DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	09/30/2014

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 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY - FUNDAMENTAL ANNUAL LICENSURE SURVEY INSPECTION OF CARE	W 000		
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure individuals the opportunity to participate in community outings during the month of February for 3 of 4 individuals in the sample (R1, R3 and R4) and 4 individuals outside of the sample (R5, R7, R11 and R14) and none for July. Findings include: Record review of facility "Community Outing Log" notes that a total of 6 community outings were conducted over a 8 month period. Months: February 2014 -1 community outing, 8 individuals attended (R2, R6, R8, R9, R10, R12, R13 and R15). March 2014 - 1 community outing, all attended. April 2014- 1 community outing, all attended. May 2014-1 community outing with no information as to how many individuals attended. June 2014- 1 community outing , all attended.	W 136		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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W 136	Continued From page 1 July 2014- No community outings. August 2014- 1 community outing, all attended. September 2014- 1 community outing, all attended. An interview was conducted with E1 (Residential Services Supervisor) on 9/25/14 at 11:35am. E1 stated "If you do not see the outings in the book, then the individuals did not go. Some of the individuals do not like to go out on community outings. I guess, I should write down who refuses. E7 (Service Coordinator) at the main office schedules all of the community outings for all of the houses". E1 confirmed that community outings were not held on a regular basis and no outings were held for the month of July for individuals.	W 136		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff demonstrated competency in implementing the Individual Service Plan when staff failed to 1) implement per program methodology the self medication programs for 2 of 3 outside the sample, R6 and R7 2) ensure the tube used to ingest liquid Dilantin for R3 during the medication pass was not left on the breakfast table while residents were eating 3) ensure there was enough time for 1 of 4 in the sample, R1, and for 1 of 11 outside the sample R9, to eat their breakfast prior to leaving for workshop 4) failed to	W 194		

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have 4 of 4 in the sample, R1, R2, R3 and R4 and for 10 of 11 outside the sample, R5, R6, R7, R9, R10, R11, R12, R13, R14 and R15 the opportunity to serve themselves cereal and for 1 of 4, R1, to serve himself water.

Findings include:

1) Observations were conducted at the residential site on 9/24/14 from 6:10 am thru 8: 10 am. At 6:39 am E6, Direct Support Person, was assisting with the medication pass. R6 was asked tell me your medication program. R6 did not know. At that point E6 asked her why do you take pot. chloride? Review of the program methodology states, "tell staff the name, shape, color, how many pills and why she takes the medication. This was not observed to be implemented.

At 11:30 am E2, Qualified Individual Disability Professional, QIDP, stated the program that was in the medication administration book was incorrect. E2 presented a different methodology stating, "when I change goals I put the correct 1 in. I don't know what happened."

At 6:58 am R7 was assorted with her medications by E6. E6 stated to R7, "What is your self medication program?" R7 stated she did not know. E6 asked her what are 5 side effects of Risperdal. R7 again stated she did not know. E6 stated outloud side effects and then assisted R7 in taking Risperdal. Review of R7's self medication program methodology notes staff are to inform R7 of the side effects and then asked R7 to repeat them. E6 did not ask R7 to repeat the side effects.

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At 7:05 am E6 Direct Support Person, was asked is that part of the program methodology to ask R6 and R7 tell me your self medication program E6 stated they have been on the programs for 6 months and know it. When it was pointed out R7 did not know her program or the side effects and possibly should R7 repeat the side effects for learning purposes stated, "I was not trained to do that."1)

2) At 6:50 am E6, Direct Support Person, was assisting R3 with her medications. R3 was observed to drink Dilantin which had been poured in a tube measuring container. R3 was prompted to wash it out but had trouble thoroughly cleaning it. E6 request R3 to give her the tube which she wrapped in plastic and set on the dining room table stating she would clean it later. E6 proceeded to assist other residents with their medications.

At 7:57 am R1 was eating breakfast. At the table was the tube that had been used by R3 that had contained the liquid Dilantin. When brought to the attention of E6 she picked up off the table and stated, "I thought I had it in my hand."

3) Breakfast on 9/24/14 consisted of cold cereal, scrambled eggs and waffles. R1 thru R16 participated in family style dining helping themselves to the eggs and waffles. R1, R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R14 and R15 were not afforded the opportunity to serve themselves as R8 and E6 pre-plated the cold cereal. All individuals were observed to eat independently. When asked why individuals did not serve themselves the cereal E6 stated there were running late and the buses from the workshop was coming.

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4) On 9/24/14 the buses to take individuals to the workshops arrived at 8:00 am. Individuals were still eating breakfast. 2 individuals did not have time to eat their cereal, R1 and R9. Interview with E4, Direct Support Person, stated breakfast was ready to be served. The delay was due to E6 assisting with the medications in the dining area. Breakfast was delayed and some individuals did not have the opportunity to finish their breakfast even though breakfast was ready due to the delay of the medication pass which continued in the dining area.
5) Dinner meal observations were conducted in the home on 9/23/14 at 5:00pm. E5 (Direct Support Person) was observed assisting individuals with placing the family style meal on the table. R1 was observed sitting at table #1 and independently scooping the food from the bowls into his plate. E5 (Direct Support Person) was observed picking up the pitcher of water and pouring it for R1.

An interview was conducted with E2 (Qualified Intellectual Disability Professional) on 9/23/14 at 5:15pm. E2 stated "R1 is able to eat and serve himself independently. I do not know why E5 poured the water for R1". An interview was conducted with E5 (Direct Support Person) on 9/23/14 at 5:20pm. E5 stated "R1 is able to eat and serve himself independently. He can do everything independently for meals. I poured water in his cup because sometimes he needs assistance because he misses the cup. If I assist him, I will normally do the hand over hand". E5 stated "I just saw that R1 had already put his food on his plate and I was just trying to help out". E5 confirmed that she did not give R1 the opportunity for choice when she poured the water for him and

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W 194	Continued From page 5 stated that she really, had no excuse for doing so.	W 194		