "I was so excited, the nurse was the first person I called, and I forgot to call the Director." (A)	W9999		