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 03/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE	**4237 SOUTH INDIANA AVENUE CHICAGO, IL 60653**

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W 157	Continued From page 19 sits next to a bus monitor. 2) Record review of a Special Incident Report dated 4/10/06 notes on 4/10/06 in the morning R3 went into the bathroom stall at the day training site and pulled up a peers shirt, took the peers penis out, placed in his hands and massaged it. R3 was counseled and on going counseling was established. R3's bathroom breaks were to be closely monitored. On 3/3/08 at 10:22am E3, Work Services Program Coordinator, was interviewed. E3 was asked what is close monitoring for R3 when he uses the restroom at the day training site. E3 stated because of past sexual incidents we watch R3 when he goes to the bathroom. We monitor the time and if he is in the bathroom longer than 5 to 7 minutes we will go in and check. She said, " R3 will target lower functioning people, we monitor time and nothing has happened here. We pay attention". E3 was asked if more than 1 person can use the bathroom. She stated it has 2 stalls. A 2 stall bathrom allows for others to use the bathroom with R3.	W 157		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a)d)e)h) 350.3240a)b)c)d)f) 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	W9999		

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W9999	Continued From page 20 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 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. 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. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. 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. c) A facility administrator who becomes aware of	W9999		

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W9999	Continued From page 21 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. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. These Requirements were not met as evidenced by: Based on record review and interview, the facility failed to ensure implementation of their policy prohibiting sexual abuse when they failed to: 1) Ensure 1 employee, E12, followed the facility policy prohibiting abuse. R3 was sexually abused by E12 who had not received formal abuse training. E12 had sexual contact with R3.	W9999		

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W9999	Continued From page 22 2) Ensure the safety of male individuals at the workshop when R3 uses the bathroom. R3 had a sexually history aggressing a male peer in the bathroom. He is unsupervised in the bathroom for a 5 to 7 minutes period. The facility also: 3) Failed to conduct a thorough investigation of an alleged sexual incident between E12 and R3. The investigation does not include information on R3's possession of a sexual explicit tape. 4) Failed to notify the Illinois Department of Public Health (IDPH) and the administrator of an incident of sexual contact involving R3 during the day training bus ride and a male peer. Findings include: 1) R3, per the Physician's Orders Sheet dated 1/30/08, is a 31 year old male whose diagnosis includes Mild Mental Retardation. R3, per his Individual Program Plan dated 5/4/07, is ambulatory, communicates verbally and has been adjudicated incompetent. Adaptably per the ICAP dated 5/3/07, R3 functions at the 8 year 3 month level. The facility's policy regarding Abuse and Neglect notes, "An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident." Sexual Abuse is defined as, "Any act of sexual contact, sexual penetration, sexual coercion, or sexual exploitation of an individual by an employee of the community agency."	W9999		

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W9999	Continued From page 23 Sexual Contact is defined as, "Inappropriate contact involving between an individual receiving services and another person involving either an employee's genital area, anus, buttocks or breast(s) or an individual's genital area, anus, buttocks or breast(s)." A memo written by E3, Work Services Program Coordinator to E2, Interim Habilitation Director, on 2/19/08 documents an allegation made by R3. At 2:15pm on 2/19/08 R3 alleged E12 (Program Aide) had sexual contact with him on 2 occasions at the residential site. The first was alleged to have occurred on a Monday with R3 unable to give the time or date. The 2nd occurred on 2/17/08 during the evening. The memo notes, "According to R3, the staff person motioned for him to go to his room. The staff person told his co-partner (E6, Program Aide) he was going to the men's side to assist them with personal care skills (bathing/grooming). According to R3, once in the room, the staff person closed the main door to the bedroom and the door leading to the bathroom. Next according to R3, he was directed by the staff person to disrobe. According to R3 he pulled his sweat pants and boxer shorts down. Next R3 stated he leaned against his bed, the staff person unzipped his pants, released his penis, lubricated his penis with lotion, spread R3's leg and entered him anally. According to R3, while the staff was thrusting inside him, the staff grabbed R3's penis and began massaging him until he climaxed. According to R3, the staff person stopped when he heard people in the hallway and told R3 to hurry and pull his pants up. According to R3 he did as he was told. Lastly, R3 stated the staff person told him to keep this incident a secret, never tell anyone."	W9999		

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W9999	Continued From page 24 Review of the facility's investigation completed by E2 notes on 2/26/08 Z2 contacted E1, Residential Service Coordinator/Qualified Mental Retardation Professional (RSD/QMRP), notifying her E12 had admitted to the allegation. On 2/20/08 E1, RSD,QMRP, at 10:30am was interviewed. E1 stated E12 began work on 1/16/08. A background check was completed on 11/16/07 and E12 had no disqualifying convictions. E1 provided a Work Center Orientation Checklist dated 1/16/08 for E12 that includes rules and regulations governing work performance and personal and professional behavior. On 2/29/08 at 3:45pm E1 was asked if E12 had completed the training for abuse and neglect. She stated he was scheduled to attend in 4/08. She stated she had gone over with E12 appropriate contact with regards to touch for both males and females. She stated E12 was suspended pending the results of the investigation and once she became aware E12 had admitted the allegation he was terminated. 2) Record review of a Special Incident Report dated 4/10/06 notes on 4/10/06 in the morning R3 went into the bathroom stall at the day training site and pulled up a peers shirt, took the peers penis out, placed in his hands and massaged it. R3 was counseled and on going counseling was established. R3's bathroom breaks were to be closely monitored. On 3/3/08 at 10:22am E3, Work Services Program Coordinator, was interviewed. E3 was asked what is close monitoring for R3 when he	W9999		

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W9999	Continued From page 25 uses the restroom at the day training site. E3 stated because of past sexual incidents we watch R3 when he goes to the bathroom. We monitor the time and if he is in the bathroom longer than 5 to 7 minutes we will go in and check. She said, "R3 will target lower functioning people, we monitor time and nothing has happened here. We pay attention." E3 was asked if more than 1 person can use the bathroom. She stated it has two stalls. A two stall bathroom allows for the possibility of others being in the bathroom with R3. 3) Review of the facility's investigation completed by E2 notes on 2/26/08 Z2 contacted E1, Residential Service Coordinator/Qualified Mental Retardation Professional (RSD/QMRP), notifying her E12 had admitted to the allegation. E1, RSD/QMRP stated in the investigation E12 was suspended pending the results of the investigation and once she became aware E12 had admitted the allegation he was terminated. On 2/28/08 at 9:40am Z1 contacted surveyor and stated R3 had in his possession during the sexual contact with E12 a sexual tape. On 2/29/08 at 3:45pm E1 was interviewed. E1 stated 1 individual in the house, R4, had requested a year ago to view a sexual tape and with the guardian's permission R4 was given one. She said, " R4 does not bother anyone, he just looks at his movie". When asked how a sexual tape was in R3's possession E1 stated she didn't know and had just found out about it. R4, per his Individual Program Plan dated 1/20/08, is a 42 year old male whose diagnosis	W9999		

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W9999	Continued From page 26 includes Moderate Mental Retardation. R4 was interviewed on 3/3/08 at 3:05pm. R4 stated he kept the tape in his room and he didn't give it to anybody. ON 3/3/08 at 3:55pm R3 was interviewed. He stated he was aware of the tapes but E1 had stopped them. R3 said he did have a sexual tape during 2/08. On 3/3/08 at 12:23pm E2, Interim Director, was interview. E2 stated she initially was not aware of a sexual tape but became aware there was one in the house. E2 said E1 told her Z5 had called and said R3 had watched it before. The facility's investigation of sexual contact between R3 and E12 does not contain information regarding a sexual tape. 4) Per a Special Incident report dated 2/15/08, on 2/13/08 a male peer alleged R3 had oral sex with him on the bus in route home from the day training site between 2:30pm and 3:00pm. The male peer reported the sexual contact with R3 on 2/15/08. In the Report when R3 was asked about the allegation he stated, "I know I was wrong but I did it anyway". When he was asked what he meant by that statement, R3 said, "I put (male peer's) penis in my mouth and sucked while seated beside (male peer) on the bus". The Special Incident Report notes on 2/15/08 E3, Work Services Program Coordinator, phoned E1, Residential Services Director/Qualified Mental Retardation Professional (RSD/QMRP). E1 was not there and E3 left a message asking her to call her before the end of the day.	W9999		

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W9999	Continued From page 27 On 3/4/08 E1, RSD/QMRP, at 3:55pm was interviewed. E1 was asked when she became aware of the 2/13/08 incident involving R3. E1 stated she became aware on 2/19/08 when she came back to work. She said E15, the Administrator, was contacted on Tuesday or Wednesday the 19th or 20th. E1 was asked on 3/3/08 at 2:15pm if the Illinois Department of Public Health was notified of the incident of 2/13/08. E1 said, "No, I wasn't aware I needed to; now I know". On 3/4/08 at 2:15pm E14, Division Director, was interviewed. E14 said he first became aware of the incident involving R3 and the male peer on 2/20/8. (A)	W9999		