STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E160	A. BUILDING ______ B. WING ______	C 10/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART HOME	**1550 SOUTH ALBANY CHICAGO, IL 60623**

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F9999	Continued From page 2 LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Reuirements were not met as evidenced by:	F9999		

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F9999	Continued From page 3	F9999		

Based on observation, interviews and record review, the facility failed to supervise a resident (R4) on suicide watch to ensure that the resident does not harm herself. This failure resulted in R4 jumping off from the 2nd floor stairwell which resulted in her sustaining a T-7 and T-8 level vertebral fracture and paralysis.

Findings include:

R4 was admitted from St. Elizabeth's Hospital to the facility on 12/14/07 with diagnoses of Bipolar Disorder, Psychotic Features, Schizophrenia, Paranoid Type, Esophageal Stricture secondary to Bleach Ingestion, Head Banging and Pleural Thrombosis. Review of hospital record showed that R4 was sent by another facility to the hospital on 12/8/07 because R4 was banging her head against the wall and cutting her fingers with glass at the other facility.

Per 10/1/08 interview of Z1, R4 has a history of trying to harm herself and had cut her wrist at home in November 2006, and had put a bag over her head and had tried to jump off the window in the other facility prior to hospitalization at St. Elizabeth on 12/8/07. Z1 added that R4 also took a mixture of ammonia and other chemicals in the past to kill herself.

Review of R4's hospital record showed that on 12/12/07, she was assessed with little insight about her mental illness and displays poor judgment. R4's hospital record also showed that R4 is going to be discharged to a nursing facility where R4 would benefit from the structured environment and from the supervision at the facility. Per hospital's transfer form, although R4

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F9999	Continued From page 4 denied being suicidal at the hospital, R4 was admitted at the hospital for suicidal ideation and for the attempt to harm self and the actual injury from self harm at the other facility. According to R4's Nurses Notes dated 12/21/07, at around 2:20 PM, R4 was found in the back stairwell when Code Gray was called. R4 was found without clothing, in her bra and diaper, lying on her back with a laceration to the forehead and a superficial tear to the right knee. E3 (Nurse Supervisor) was interviewed on 10/3/08 at 1:59 PM, E3 said that she was the first one to discover R4 at the back stairwell lying on the 1st floor concrete floor next to the stairwell. E3 explained that she heard a man screaming that someone had fallen at the stairwell. E3 said that she found R4 in her bra and diaper only, her clothes nowhere to be found in the stairwell area. E3 continued that R4 was conscious and her body was rigid and sustained a cut to her forehead and right knee. E3 later explained that she could not see the back of R4's head but noticed that the blood started pooling on the ground. E3 also said that 911 was called and took R4 to the hospital. According to E3, when R4 was admitted to the facility, the hospital told the admitting nurse that R4 has suicidal ideation. E3 said that R4 was placed on suicide watch and the staff took turns keeping an eye on R4 per schedule posted on the 2nd floor nurses station. E6 (Nurse) confirmed during 10/3/08 interview that R4 was placed on an hourly check by staff because of her history of suicide. When E4 (Nurse aide) was interviewed on	F9999		

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F9999	Continued From page 5 10/3/08, E4 said that E4 last saw R4 during her rounds at around 2:00 PM of 12/21/07. E4 said that she saw R4 in her room asleep and fully clothed. E4 explained that when R4 was admitted, the nurse told E4 to keep an eye on R4 because R4 is suicidal. E4 also said they did not do any 1:1 supervision with R4. During 10/3/08 interview at 2:30 PM, E5 (Nurse Aide) said that she saw R4 about five minutes prior to R4 being found on the 1st floor stairwell area after falling from the 2nd floor. E5 said that when she last saw R4, R4 was in her room in bed covered with blanket but with her clothes on the floor. E5 continued that R4's room was next to the exit door and stairwell, and the 2nd floor nurses station is at the other end of the hallway. E5 also said that R4's room (room 206) is not visible from the nurses station. E5 said that although she was told R4 was suicidal, she had no idea how R4 would try to harm herself. During 10/3/08 observation of the 2nd floor area, the nurses station was noted as facing east, and all of the residents' rooms including room 206 and the hallway are located towards the west side and are all behind and not visible to the 2nd floor nurses station. R4's room (206) was also far away and at the opposite end of the hallway from the nurses station. Room 206 is located next to room 205, which is just across the exit door and back stairwell. There are residents' rooms closer to the 2nd floor nurses station where R4 could have been placed. The exit door was noted as with an alarm device. However, the alarm is not on until nighttime per E3. Review of R4's record shows that although R4 has an unsteady gait, R4 is ambulatory. Review	F9999		

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F9999	Continued From page 6 of R4's Assessment Summary for Mentally Ill Residents dated 12/17/08 indicated that "all staff will monitor her for possible self harm" as specific interventions to address suicide history and safety risk to self. When facility's training and inservices were reviewed, there was no indication that there were training/inservices on how to deal with residents with suicidal ideations and histories prior to R4's admission and incident on 12/21/07. There also is no evidence of any inservice of the same nature after the incident. When E6 was asked on 10/3/08, E6 said that he started in the facility in October 2007 and did not recall any training provided by the facility on how to handle residents with suicidal issues, nor did E6 recall any training or inservices after R4's incident. According to R4's nurses notes, R4 sustained a fracture of the vertebra at level T-7 and T-8 with total rupture of T-8. Per Z1, R4 was paralyzed from waist down and was on a ventilator in the hospital after the fall. (A)	F9999		