DEPAR	IMENT OF HEALTH	I AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
	POINTE REHAB & NU	IRSING			5825 WEST CERMAK ROAD		
OLDAIT					CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F	000	0		
	Annual Licensure a	and Certification.					
	Licensure Survey for	or Subpart S: SMI					
	Complaint investiga 1191983/IL53508 - 1192320/IL53905 - 1192718/IL54375 -	no deficiencies no deficiencies					
F 155 SS=D	An extended survey 483.10(b)(4) RIGH ADVANCE DIRECT	T TO REFUSE; FORMULATE	F	155	5		
	refuse to participate and to formulate an	e right to refuse treatment, to e in experimental research, a advance directive as aph (8) of this section.					
	by: Based on record re failed to ensure res residents (R14) by right to refuse psyc Findings include: Review of R14 's F Psychotropic conse was no signed cons concentrate. Attached to the outs was a note, informi refuses his medicat food. A physician 's order	NT is not met as evidenced eview and interview, the facility ident rights to 1 of 30 sampled failing to honor the resident 's hotropic medications. Physician Order Sheet and ent form indicated that there sent for Haloperidol side of R14 's medical record, ng nursing staff, that if R14 tion, it may be put into his er form was located in R14 's t Haloperidol concentrate may					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	√G		10/25	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 155 F 157 SS=D	be mix in R14 's for R14 's medication a initialed boxes, india given to R14 from 9 Interviews: On 9/28/11 at 1015 stated that, to his kn refusing all psychot was unaware that n R14 's food, until it by the survey team attached to the cove 9/28/11. On 9/29/11 at 1045 take any psychotrop do so. On 9/27/11 at 1240 nurse on the 8th flo psychotropic nurse meds were being m On 9/28/11 at 4PM, on the evening shiif medication adminis putting Haloperidol 483.10(b)(11) NOT (INJURY/DECLINE A facility must immed consult with the res known, notify the re or an interested fam accident involving the injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life to	od. administration record, show cating, Haloperidol had been 0/22/11 thru 9/27/11. AM, R14 's PRSC (E7) nowledge R14 has been tropic medications and says he nedications were being put in was brought to his attention and after seeing the note er of the R14 's chart on AM, R14 stated, he doesn 't pic medications and refuses to PM, E23 ( LPN) a regular for and the facility 's (E24), admitted that R14 's nixed in with his food. , E25 (LPN) a full time nurse ft, verified her initials on the stration record and admitted to concentrate in R14 'S coffee. IFY OF CHANGES		155			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WING		10/2;	5/2011
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	existing form of treaconsequences, or the resident from the §483.12(a). The facility must also and, if known, the reor interested family change in room or a specified in §483.1 resident rights under regulations as specified in §483.1 resident rights under regulations as specified in section. The facility must react the address and philegal representative. This REQUIREMENT by: A. Based on closed the facility failed to resident (R30) in a regarding transfer the facility failed to resident on 7/31/11 the hospital on 8/1/ showed no evidence notified of his transfer.	need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced d record review and interview, notify the family of one sample of 30 residents, o the hospital.	F 157	7		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WING		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	Continued From pa 's family about his During 9/27/11 in the facility did not n from the facility. B. Based on record facility failed to notif lab draws involving lab orders (R9), in a Findings Include: 1) Review of R9 ' and 9-22-11, both in refused the labs to notes dated July an not indicate that the Interview with R9 of the surveyor that he that " no one is goi at 4:30 PM, during	ge 3 hospital transfer. aterview at 11:46 AM, Z4 said otify her that R30 was gone review and interview, the fy the physician of refusal of 1 of 3 residents reviewed for a sample of 30. s lab reports dated 7-27-11 ndicate that the resident be drawn. Review of nursing d September of 2011 does e physician was notified. n 9-27-11 at 1:00 PM stated to e does not like needles and ng to stick me. " On 9-28-11 the daily status meeting, the	F 15	DEFICIENCY)		
F 225 SS=E	been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for	(c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a c an employee, which would or service as a nurse aide or the State nurse aide registry	F 22	5		

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STATE NEERON OF DEFICIENCIES AND PLAN OF CORRECTION     (xt) PROVIDERSUPPLIER 145850     (xt) MULTIPLE CONSTRUCTION A BUILDING 1025/2011     (xt) DATE       NAME OF PROVIDER OR SUPPLIER CEDAR POINTE REHAB & NURSING     STREET ADDRESS, CITY, STATE, ZIP CODE SE2S WEST CEMMAK ROAD CECRO, IL GOBG 4     Street ADDRESS, CITY, STATE, ZIP CODE SE2S WEST CEMMAK ROAD (CERO, IL GOBG 4)       Image: Comparison of the Comparison of Deficiencies Preprix TAG     Street ADDRESS, CITY, STATE, ZIP CODE SE2S WEST CEMMAK ROAD (CERO, IL GOBG 4)     The CERO, IL GOBG 4       Image: Comparison of the C			I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       CEDAR POINTE REHAB & NURSING     STREET ADDRESS, CITY, STATE, ZIP CODE       CMUDIC     SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECIEDED BY FULL TAG     D       PREFIX     (EACH DEFICIENCY MUST BE PRECIEDED BY FULL TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION OR LSC IDENTIFYING INFORMATION)     D       F 225     Continued From page 4     F 225       The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).       The facility must have evidence that all alleged violations are throughly investigated, and must prevent further potential abuse while the investigation is in progress.       The results of all investigations must be reported to the administrator or this designated appropriate corrective action must be taken.       This REQUIREMENT is not met as evidenced by.       Based on interview and record review, the facility failed to ensure all alleged violations involving allegations are reported immediately to the administrator of the facility and to the State of Illinois for 6 of T residents (R4, R13, R15, R16, R23, R30) reviewed for abuse and 3 residents (R34, R44, R69) in the supplemental sample.								
CEDAR POINTE REHAB & NURSING         Discrete control         Discrete control <thdiscre< td=""><td></td><td></td><td>145850</td><td>B. WI</td><td>NG _</td><td></td><td>10/2</td><td>5/2011</td></thdiscre<>			145850	B. WI	NG _		10/2	5/2011
CEEDAR POINTE REHAB & NURSING         CICERO, IL 68804           (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ER PRÉCEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX PREFIX         PROVIDER SPLAN OF CORRECTIVE (EACH DEFICIENCY MUST ER PRÉCEDED BY FULL RECULATORY OR LSC. IDENTIFYING INFORMATION)         ID PREFIX PREFIX         PROVIDER SPLAN OF CORRECTIVE (EACH DEFICIENCY)         Comparison (29), (29), (20), (2), (2), (2), (2), (2), (2), (2), (2	NAME OF P	ROVIDER OR SUPPLIER						
Preferst TAG       (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE)       Configure DEFICIENCY)         F 225       Continued From page 4       F 225         The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).       F 125         The results of all investigations must be reported to the administrator or the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.       This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all alleged violation is involving injuries of unknown sources and abuse allegations are reported immediately to the administrator of the facility and to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is involving injuries of unknown sources and abuse allegations are reported immediately to the administrator of the facility and to the State of illinois for 6 of 7 residents (R4, R13, R15, R16, R23, R30) reviewed for abuse and 3 residents (R34, R44, R69) in the supplemental sample.       Preference TAG	CEDAR F	OINTE REHAB & NU	RSING					
The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all alleged violations involving injuries of unknown sources and abuse allegations are reported immediately to the administrator of the facility and to the State of Illinois for 6 of 7 residents (R4, R13, R15, R16, R23, R30) reviewed for abuse and 3 residents (R34, R44, R69) in the supplemental sample.	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all alleged violations involving injuries of unknown sources and abuse allegations are reported immediately to the administrator of the facility and to the State of Illinois for 6 of 7 residents (R4, R13, R15, R16, R23, R30) reviewed for abuse and 3 residents (R34, R44, R69) in the supplemental sample.	F 225	Continued From pa	ige 4	F	225	5		
		involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must haviolations are thoroo prevent further pote investigation is in pu The results of all int to the administrator representative and with State law (inclu- certification agency incident, and if the a appropriate correction This REQUIREMENT by: Based on interview failed to ensure all a injuries of unknown allegations are report administrator of the Illinois for 6 of 7 res R23, R30) reviewed	<ul> <li>ent, neglect, or abuse,</li> <li>inknown source and</li> <li>resident property are reported administrator of the facility and accordance with State law</li> <li>d procedures (including to the ertification agency).</li> <li>ave evidence that all alleged ughly investigated, and must ential abuse while the rogress.</li> <li>vestigations must be reported to other officials in accordance uding to the State survey and the state survey and the state survey and the alleged violation is verified ive action must be taken.</li> <li>NT is not met as evidenced v and record review, the facility alleged violations involving a sources and abuse orted immediately to the state of sidents (R4, R13, R15, R16, d for abuse and 3 residents</li> </ul>					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WIN	IG		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	IRSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	<ol> <li>The incident repordocument R34, an with diagnoses that disorder, demential lip was swollen and happened. There winjury nor was this i of Illinois as an alle</li> <li>The incident repordocument R44, a 5 with diagnoses that disorder and seizur station and he had arc of the left eye. If happened. There wincident nor was it ras an alleged abust</li> <li>R13 has diagnohistory of substance admitted to the facinger and was a convictions from for vehicle, several drup prostitution. Her se analysis is, R13 regular monitoring behavioral changes</li> </ol>	ort dated 6/8/11 at 10 P.M. 85 year old ambulatory female includes severe bipolar and schizophrenia. R34's top I R34 was unable to say what vas no investigation in to the ncident reported to the State ged abuse. Ort dated 4/25/11 at 10:30 P.M. 6 year old ambulatory male t includes schizoaffective res, approached the nurses ' a small wound in the upper R56 was unable to say what vas no investigation into the reported to the State of Illinois e	F2	225			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	√G		10/2	5/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	on a limited time bai indicated, that R13 alcohol and had reco R13 's nurses n indicated that R13 v kin, Z1, and that Z1 AM. Per nurses not 11:30 ( no indication to the facility stating altercation, and that eye is shut, swollen having spasms. R13 swollen and red. R and came back on a Review of facility shows no evidence was done, nor was aware of an initial a investigation. During 9/28/11 in Administrator ) said allegation of abuse family or another no Per E8 ( case wo at 11:27 AM, R13 re pass on 9/21/11, an because she had a police initially came upset and did not ta after the police left, the man who hit hei R13 again on 9/27/7 that she had a phys	asis. This assessment also admitted to currently drinking cently snorted cocaine. notes dated 9/21/11 at 12 AM, was staying with R13 's next of I said that R13 will be back in tes dated 9/21/11 written at n if AM or PM ), R13 returned g that she got into a physical it, a man hit her. R13 ' s right n, very dark and red, and was 3 ' s left eye is also slightly c13 was sent to the hospital	F	225			

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		AND HUMAN SERVICES					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	the man unexpecte fight ended. E8 said friend and did not s was. E8 said she o 9/21/11. Per R13 's Phys R13 was placed on 9/21/11 and 9/22/1 said that the pass r for her own safety, really say who hurt Review of R1 9/28/11, the facility allegation of physic interview at 11:15 A Nursing ) said that yesterday on 9/29/1 investigation when 9/21/11, that she way with a pole. Per E3 who hit her was her interview however, is currently incarcer is the only man R13 AM. R13 's nurses that at 12 AM, Z1 ir back to the facility in There was no evide Z1 to determine if Z physical abuse incid being referred to by her with a pole. Wh at 11:15 AM why R facility and be expo the person who phy	dly hit her with a pole after the d that R13 just said it was a ay what the person ' s name did not ask R13 further on sician Order Sheet ( POS ), restriction for 7 days on both 1. On 9/30/11 at 12:24 PM, Z2 estriction for 7 days for R13 is as sometimes, resident don ' t	F	225			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	especially if the phy current assessment allegation incident of that R13 is safe to be herself, to prevent f who physically assa caused her injuries. Criminal Assessment risk and needs closs R13 sustained injure assaulted by a pers she was drinking. I 11:45 AM and social indicated that the all R13 's drinking. R1 also indicated that fe using drugs, behavior addressed by the fa- she had been doing altercation happene CHASRR and as the involving R13 on 9/2 addressed first prio community unsuper Review of R13 's 9/28/11, Z3 made a may go out of the fa- 9/28/11 POS also in at 3:30 PM, Z3 made resume community observed leaving the During 9/30/11 in 11:38 PM, E27 said Z3 after R13 went t she is allowed to ha	vsician ordered it. There is no t after the physical abuse on 9/21/11 that would indicate be outside of the facility by further contact with the man aulted her with a pole, and . Added to this, per R13 ' s ent Analysis, R13 is moderate be supervision, especially that ries after being physically son she knew outside, after interview on 9/30/11 of E8 at al service notes dated 9/27/11 Itercation was the result of I3 ' s CHASRR on 8/30/11 R13 admitted to drinking and iors that has not been acility after R13 admitted as g ( drinking ) when the ed. As this was identified in the his was a part of the altercation 21/11, this should have been ir to allowing R13 to be in the	F	225			

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 9 F 225 R13's pass restriction. E27 said that she told Z3 to give R13 another chance, and that Z3 ordered that R13 may go out to the community again. E27 said that she was not at the facility when R13 came back with eye injuries. E27 also said that she does not know who hit R13 up to now. E8 said during 9/30/11 interview that she was with Z3 on 9/28/11. E8 said that Z3 asked her what she thought about R13 's community pass. E8 said that she told Z3 that it is okay for R13 to have her community pass resumed. However, when showed of R13's CHASRR, E8 said she has no access to this report previously, and is not aware that R13 was assessed on 8/30/11 as Moderate Risk and needs closer supervision. E8 also said that she is not aware that R13 's convictions involves criminal trespass, several drug related offenses, and prostitution. E8 added that she also is not aware that the CHASRR indicated that currently R13 was using alcohol and snorted cocaine. E8 was also not aware that R13 admitted to E3, that the man who hit her was her boyfriend. E8 said that R13's boyfriend is currently incarcerated. E8 was also made aware that R13's nurses notes indicated that R13 was only with Z1 on 9/21/11 at 12 AM, and that R13 alleged that she was hit by her boyfriend on 9/21/11. When asked if she would have recommended to Z3 to order a community pass for R13 after having known this information, E8 said no. E8 said R13's safety is her first concern. 4. R23's nurses notes dated 6/7/11 showed that there is a need to separate R23 from other residents who are physically attacking R23, and that social service will be made aware. Review of

FORM CMS-2567(02-99) Previous Versions Obsolete

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	<ul> <li>social service notes was addressed or in and final report sen</li> <li>Social service not also indicated that Faltercation with ano report and abuse investigat determine abuse. The not notified of any in Review of facility incident or abuse in altercation mention According to this not smoking room and another resident.</li> <li>5. Per R30's nur 7:10 AM, R30 push floor and hit the oth incident nor abuse in determine abuse, n IDPH.</li> <li>6. According to the set of against the bedpost bleeding, and when hit in the nose by a that R16's physiciar According to the fact reports there were not state and the set of t</li></ul>	s showed no indication this nvestigated, or results of initial it to IDPH. totes dated 3/28/11 at 10 AM R23 was involved in a physical other peer. Review of incident les showed no indication that tion was also done to The state department was also nvestigation related to this. T's incident report showed no nvestigation for 11/4/10 ed in social service notes. ote, this occurred in the R23 was hit in the mouth by reses notes dated 7/31/11, at red another resident on the ner resident with a chair. No investigation was done to for was there notification of the nursing notes 6/22/11 bund on the floor in her room t, R16's nose was noted as a sked R16 said that she was co-peer. The note indicates in was notified and ice applied.	F	225			
		no reports noted on the log, found after review of all					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF PROVIDER OR	SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REI	HAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
abuse inverse of inve	aports for estigation restigation R16 that a 1 at 4:00p 2 (acting both said estigation s of abuse of the state of potentia nent has o ill be infor stained a d by an Ur 4/11. The a fall whick s no evide a fall whick s no evide s no evide a fall whick s no evide s no	June, 2011. According to the s provided by the facility there ons noted with the allegations another resident hit her in the om during the daily status administrator), E3 (director of that she couldn't locate any s, and therefore the e made by R16 was not	F	225			

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CENTERS FOR MEDICARE & MEDICAID SERVICES		PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
145850 <sup>B. W</sup>	ING	10/25/2011
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD	
CEDAR POINTE REHAB & NURSING	CICERO, IL 60804	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPRETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TA	FIX (EACH CORRECTIVE ACTION SHO	ULD BE COMPLETION
<ul> <li>F 225 Continued From page 12 of the facility's incident report book from October 2010 thru September 2011, does not indicate that the State Agency was notified of the two incidents involving R4. Interview with E2(Director of Operations), on 9-30-11 at 10:15 AM stated that at this time, she is not aware as to why the incidents were not sent to the State Agency.</li> <li>9. On 7/13/11, R15 returned to the facility with a laceration to his right eye, bruising to his face and an injured finger on his right hand. After an initial assessment of R15 's injuries, he was subsequently sent to an area hospital for evaluation. On 9/29/11 at 1015AM during an interview, R15 admitted tripping over a pot hole on 7/13/11. He stated that he had been drinking and lost his balance. Review of the facility 's accident/incident reports indicated that the incident was never reported to IDPH.</li> <li>On 9/30/11 at 9:55 A.M. during daily meeting with administration, E3 (acting director of nursing) and E2 (director of operations) stated they are unable to answer why no investigations were done into the falls, the physical altercations between residents and incidents of unknown origins. E2 stated she was hired one month ago and E3 stated Z7 was employed from 10/25/10 to 7/29/11 when she resigned. The personnel file reflected the same dates.</li> <li>The facility 's policy on Abuse Prevention Program instructs employees to report any incident, allegation or suspicion of potential</li> </ul>	225	

Facility ID: IL6009948

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY COMPLETED         145850       B. WING       10/25/2011         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CICERO, IL 60804       10/25/2011         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)			HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
143830       10/25/2011         NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         CEDAR POINTE REHAB & NURSING         (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X5) (COMPLET DATE         F 225       Continued From page 13 abuse, neglect or mistreatment they observe, hear about, or suspect to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. All incidents or allegations involving abuse or mistreatment will       F 225	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	、 <i>′</i>			(X3) DATE SU	JRVEY
CEDAR POINTE REHAB & NURSINGSate west cermak ROAD(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)ID PREFIX PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLET COMPLET DATEF 225Continued From page 13 abuse, neglect or mistreatment they observe, hear about, or suspect to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. All incidents or allegations involving abuse or mistreatment willF 225			145850	B. WIN	1G		10/2	5/2011
CEDAR POINTE REHAB & NURSING(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLET COMPLET DATEF 225Continued From page 13 abuse, neglect or mistreatment they observe, hear about, or suspect to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. All incidents or allegations involving abuse or mistreatment willF 225	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLÉT DATE         F 225       Continued From page 13 abuse, neglect or mistreatment they observe, hear about, or suspect to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. All incidents or allegations involving abuse or mistreatment will       F 225	CEDAR	POINTE REHAB & NU	IRSING					
abuse, neglect or mistreatment they observe, hear about, or suspect to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. All incidents or allegations involving abuse or mistreatment will	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
<ul> <li>the injury of unknown origin will be reported to the State within 24 hours from the occurrence and the final report will be sent within 5 working days of the initial reporting. The report will include the steps the facility has taken in response to the allegation.</li> <li>F 241 483.15(a) DIGNITY AND RESPECT OF SS=E INDIVIDUALITY</li> <li>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</li> <li>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide well-fitting clothing, clothing in good repair, provide regular dish ware and utensils, assist and cue residents (R2, R7, R9, R19) reviewed for dignity in the sample of 30 residents and 12 residents (R38, R31, R40, R44, R36, R37, R42, R32, R39, R43, R55, R34) in the supplemental sample. The findings include:</li> <li>1. On 9/27/11 between 9:50 a.m. to 10:35 a.m. with E13 (nurse/MDS coordinator), in the 4th floor</li> </ul>	F 241	abuse, neglect or m hear about, or susp nursing staff is add reporting on a facili appearance of bruis abnormalities as the allegations involving result in an abuse in the injury of unknow State within 24 hou the final report will b of the initial	nistreatment they observe, bect to the administrator. The litionally responsible for ity incident report the ses, lacerations, or other ey occur. All incidents or g abuse or mistreatment will nvestigation. An initial report of wn origin will be reported to the trs from the occurrence and be sent within 5 working days ng. The report will include the is taken in response to the Y AND RESPECT OF comote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality. NT is not met as evidenced tion, record review and by failed to provide well-fitting ogod repair, provide regular sils, assist and cue residents essing for 4 of 9 residents (R2, wed for dignity in the sample of 2 residents (R38, R31, R40, -2, R32, R39, R43, R55, R34) il sample. The findings include: reen 9:50 a.m. to 10:35 a.m.					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	۹G		10/2;	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	dining room, R38, a inch)finger nails and a male, has long (o and the right thumb thick. R54, a male w noted with the same 426 was open and Residents clothing all over the room. E residents on the flo been locked. 2. On 9/27/11 at 11 pushed R2 in his w room to room 406, room is across from bathroom. E16 wer grabbed some pant she starts her shift, gather clothes she residents and puts E16 stated it is mor which is resident ro R67. E16 stated th and returned to the clothes are not labe and given to reside 3. On 9/27/11 at 11 dining room wande his pants which wer waist and legs. R19 and halls. R19 ' s p wide and the waist belt due to waist be 4. On 9/28/11 at 9:3	a male, has long (one d wearing a winter coat, R31, one inch), curved finger nails o nail is brown- discolored and was wandering the unit and e clothes on for 3 days. Room the room was in disarray. and belongings were spewed E13 stated the clothes are for or and the room should have :47 A.M., E16 (nurse aide) heel-chair out of the dining which is not his room. This in the Men 's common in to the closet of bed 2 and ts from it. E16 stated when she will go to room 426 to will need for her assigned them in 406 bed 2 's closet. re convenient to use room 406 oom to R61, R62, R66 and he clothes are used, laundered froom 406 for storage. The eled with residents ' names	F	241			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145850	B. WI	NG		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING	1		825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	Continued From pa in the groin area.	ige 15	F	241			
	<ul> <li>5. On 9/28/11 at 11 room, R36 was ser disposable dinner-w E18 (nurse aide), E present were unable meal on disposable Technician) stated surveyor should sh on regular dish-war</li> <li>6. On 9/28/11, all d room, R37 was sea seat cushion in his black sweat pants we buttocks area expo over. At one point, nurses ' station aft attempting to touch E17 (activity aide) r sit down on chair. F all day.</li> <li>Other residents wit sweat pants above tight pants that wer holding up his pant the length was seve dragging when he w same clothes for 2 while walking due t wearing a shirt seve assisted by E17 (act room to a chair at t back-side of his pa was folded up due wearing pants seve</li> </ul>	:54 A.M. in the 4th floor dining ved his noon meal on ware, cups and plastic utensils. E13 and other nurse aides e to say why he received his e dinner-ware. E26 (Dietary it was a mistake. E26 asked e send him another noon meal re. ay, in the 4th floor dining ated on an extensively cracked wheel-chair. R42 is wearing with a quarter-size hole on sing her skin when she bent when she was bent over at the er the noon meal, R54 was R42 's buttocks area when re-directed him and had R42 R42 's pants remained on her h ill-fitting clothes are R7 with her ankles. R40 is wearing e above his ankles. R32 was s when he walked the unit and eral inches too long and walked. R39 was wearing the days and holding the pants up o waist too big. R19 was eral sizes too big. R44 was ctivity aide) from the dining he nurses ' station and his nts were visibly wet. The hem to being too long. R38 was eral sizes too big. The legs le and the length was several					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	<ul> <li>inches long. R31 widiscolored finger nathem cut. R31 's hard R43 's speech was E15 at 12:20 p.m. a was never instructer had the same cloth</li> <li>7. On 9/29/11 at 11 (Maintenance Direct wheel-chair, very dispeech. R55 's part E20 summoned nut pants.</li> <li>8. On 9/29/11 at 12 'station, the resider and/or wheel-chairs pants for two days, outfit for 3 days and spoke. R2 was weat for 2 days. R42 was white shirt with emb was seated in the dincoherently and core ating. No re-direct All these residents 4th floor, which is the secured unit. Revise Data Set for R42, Fassistance by staff R36, R38, R43, R4, staff for dressing; a</li> </ul>	as noted with long, curved ails. He stated he would like air was greasy and slick back. s gurgling when she spoke to and again at 3:45 P.M. and ed to clear her throat. R43 also es on for 2 days.	F	241			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145850	B. WIN	\G		10/2;	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 825 WEST CERMAK ROAD		
CEDAR F	POINTE REHAB & NU	RSING			CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241 F 241 F 247 SS=D	Continued From pa 9. On 3 of 4 days of 9-29-11), observed Surveyor noted that unkempt, wearing of showed dried food s and pulled up over the are damaged. The separated from the resulting in the flapp resident walks. Inte 10:00 AM stated that little difficult to walk Interview with E19(/ 11:00 AM stated that condition of the sho is a scheduled trip the time, R9 's shoes we 483.15(e)(2) RIGHT ROOM/ROOMMAT A resident has the re the resident's room changed. This REQUIREMEN by: Based on record re failed to ensure that room change involved	ge 17 f the survey(9-27-11 thru R9 walking on the unit. t R9 's hair appeared to be of the same shirt which stains, pants extremely loose the stomach and shoes that bottom portion of the shoes is upper portion of the shoe, ping appearance as the erview with R9 on 9-29-11 at at the shoes are worn and a in, but otherwise ok. Activity Director) on 9-28-11 at at she is aware of the bes and that next week, there to the thrift store, where at that will be replaced. T TO NOTICE BEFORE	F2	241			
	9-27-11, R4 was mo of the psych social	cord indicates that on oved to another room. Review progress notes dated 9-27-11, nat the family was notified.					

		I AND HUMAN SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WIN	IG	10/2	5/2011
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		IOULD BE	(X5) COMPLETION DATE
F 247 F 250 SS=D	Review of the face state appointed gua E11(Psych Rehab S at 10:30 AM stated prior to the room tra guardian. 483.15(g)(1) PROV RELATED SOCIAL The facility must pro- services to attain or	sheet indicates that R4 has a ardian. Interview with Social Coordinator) on 9-28-11 that he notified the resident ansfer, but did not notify the TISION OF MEDICALLY SERVICE ovide medically-related social maintain the highest I, mental, and psychosocial	F 2	247		
	by: A. Based on intervi facility's social serv address the illicit di reviewed for social Findings include: According to the cli dated 7/11/11 R16 benzodiazepine, an According to the ps there were no entrie to R16 ' s testing po cocaine. According to R16 ' s was no care plan id					

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WIN	G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			325 WEST CERMAK ROAD ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	Continued From pa	ae 19	F 2	250			
	According to the su	bstance abuse and alcohol 16 was not referred or	1 4	.00			
	that he was unaway benzodiazepine, an should have been s put into place. E7 s his case-load. E7 s clinical record upon but didn ' t review th	om E7 (social service), said re of R16 's testing positive for ad cocaine, and said that there some behavior modifications said that R16 's was new to said that he reviewed R16 's taking R16 in his case-load, he laboratory results indicating sitive for benzodiazepine, and					
	interview, the facilit residents reviewed appropriated private Offender), and faile for 1 of 3 residents services(R8), in a s Findings Include: 9-27-11, observed another resident. F indicates that R4 is Because of R4 ' s of have been in a priv E11(Psych Rehab 3 at 10:00 AM stated a resident who is an not think that it was room. The state gu Registered/Convict	vation, record review, and y failed to ensure that 1 of 3 for abuse(R4), was in the e room(Registered Sex ed to provide behavior services reviewed for behavior ample of 30. R4 in a room shared with Review of R4 ' s record a Registered Sex Offender. conviction status, R4 should ate room. Interview with Social Coordinator) on 9-27-11 that R4 shared the room with n Identified Offender, thus, did required to be in a private uidelines indicate that all ed Sex Offenders that resides re to be in a private room,					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION		(X3) DATE SU COMPLE	JRVEY
		145850	B. WING	G		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STAT			
CEDAR	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROA CICERO, IL 60804	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCE	E ACTION SHOU	JLD BE	(X5) COMPLETION DATE
F 250	close to the nursing bathroom. Review of R8 's re diagnosis includes Review of the facilit substance abuse, of Interview with E11 f involved in a group but has not displaye usage. C. Based on record failed to provide dis resident (R11) out of social services in a Findings Include: Interview with R11 of states he informed quit that he wanted states that after his (Psychiatric Rehabil from the 7th floor the R11 states he (E11 on the housing list f Interview with E11 of R11 inquired about states he was told for rather delegated it for Rehabilitation Servin Interview with E9 of she does not know asked to assist R17 Record review of R assessment, review	g station, and to have a private cord indicates that R8 medical a history of alcohol abuse. by 's behavior group related to does not list R8 as a member. further stated that R8 is not related to substance abuse, ed any behaviors of alcohol review and interview facility scharge planning to one of 25 residents reviewed for sample size of 30 residents.	F 2				

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WIN	1G		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250 F 251 SS=F	R11 's comprehensi discharge dated 4 favor discharge ever extensive physical a Goal: resident will r and significant othen needs by 7-16-11. Interview with E9 (F Services Coordinat states she did not r to accurately review charts. E9 states the brought to attention addressed and care 483.15(g)(2)&(3) Q WORKER > 120 BI A facility with more qualified social wo bachelor's degree i degree in a human limited to sociology rehabilitation couns one year of supervi a health care settin individuals. This REQUIREMEN by: Based on interview	sive care plan; anticipating 16-11 denotes the resident en though the resident requires and/or mental heath service. meet with social worker, nurse er(s) to identify post-discharge Psychiatric Rehabilitation for) on 9-29-11 at 11:45 AM have the opportunity and time w R11s ' chart and other his issue and others were n yesterday and now are being e plans are being updated. UALIFICATIONS OF SOCIAL		250			

Facility ID: IL6009948

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 251 Continued From page 22 F 251 During the entrance conference on 9/27/11 at approximately 9:15am, E1 (Administrator) told survey team that the facility has a total of 441 beds with a census of 293 residents (11 Medicare and 282 Medicaid). E1 stated that the facility 's social worker position has been vacant since 9/20/11 and E6 (Consultant Social Worker) has been working in an acting position until a full time social worker is hired. E1 was not able to provide documentation of number of hours of social service coverage provided by E6, nor details of how E6 's time was utilized. During a telephone interview with E6 on 9/29/11 at approximately 1:25pm, E6 stated that the full time social worker position was vacated on 9/14/11, and that she (E6) has been in the facility for the sole purpose of staff training and program development. E6 has not provided any direct services for facility residents. E2 (Consultant, Director of Operations) told survey team on 9/29/11 at approximately 3:30pm, that the social worker and the psychosocial rehabilitative director (PRSD) is a combined job position. The facility employs 5 psychosocial rehabilitative service coordinators (PRSC) who are responsible to meet all social service and psychosocial rehabilitative needs of all 293 residents which translates to a caseload on 59 residents for each PRSC. F 252 483.15(h)(1) F 252 SAFE/CLEAN/COMFORTABLE/HOMELIKE SS=E **ENVIRONMENT** The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: IL6009948

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PRINTED: 02/22/2012

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE <b>5825 WEST CERMAK ROAD</b>		
CEDAR F	POINTE REHAB & NU	RSING			CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 252	Continued From pa	ge 23	F	252			
	This REQUIREMEN	NT is not met as evidenced					
	Based on observat	tion and interview, the facility					
	clean, and homelike	t the environment was safe, e involving 7 supplemental ), in a sample of 30.					
	Findings Include:						
F 279	tour, accompanied Nurse), the followin 701 involving R70-f front cover not secu inside mechanical p curtain not secured 702 involving R74-f front cover loose re mechanical parts e mechanical parts e mechanical parts a of dust. 3. Mens B strong pervasive ur substance on show substance on the c 9-28-11 at 4:30 PM meeting, the facility Interview with E2(D 9-30-11 at 9:30 AM environmental conc	xposed. The inside re saturated with large amount bathroom/Shower Room is with ine/musty odors, mold like ver stall floor # 1, and mold like eiling of shower stall # 2. On during the daily status was notified of the findings. virector Of Operations) on stated that some, but not all cerns were addressed, and e time to correct all of the ns.	F	279			
SS=E	COMPRÉHENSIVE A facility must use t	É CÁRE PLANS the results of the assessment and revise the resident's		-			

Facility ID: IL6009948

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2;	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ige 24	F	279			
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable atables to meet a resident's nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment b).					
	by: Based on interview failed to put in place assessment instrum	NT is not met as evidenced v and record review, the facility e care plans based on resident nent (RAI) for 5 residents out ewed for care plans (R3, R8, ample of 30.					
	Disorder and has h R3 ' s last suicida hospitalization was R3 ' s nurses notes	ses of Manic depressive istory of Suicidal Ideation. al ideation that resulted to her 6/20/11 per hospital record. dated 5/18/11 indicated that supset about her purse being					

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		I AND HUMAN SERVICES			FOF	ED: 02/22/2012 RM APPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	JLTIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		145850	B. WING	G	10	/25/2011
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP	CODE	
CEDAR I	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 279	slash her wrist. R3 trying to poison and Review of R3 ' s of any care plan for Her care plan wa by E8 ( case worke interview at 11:08 A on 9/28/11 as there about suicidal ideat 2) R13 has diagno R3 ' s Criminal Hist Recommendation F offender for forgery related offenses, ar Review of R3 ' s plan for her diagnos nor of her drug use offended. Per E8 ( case wo at 11:27 AM, R3 ' s on 9/27/11. R3 has 7/19/11.	alized that she is going to was also paranoid about staff I kill her. care plan showed no evidence suicidal ideation. as finally updated on 9/28/11 r ). Per E8 during 9/28/11 M, her care plan was updated e was no previous care plan ion previously. bosis of Bipolar Disorder. Per ory Analysis security Report, R3 is an identified r, criminal trespass, drug nd prostitution. care plan showed no care sis of severe mental illness, and being an identified prker ) during 9/28/11 interview care plan was updated only been in the facility since	F 27	79		
		ychosocial progress notes es, or documentation related				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WING	G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER		:		EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			25 WEST CERMAK ROAD ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 26	F 2	79			
	to R16 ' s testing po cocaine.	ositive for benzodiazepine and					
	was no care plan id	s current plan of care there entifying R16 ' s behavior of azepine, and cocaine.					
		bstance abuse and alcohol 16 was not referred or					
	that he was unawar benzodiazepine, an should have been s put into place. E7 s his case-load. E7 s clinical record upon but didn ' t review th	om E7 (social service), said re of R16 's testing positive for d cocaine, and said that there some behavior modifications said that R16 's was new to said that he reviewed R16 's taking R16 in his case-load, ne laboratory results indicating sitive for benzodiazepine, and					
	alcohol abuse. Rev not address the his Interview with E11( Coordinator) on 9-2	record indicates a history of view of R8 ' s care plan does tory of alcohol abuse. Psych Rehab Social 28-11 at 10:00 AM stated that ed any behaviors associated					
	9-22-11, both indica the lab to be drawn does not address th on 9-27-11 at 1:00	lab reports dated 7-27-11 and ate that the resident refused . Review of R8 's care plans he behavior. Interview with R9 PM stated that he does not at " no one is going to stick					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	₩G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	OINTE REHAB & NU	RSING			325 WEST CERMAK ROAD ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279		ge 27 at 4:30 PM, during the daily facility was informed of the	Fź	279			
F 280 SS=D	483.20(d)(3), 483.1 PARTICIPATE PLA	0(k)(2) RIGHT TO NNING CARE-REVISE CP	Fź	280			
	incompetent or othe incapacitated under	r the laws of the State, to ing care and treatment or					
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after					
	by: Based on interview failed to update a fa assessment for 3 c R15, R16) reviewed	NT is not met as evidenced and record review the facility all care plan and fall risk of 13 sampled residents (R11, d for falls in a sample of 30.					
	Findings include:						
	1. According to the	nurses notes 7/6/11 8:00pm					

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CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
145850	B. WING	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE	
CEDAR POINTE REHAB & NURSING	5825 WEST CERMAK ROAD CICERO, IL 60804	0
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE TO THE APPROPRIATE DATE CIENCY)
<ul> <li>F 280 Continued From page 28 indicates R16 was found sitting on the floor, stating she slipped to the floor. The nurse note indicates that R16 was wearing co-peer shoes that were to large. The note indicates that R16 was assessed to have no injuries.</li> <li>According to the facility 's incident and accident reports there were no incident report completed noting R16 's fall incident on 7/6/11.</li> <li>On 9/28/11 at 4:00pm during the daily status meeting E3 (director of nursing) said that after residents are involved in fall incidents staff are required to complete an incident report, complete a post fall risk assessment, and update the plan of care as it relates to the fall.</li> <li>According to the fall prevention program a fall risk assessment will be performed after any fall incident, and safety interventions will be implemented for each resident. The fall prevention program denotes the care plan will include interventions to reduce the residents risk for falls, the policy denotes interventions are changed with each fall.</li> <li>2. Record review of R11 's monthly weights and vital record denotes in July 176 pounds, August 183 pounds and in September 189 pounds. Record review of quarterly nutritional progress note dated 7-6-11 denotes R11 weight of 176 pounds, weight increasing gradual monthly, low sodium diet continued. Record review of nutritional progress notes dated 9-7-11 R11 re-admitted general/ regular diet. Record review of nutritional progress notes dated 9-12-11</li> </ul>	F 280	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 02/22/2012

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 29 F 280 denotes significant weight gain increase 13.86 pounds in three months. Appetite has been good, general diet no dentures. Record review of R11 's care plan therapeutic diet dated 7-13-11 and 9-7-11, Goal: will ingest adequate nutrition and fluids. Approach: provide diet as ordered, monitor weights and offer food preferences. Interview with E12 (Registered Dietician) on 9-28-11 at 11:50 AM states we did not address the issue in the dietary notes or in the care plan. E12 states she will address it now, not sure how it was missed. Interview with E2 (Director of Operations) on 9-29-11 at 9:55 AM, states dietary missed addressing R11 's weight gain in the care plan and dietary notes. Record review of R11 's therapeutic diet care plan dated 9-27-11, problem: resident with weight gain increase 13.8 pounds, probable snacking/eating between meals. Approach: registered dietician consult and educate resident per prescribed diet orders. 3. R15 is a 54 year old resident with a history of anxiety, osteoarthritis, esophageal reflux, bipolar disorder, alcohol dependence, hypertension, mild arterial stenosis, bilateral lower extremities and a history of falls. R15 had fall incidents on 4/29/11, 3/22/11 and on 7/13/11. All three fall incidents occurred after R15 went out of the facility on pass and became intoxicated on alcohol. Review of R15 ' S medical record and care plan, showed that the facility failed to reassess R15 's fall risk after each fall and did not develop a care plan for falls until after R15 's fall on 7/13/11, when R15 fell while out on pass. There was also

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280 F 281 SS=D	no substance abuse record, although R1 abuse and has retu on numerous occas During an interview rehabilitation servic 9/28/11 at 5PM, she hired and was rece 9/1/11. She stated th hasn ' t been able to review his case or of substance abuse ca survey team on 9/2 meeting. R15 ' s for employed with the f interview. Per the facility ' s fat is to be assessed u after a fall. The resi developed and revisi needs. 483.20(k)(3)(i) SER PROFESSIONAL S The services provid must meet professi This REQUIREMEN by: Based on interview failed to follow their complete an incider	e care plan in R15 ' s medical 15 has a history of substance irned to the facility intoxicated sions. with R15 ' s psychiatric e coordinator (E15) on e stated that she was just ntly assigned to R15 on that due to her caseload she o make contact with R15 to care plan. A newly created are plan was provided to the 9/11 during the daily status rmer PRSC is no longer facility and was unavailable for all policy, a resident ' s fall risk igon admission, quarterly and ident ' s care plan is to be sed based on assessed		280			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/25	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	1. According to the R16 was found on the B16 was found on the bedpost, R16 's and when asked R nose by a co-peer. s physician was not According to the far reports there were and no report was for abuse investigation there were no invest allegations made by her in the nose. On 9/28/11 at 4:00 meeting E2 (acting nursing), both said incident report and/ According to the nur indicates R16 was stating she slipped indicates that R16 was stating she slipped indicates that R16 was stating to the far reports there were noting R16 's fall in On 9/28/11 at 4:00 meeting E3 (director residents are involve required to complet	nursing notes 6/22/11 3:20pm the floor in her room against s nose was noted as bleeding, 16 said that she was it in the The note indicates that R16 ' tified and ice applied. cility ' s accident and incident no reports noted on the log,, found after review of all June, 2011. According to the is files provided by the facility stigations noted with the y R16 that another resident hit of that she couldn't locate the for abuse investigations. urses notes 7/6/11 8:00pm found sitting on the floor, to the floor. The nurse note was wearing co-peer shoes The note indicates that R16 ave no injuries.	F	281			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 825 WEST CERMAK ROAD		
CEDAR F	POINTE REHAB & NU	RSING			CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	incidents and accid incident form should nursing.	cates to document all ents, and that the completed d forwarded to the director of	F	281			
F 309 SS=D	evidenced by an Ur dated 7/14/11. The reported a fall which There was no evide done to rule out abut the injured hand an 7/14/11. The X-Ray of fracture nor dislo after 2 days R69 co pain and was sent of repeat X-Ray show E3 (Director of Nurs- incident was not invi- injury reported to th 483.25 PROVIDE C	CARE/SERVICES FOR	F	309			
55=D	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment					
	by: Based on interview failed to ensure that	NT is not met as evidenced and record review, the facility t lab tests were followed up R13) residents out of 5					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WIN	1G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309		ige 33 for lab tests in the sample of	F	309			
	Findings include :						
	1) R13 has diagno of Substance Abuse	oses of Breast cancer, History e and Asthma.					
	dated 8/22/11, a sto was ordered. Only o dated 8/25/11. R13 Hepatitis B RNA wa of 9/29/11, no Hepa	ician Order Sheet (POS) bol specimen for C. Difficile x 2 one result was in the record ' s POS also indicated that as ordered on 9/23/11, yet as atitis RNA was done. R13 ' s tibodies was tested positive.					
	2) R12 has diagno and Gastric Ulcer.	oses of Hypertension, BPH,					
	blood, Urinalysis for	cated that a stool for occult r micro-albumin, and EKG / 6 months. There were no ts in R12 ' s record.					
F 314 SS=D	9/29/11 during daily R12 ' s EKG will be 483.25(c) TREATM		F:	314			
	resident, the facility who enters the facil does not develop p individual's clinical they were unavoida pressure sores rece	orehensive assessment of a r must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and					

Facility ID: IL6009948

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa prevent new sores	-	F	314			
	by: Based on interview failed to provide phy	NT is not met as evidenced and record review the facility ysician ordered wound s for 1 of 30 residents R26, sure ulcers.					
	Findings include:						
		nical record nurse notes dated was admitted to the facility.					
	dated 9/2/11 indicat include; right lateral saline, apply Hydrog day and as needed cleanse with norma every three days an cleanse with norma foam, dry dressing healed, coccyx clea	Imitting physician orders sheet tes wound treatment orders to I leg cleanse with normal gel, dry dressing every other until healed, right lateral foot al saline apply dry dressing nd as needed, right gluteal al saline apply non-adhesive daily and as needed until anse with normal saline, apply sing foam, dry dressing daily aled.					
	wounds wasn't asse 9/5/11. The note in	ound treatment notes R26 essed and measured until included the first description of note indicates that the ere carried out.					
	9/5/2011 was the fir R26. The orders or	eatment administration record, rst treatment administered to n the treatment administration de: right lateral leg cleanse					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145850	B. WI	IG		10/2	5/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314 F 323 SS=H	with normal saline, every other day and lateral foot cleanse dressing every three gluteal cleanse with non-adhesive foam needed until healed saline, apply non-ad dressing daily as ne orders that given at treatment administr 9/2/11, 9/3/11, and On 9/30/11 at 10:45 was unable to verba any wound treatme said that she wasn't the time of the miss the former treatmer employed by the fac wound nurse is not nurse make the ass and administer trea 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and adequate supervisio prevent accidents.	apply Hydrogel, dry dressing d as needed until healed, right with normal saline apply dry e days and as needed, right normal saline apply d, dry dressing daily and as d, coccyx cleanse with normal dhesive dressing foam, dry eeded until healed. The same t admission on 9/2/11. The ration record was blank for 9/4/11. 5am E21 (treatment nurse), alize why R26 didn ' t receive nt for 3 days, however E21 t employed by the facility at sed treatments. E21 said that nt nurse was no longer cility. E21 said that when available it up to the primary sessment of residents wounds itments. F ACCIDENT VISION/DEVICES hsure that the resident ns as free of accident hazards each resident receives on and assistance devices to		314				
	5	tions, interview and record						

		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG		10/2;	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	cognitively impaired risk for falls and fail interventions to pre falls resulting in frac R19 and R44, failed cognitively impaired physical altercation residents and result investigate and ass cause for falls in 6 of R15,R18, R19, R23 sample of 30 reside R44, R38, R36, R3 supplemental samp The findings include 1) R2 is a wheel-ch who has a diagnose dementia, hyperten Accident per the cu Set (MDS). R2 is di (person, place and 9/14/11 care plan for making. On 9/27/11 at 10 A room, R2 was seate aide) was standing semi-cast and wrap stated he has a ten she is re-applying it his chair alarm and On 9/28/11 at 9:30 the hall near the nu	ailed to provide supervision for d individuals assessed as high led to provide effective vent the numerous falls, some ctures for R2 and sutures for d to provide supervision for d residents who have been in with other cognitively impaired ted in injuries and failed to sess individuals for the root of 13 residents (R2, R13, B) reviewed for falls in the ents and 8 residents (R34, 3, R32, R39, R45) in the ole.	F	323			

		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB 145850		(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG		10/2	5/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	around his neck wa is swollen. E13 (nut the cast is off but st it needs to be repla the physician 's orc R2 needs to keep th E13 stated the nurs find the semi-cast in contact the restorat R2 removed from th fitted for a semi-cast can not be found, F A.M., R2 is back in semi-splint is off an aide) and E15, the Rehabilitation Servi the room. Throughd wheel-chair in the d near nurses ' static splint and throw it o resident needed ren wheel-chair. R2 is care planned to be re-applied wh always put back on Review of the facilit 11 to September ' were not witnessed and no investigation occurred. Review of the incide fall on 6/8/11 at 6:1 room, where R2 is for over-bed table brok	as not in use. R2 's right hand rse) stated not to know why tated he often removes it and ced. E13 returned and stated der has not been changed and he semi-cast on at all times. Se aide stated she could not n his room. E13 stated she will tive department. At 10 A.M., he 4th floor dining room to be st. E13 stated since the cast R2 will be refitted. At 10:55 the dining room. The nd on the floor. E17 (activity P.R.S.C. (Psychiatric ice Counselor) were circulating but the week, R2 was in his dining room and/or in the hall on. R2 was seen to remove his on the floor. Numerous times minders not to get out of his	F	323			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/2	5/2011	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	Continued From pa say what happened	-	F	323	3			
	document R2 found confused however	es ' notes dated 6/8/11 d on dining room floor. R2 is he interacts with staff. If R2 fused, he will be sent out to						
	on the floor in the h staff saw him walkin The report does no saw him walking ar have been walking unsteady gait. The	/11 at 12:15 P.M. when R2 is all. The report documents that ng down the hall prior to fall. t indicate which staff person ad whether or not be should independently due to his report does not document if ries. It documents 911 was						
	document R2 was went to floor. R2 for right arm and hand pain to head and ar dizziness while star R2 's right side of f R2 was admitted to of Syncope. When	es' notes dated 6/11/11 walking down hall to lunch and und on his right side with his under him. R2 complained of m. R2 complained of nding and while on the floor. face was red. 911 was called. the hospital with a diagnosis he returned from the hospital, gnosis of encephalopathy.						
	p.m. where R2 was documents he was placed in wheel-cha injury but there is n determine how and any follow-up to ens	ted fall is dated 6/14/11 at 6:30 found on his floor. The report removed from floor and air. The report documents no o investigation into the fall to why it happened. Nor is there sure there is no injury.						

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	√G _		10/25	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	11:40 A.M. where F floor. R2 can not s disoriented to all 3 reminded to stay in are to continue to n evaluate resident for no investigation into was not effective du facility implemented frames are unclear discontinued and th The report dated 8/ R2 stated another r a new cut on the rig to cut. There was n other resident ident The report dated 9/ documents R2 on f was asked what ha onto the floor becau arm cast is with in r edema. It document this fall and R2 has incident reports doo a fall. Review of nurses ' document R2 on th claimed to not fall.' seen or any investig note dated 8/11/11 swollen and R2 cor ordered. There wa incident.	R2 is found on the dining room ay what happened. R2, who is spheres and confused, was his chair. The interventions nonitor resident and to or laptop cushion. There was to the fall. The laptop cushion ue to R2 removing it so the d the chair alarm but the time as to when the laptop was he chair alarm implemented. (31/11 at 2:40 p.m. document resident hit him and there was ght cheek. R2 received first aid to investigation nor was the	F	323			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850		(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG		10/2	5/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa documents no fract	-	F	323				
	documents R2 to be was pale in color ar orbital area and ser note dated 9/4/11 a admitted under alte back to the facility of done on 9/6/11 at th documents there is the 5th metacarpal close opposition of no investigation into	es' notes dated 9/4/11 e very lethargic and weak. R2 nd had swelling in the right eye nt out to hospital. Nurses' at 8 P.M. documents R2 was ered mental status. R2 returns on 9/6/11 and an x-ray was he hospital. The hospital x-ray a fracture through the neck of of the indeterminate age with fracture fragments. There was to the fracture to determine ractured his 5th metacarpal.						
	a portable x-ray ma and R2. Z6 stated r R2 ' s right wrist an A.M., E3 (acting dir x-ray was done bed	5 A.M., in R2 's room, there is achine and Z6 (a technician) ne was called to do an x-ray on d hand. On 9/30/11 at 9:38 rector of nursing) stated the cause he keeps removing the ults are the fracture is still						
	9/19/11 and 9/22/17 with injury. The inc	rrent care plan for falls dated 1 document a fall on 9/14/11 ident of 9/14/11 does not to the fall. R2 already had the 11.						
	administration, E3 a stated they are una investigations were physical altercation	A.M. during daily meeting with and E2 (director of operations) ble to answer why no done into the falls, the s between residents and vn origins. E2 stated she was						

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2;	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	hired one month ag Z7 (ex-director of n investigations. E3 s 10/25/10 to 7/29/11 personnel file reflect 2) R19 is a 70 year wanders the unit wi extremely thin. At 7 per the 8/24/11 MD spheres, person, pl care plan for orienta throughout the wee dining room, reside wears a cervical co care plan documen worn at all times. O to 10:35 A.M. durin with E13, E13 state collar due to his nut Review of the incide falls on 7/26/11, 8/1 witnessed and 2 of injuries. The incide P.M. documents R7 resident ' s room. R forehead, above the left and right knees There was no inves 8/19/11 at 2:45 P.N underneath a dress room. R19 sustaine the left elbow. No in 7/26/11 at 10:40 A. the floor in the hally	go and E3 stated she thought bursing) was handling the stated Z7 was employed from I when she resigned. The cted the same dates. Told, ambulatory male who ithout purpose. R19 is tall and '2 inches tall, he weighs 109# OS. R19 is disoriented to all 3 lace and time per the current ation. R19 was seen ek to wander in and out of ent rooms and in the hall. R19 ollar at all times. The current ths the cervical collar is to be on 9/27/11 between 9:50 A.M. g the initial tour of 4th floor ed R19 wears the cervical	F	323			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		-	825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	The incidents dated document R19 fell f left orbital area " su wound. R19 require The reports docum witnessed the incid from her nor was the incident dated 5/29, housekeeper and a ambulating in the d balance and fell. R 's left elbow is swo an x-ray to entire lei identified by name f There were no x-ra This incident was n There is an inciden P.M. documents wha another resident was the hallway. R19 su wrist area. No injuri resident was identifiname. Both separa investigation as to w and other resident was dementia and conv (6/11/11 and 7/5/11 A.M. to 10:30 A.M. R38 was seated in dining room. R38 w	d 7/18/11 at 4:20 A.M. from bed and " hit his upper ustaining a small 1 inch ed 4 sutures to the forehead. ents E32, a nurse aide, ent but there is no statement here an investigation. An /11 at 1:15 P.M. documents a nurse aide see R19 ining room, stood still, lost 19 landed on his left side. R19 illen. An order is obtained for ft arm. The staff were not nor are there any statements. y results provided or seen.	F :	323			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850		(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR P	OINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	himself throughout and dining rooms. On 9/29/11 at 11:35 environmental tour environmental tour common bathroom, opposite side of the wheel-chair in a toil spoken to, R38 did summoned. In the r the wheel-chair usir stall, failing to lock H rolled backwards. R incontinent brief and was then E13 enter what he was doing response from R38 Review of the curre documents R38 red assistance for toilet bowel and bladder. Review of the incide 2:10 P.M. documen in the 4th floor dinin side of his body and R38 could not say w witnessed it but the from the person. Ar and it was negative determine the caus and fall. Review of the incide	ek, R38 was seen propelling the unit, in and out of rooms 5 A.M. during the with E20 (director of ), R38 was in the female , which is located on the e unit. R38 was in his et stall, facing toilet. When not respond. E13, nurse, was meantime, R38 stood up from ng the grab bars in the toilet his wheel-chair, the chair R38 removed his pants and d dropped them to the floor. It red the room and asked R38 in the female bathroom. No c.	F	323	3		

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PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE       COMPARING DEFICIENCY         F 323       Continued From page 44       F 323         There is second page to the Unusual Occurrence Report (incident report). The second page is labeled Management Follow-up to Incidents. There is a section labeled " interview with staff" it documents the staff found R38 on the floor. R38 was unable to say what happened. R38 was stood up after the fall and he walked to the smoke room (the outside patio adjacent to dining room). There was no investigation to determine what happened to cause his fall. Nor does the report identify the staff person.         The incident report date 6/14/11 at 6 P.M. documents R38 is orient times one, loss stability and fell to the floor onto his right side. R38 was picked up and placed into wheel-chair. This was witnessed by a nurse on the floor. There is no investigation into the fall. R38 was ambulating or stood up from wheel-chair prior to the fall.         The incident report dated 7/5/11 at 8:35 A.M. documents R38 laying on the dining room floor and it was not witnessed. R38 placed in wheel-chair. No investigation was done.         The incident report dated 7/28/11 at 12:30 P.M. documents R38 was stiking a female resident in			AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       CEDAR POINTE REHAB & NURSING     SECOND STATE, ZIP CODE       (24) ID PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX TAG     PROVIDER'S FLAN OF CORRECTION (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX TAG     PROVIDER'S FLAN OF CORRECTION (EACH OERCIENCY)     OWN CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 323     Continued From page 44 4th floor dining room landing on his left side. The incident does not document if it was witnessed. There is second page to the Unusual Occurrence Report (Incident report). The second page is labeled Management Follow-up to Incidents. There is a section labeled " interview with staff" it documents the staff found R38 on the floor. R38 was unable to say what happened. R38 was stood up after the fail and he walked to the smoke room (the outside patio adjacent to dining room). There was no investigation to determine what happened to cause his fail. Nor does the report identify the staff person.     F 323       The incident report date 6/14/11 at 6 P.M. documents R38 is orient times one, loss stability and fell to the floor onto his right side. R38 was picked up and placed into wheel-chair. This was witnessed by a nurse on the eis no investigation into the fail. R38 was unable to say what happened. It is unclear if R38 was mubulating or stood up from wheel-chair prior to the fail.       The incident report dated 7/5/11 at 8:35 A.M. documents R38 laying on the dining room floor and it was not witnessed. R38 outen to say how he feil. No injuries noted and R38 placed in wheel-chair. No investigation was done. <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
CEDAR POINTE REHAB & NURSING       SUMMARY STATEMENT OF DEFICIENCIES (EACH OERCIENCY MUST BE PRECEDED BY FULL (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PREFX TAG     PROVIDER'S FLAN OF CORRECTION (EACH OERCIENT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       F 323     Continued From page 44 4th floor dining room landing on his left side. The incident does not document if it was witnessed. There is second page to the Unusual Occurrence Report (incident report). The second page is labeled Management Follow-up to Incidents. There is a section labeled " interview with staff" it documents the staff found R38 on the floor. R38 was unable to say what happened. R38 was stood up after the fail and he walked to the smoke room (the outside patio adjacent to dining room). There was no investigation to determine what happened to cause his fail. Nor does the report identify the staff person.       The incident report date 6/14/11 at 6 P.M. documents R38 is orient times one, loss stability and fell to the floor on the fail, thor does the report identify the staff serson.       The incident report date 6/14/11 at 825 A.M. documents R38 laying on the dining room floor and it was not withessed. R38 was picked up and placed into wheel-chair. This was witnessed by a nurse and there is no investigation into the fail. No injuries noted and R38 placed in wheel-chair. No investigation was done.       The incident report dated 6/28/11 at 12:30 P.M. documents R38 was striking a female resident in			145850	B. WI	NG _		10/2	5/ <u>2011</u>
CHEDRA POINTE REHAB & NURSING       CICERO, IL 60804         (M) ID TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFX TAG       PREFX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFX TAG       PREFX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFX TAG       PREFX (EACH ORRECTION MIST BE ADDREED CORSTREPENENCED TO THE APPROPRIATE DEFICIENCY)       O OME         F 323       Continued From page 44 4th floor dining room landing on his left side. The incident report, The second page is labeled Management Follow-up to Incidents. There is a section labeled " interview with staff" it documents the staff found R38 on the floor. R38 was unable to say what happened. R38 was stood up after the fall and he walked to the smoke room (the outside patio adjacent to dining room). There was no investigation to determine what happened to cause his fall. Nor does the report identify the staff person.         The incident report date 6/14/11 at 6 P.M. documents R38 is orient times one, loss stability and fell to the floor onto his right side. R38 was picked up and placed into wheel-chair. This was witnessed by a nurse on the floor. There is no name of this nurse and there is no investigation into the fall. R38 was ambulating or stood up from wheel-chair prior to the fall.         The incident report dated 7/5/11 at 8:35 A.M. documents R38 laying on the dining room floor and it was not witnessed. R38 could not say how he fell. No injureis noted and R38 placed in wheel-chair. No investigation was done.         The incident report dated 6/28/11 at 12:30 P.M. documents R38 was stikling a female reside	NAME OF PI	ROVIDER OR SUPPLIER					_	
PREPIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREPX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       Continued From page 44         F 323       Continued From page 44       F 323         There is second page to the Unusual Occurrence Report (incident report). The second page is labeled Management Follow-up to Incidents. There is a section labeled " interview with staff" it documents the staff found R38 on the floor. R38 was unable to say what happened. R38 was stood up after the fall and he walked to the smoke room (the outside patio adjacent to dining room). There was no investigation to determine what happened to cause his fall. Nor does the report identify the staff person.         The incident report date 6/14/11 at 6 P.M. documents R38 is orient times one, loss stability and fell to the floor onto his right side. R38 was witnessed by a nurse on the floor. There is no name of this nurse and there is no investigation into the fall. R38 was ambulating or stood up from wheel-chair prior to the fall.         The incident report dated 7/5/11 at 8:35 A.M. documents R38 laying on the dining room floor and it was not witnessed. R38 placed in wheel-chair. No investigation was done.         The incident report dated 6/28/11 at 12:30 P.M. documents R38 was satiking a female resident in	CEDAR P	OINTE REHAB & NU	RSING					
4th floor dining room landing on his left side. The incident does not document if it was witnessed. There is second page to the Unusual Occurrence Report (incident report). The second page is labeled Management Follow-up to Incidents. There is a section labeled " interview with staff " it documents the staff found R38 on the floor. R38 was unable to say what happened. R38 was stood up after the fall and he walked to the smoke room (the outside patio adjacent to dining room). There was no investigation to determine what happened to cause his fall. Nor does the report identify the staff person.         The incident report date 6/14/11 at 6 P.M. documents R38 is orient times one, loss stability and fell to the floor onto his right side. R38 was picked up and placed into wheel-chair. This was witnessed by a nurse on the floor. There is no name of this nurse and there is no investigation into the fall. R38 was unable to say what happened. It is unclear if R38 was ambulating or stood up from wheel-chair prior to the fall.         The incident report dated 7/5/11 at 8:35 A.M. documents R38 laying on the dining room floor and it was not witnessed. R38 could not say how he fell. No injuries noted and R38 placed in wheel-chair. No investigation was done.         The incident report dated 6/28/11 at 12:30 P.M. documents R38 was striking a female resident in	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
the face with his fist. This was witnessed by E33, a staff person. No title was given in the report. There was no investigation into the altercation nor was the female resident identified. The incident report dated 8/29/11 at 1:35 P.M.	F 323	4th floor dining room incident does not de There is second pa Report (incident rep labeled Manageme There is a section la it documents the sta R38 was unable to stood up after the fa smoke room (the out room). There was ne what happened to out report identify the star The incident report documents R38 is of and fell to the floor picked up and place witnessed by a nurse into the fall. R38 wat happened. It is und stood up from whee The incident report documents R38 lay and it was not witne he fell. No injuries ne wheel-chair. No inv The incident report documents R38 wat the face with his fis a staff person. No t There was no invest was the female rest	m landing on his left side. The ocument if it was witnessed. Ige to the Unusual Occurrence port). The second page is int Follow-up to Incidents. abeled " interview with staff " aff found R38 on the floor. say what happened. R38 was all and he walked to the utside patio adjacent to dining to investigation to determine cause his fall. Nor does the taff person. date 6/14/11 at 6 P.M. orient times one, loss stability onto his right side. R38 was ed into wheel-chair. This was se on the floor. There is no and there is no investigation as unable to say what lear if R38 was ambulating or el-chair prior to the fall. dated 7/5/11 at 8:35 A.M. ring on the dining room floor essed. R38 could not say how noted and R38 placed in estigation was done. dated 6/28/11 at 12:30 P.M. as striking a female resident in t. This was witnessed by E33, itle was given in the report. stigation into the altercation nor ident identified.	F	323			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	forehead by anothe over the peer 's fee peer is identified by other identifier for the identity is unclear. This a there a statement for were re-directed. On 9/30/11 at 9:55 with administration are unable to identi physical altercation witnessed the falls. one month and E3 Director of Nursing 4) On 9/27/11 betw A.M during the initia Coordinator/nurse), and asking for mon confused. R44 's d schizoaffective disc disorder per the inc On 9/29/11 at 11:22 environmental tour Maintenance), R44 at the doorway. In t the floor, was a yell like urine. E20 state on the floor and in t air conditioner unit room, which is not of R44 had a fixed gla	struck in the right side of the r peer because R38 had ran et with his wheel-chair. The room number but there is no his resident. The aggressor 's The incident was witnessed by aide is not identified nor is rom the aide. Both residents A.M. during the daily meeting staff, E2 and E3 stated they fy the residents involved in the s or any staff member who E2 stated to be employed for stated she thought the former was doing the investigations. een the 9:50 A.M. to 10:30 al tour with E13 (MDS R44 was ambulating the unit ey from E13. R44 was very iagnoses include paranoid order, dementia and seizure ident report (7/12/11). B A.M during the with E20 (Director of was standing inside his room he hall outside of his room, on ow-pooled liquid that looked ed R44 has a habit of urinating he air conditioner units. The in the room next to R44 's occupied, smelled of urine. re on his face and would not ns. E20 summoned the	F	323	3		

Facility ID: IL6009948

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PRINTED: 02/22/2012

		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFIC	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850		(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WIN	IG		10/2	5/2011
NAME OF PROVIDER	OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE I	REHAB & NU	JRSING			25 WEST CERMAK ROAD ICERO, IL 60804		_
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323 Continu	ued From pa	ige 46	F 3	323			
docum assista	ents R44 reo ince in toilet	ent quarterly 8/11/11 MDS quires one person limited use and occasionally el and bladder.					
Review 5:30 A. 2:30 P. 7/18/11 The 6/5 was for small a was un investig The wit disorier without rolled b forward left eye interver becaus what has see a n 8/12/11 with his " Initial seizure does no levels ( (routine investig The ind was wit stumble	v of R44 's in M., 7/12/11 M. document resulting in 5/11 incident und sitting of mount of blo table to say v gation to detern the seed fall of the seed fall of the seed fall of the booking the booking the booki	ncident reports dated 6/5/11 at at 12:30 A.M. and 7/18/11 at its all falls with the incident of sutures to the left eye brow. t was not witnessed and R44 in the floor next to bed with a bod on the right cheek. R44 what happened. There was no ermine what caused the fall. of 7/18/11 documents R44 as got up from his wheel-chair brakes and the wheel-chair brakes and the wheel-chair at lost his balance and fell head causing a cut above the juired 3 sutures. The eep him out of any wheel-chair ulatory. R44 was unable to say here was an order for R44 to The neurologist ' s report dated a R44 is a 56 year old male epsy. The chief complaint listed I exam. The patient has and dementia. " The report t any test done. Recommends d and Dilantin) and RTL nonths. There was no he witness is not identified. 7/12/11 documents the fall E34, a nurse aide. R44 had feet. The report does not ors such as condition of floor					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WIN	G		10/2	5/2011
NAME OF P	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	IRSING			325 WEST CERMAK ROAD ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	and R44 's foot we the unidentified nur floor. 5) R36 is a 60 year R36 was confused spheres. Staff woul dining room. At time propel the wheel-ch dementia and schi 4/14/11 incident rep Review of R36 's a documents R36 rec with walking and us The MDS documer lower extremities at mobility. Review of R36 's in 10:30 A.M., 4/29/11 A.M. and 6/20/11 a witnessed falls. The documents during a floor, R36 stood up his right side of the remembers falling I disturbances. The i to check with nurse the floor. R36 has a a wheel-chair when investigation or staff was not asked to re from chair with uns	ar. There is no statement from rese who assisted R44 off the rold, wheel-chair bound male. and not oriented to all 3 ld push R36 in and out of the es, R36 would use his feet to hair. R36 's diagnoses include zoaffective disorder per the port. annual 9/19/11 MDS quires one person assistance ses a wheel-chair on the unit. hts he has impairment with his nd requires a wheel-chair for ncident reports dated 4/9/11 at 1 at 2:40 p.m., 5/26/11 at 2:45 t 8:25 A.M. document e incident dated 4/9/11 a group meeting on the second by was unsteady and fell hitting face. R36 stated he but denied headache or visual intervention is for activity staff es prior to removing R36 from an unsteady gait and requires n leaving floor. There was no tements to determine why R6 emain seated when he got up	F 3	23	DEFICIENCY)		
	a dining room chair	r, stood up, walked with ss the room and fell. When					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	1G		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	R36 was asked if h no. " following the documents R36 alw the nurse is the one documents R36 's intervention was to The incident of 5/26 aide saw R36 come down the hallway a nurse, who is not id his backside on the R36 stated he was and used his hands investigation to dete The incident dated carry his own break feet, falling to the fl The intervention we Physical therapy de the floor. There is n continues to fall and interventions in plac The incident dated at 11:45 A.M. and 9 un-witnessed incide documents R36 fac room. R36 was una The intervention is was no investigatio The incident 8/28/1 identified, finds R36 stated he was walk nurse aide stated d	e was okay, he responded " " no " response, the report vays responds " no " . E35, e who witnessed the fall and gait to be unsteady. The counsel him on safety. 6/11 documents E37, nurse e out of his room, stumble nd fall. E37 informed the dentified, and she finds R36 on e hallway floor. No injuries. going home, stumbled forward is to brace his fall. No ermine why he is so unsteady. 6/20/11 documents R36 was cfast tray, tripped over his own oor and injuring both knees. ere to check vitals and notify epartment. R36 stated he fell to no investigation as to why he d why there are no ce. 4/14/11 at 7:25 A.M, 8/28/11 9/16/11 at 6:15 A.M. are ents, The 4/14/11 incident ce down on the floor in his able to say what happened. one on one monitoring. There	F	323			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT O AND PLAN OF (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2;	5/2011
NAME OF PRO	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR PO	DINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
n that a to Twirhowfrstor 6 rowwirdsdp Rhs Tdrotorir Td	he hall rails if necess assistance if needed o determine what c The incident dated 9 vas heard and R36 njuries. R36 respon- nome. The nurse ai on the floor. The inte- vheel-chair but bec- rom the chair he was station. No investig o fall. b) On 9/28/11 at 11 oom, R32 was hold valked because the vaist and the length nches too long. R32 dementia secondary subdural hematoma lisorder and status per the 6/1/11 incide Review of the annua- supervision and set supervision and set focuments R32 on oom floor. It was no o say what happen nvestigation as why The incident dated 8 documents R32 is p	<ul> <li>Intervention is for R36 to use ssary and to ask for d. There was no investigation caused him to fall.</li> <li>9/16/11 documents a noise found on floor in his room. No nded he was trying to go de, not identified, found R36 ervention is to place R36 in a cause he continued to get up as placed at the nurses ' gation as to why he continues</li> <li>:58 A.M. in the 4th floor dining ding up his pants while he e pants were too big in the nof the pants were several 2 's diagnoses include y to the traumatic brain injury, a, bipolar disorder, seizure post shunt and craniotomy ent report.</li> <li>al 9/13/11 MDS documents ent for walking but requires -up for dressing.</li> <li>6/1/11 at 2:30 P.M. his buttocks on the dining ot witnessed. R32 was unable ed. There was no</li> </ul>	F	323			

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PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM C         F 323       Continued From page 50 residents are separated and re-directed to their rooms. E30 (nurse aide) stated she saw another resident, who is not identified, grab R32 ' s collar       F 323			AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
143630       10/25/201         NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         CEDAR POINTE REHAB & NURSING         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         F 323       Continued From page 50 residents are separated and re-directed to their rooms. E30 (nurse aide) stated she saw another resident, who is not identified, grab R32 ' s collar       F 323				` '				
CEDAR POINTE REHAB & NURSING         Summary statement of deficiencies (EACH deficiency must be preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION)         F 323       Continued From page 50 residents are separated and re-directed to their rooms. E30 (nurse aide) stated she saw another resident, who is not identified, grab R32 ' s collar       F 323			145850	B. WI	NG _		10/2	5/2011
CEDAR POINTE REHAB & NURSING         CICERO, IL 60804         (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)       COM COM COM COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 323       Continued From page 50 residents are separated and re-directed to their rooms. E30 (nurse aide) stated she saw another resident, who is not identified, grab R32 ' s collar       F 323	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM CONTROL         F 323       Continued From page 50 residents are separated and re-directed to their rooms. E30 (nurse aide) stated she saw another resident, who is not identified, grab R32 ' s collar       F 323	CEDAR	POINTE REHAB & NU	RSING					
residents are separated and re-directed to their rooms. E30 (nurse aide) stated she saw another resident, who is not identified, grab R32 ' s collar	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE
<ul> <li>and push him against the elevator doors. R32</li> <li>then struck the other resident. There is no investigation into the physical altercation and why was there no immediate intervention/supervision. The intervention was to separate the residents, medication given to decrease the agitation but does not indicate if both residents were medicated or just one resident and re-direct them to their rooms, not a supervised area.</li> <li>7) Throughout the week, R34 would ambulate in and out of the room to the nurses ' station and in/out of the dining room, carrying a bible and saying incoherent gibberish and return to her room where she would mostly stay, sitting on her bed. R34 would wer a house dress and non-skid socks. R34 is an 85 year old, ambulatory female who is very disoriented. R34 ' s diagnoses include dementia, bipolar disorder and schizophrenia per the 8/23/11 incident.</li> <li>On 9/29/11 at 11:30 A.M. during the environmental tour with E20 (director of maintenance), R34 is seated on her bed with her bible as seen all week. R34 was talking to herself. She left room and began to follow us talking incoherently and swearing. As we left her side of the unit and proceeded back to the nurses ' station. There is a 12 foot electrical cord for the floor buffer that extends the width of the hallway. R34 is following us and needs to step over the cord.</li> <li>The incident reports dated 4/29/11 at 2:30 A.M. documents a loud noise was heard by nurse and</li> </ul>	F 323	residents are separ rooms. E30 (nurse resident, who is not and push him again then struck the other investigation into th was there no imme The intervention was medication given to does not indicate if medicated or just o to their rooms, not a 7) Throughout the w and out of her room in/out of the dining saying incoherent g room where she wo bed. R34 would we non-skid socks. R3 ambulatory female s diagnoses include and schizophrenia p On 9/29/11 at 11:30 environmental tour maintenance), R34 bible as seen all we She left room and b incoherently and sw the unit and procee station. There is a 1 floor buffer that exter R34 is following us cord. The incident reports	rated and re-directed to their aide) stated she saw another t identified, grab R32 ' s collar nest the elevator doors. R32 er resident. There is no he physical altercation and why diate intervention/supervision. as to separate the residents, o decrease the agitation but both residents were one resident and re-direct them a supervised area. week, R34 would ambulate in n to the nurses ' station and room, carrying a bible and gibberish and return to her ould mostly stay, sitting on her ear a house dress and 44 is an 85 year old, who is very disoriented. R34 ' e dementia, bipolar disorder per the 8/23/11 incident. 0 A.M. during the with E20 (director of is seated on her bed with her eek. R34 was talking to herself. began to follow us talking wearing. As we left her side of eded back to the nurses ' 12 foot electrical cord for the ends the width of the hallway. and needs to step over the	F	323	3		

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR P	OINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	R34 on the floor on complained about s but refused the Tyle fracture and disloca dream that there we ran to the window. put in place. The incident dated d documents R34 is f and has a cut on he re-directed and resi no investigation into it does not identify t out to hospital for e follow-up to this info The incident dated d a nurse aide, not ide on the floor. The nu floor and onto the b what happened. The nurse aide as to wh an investigation into cognitively impaired assistance. The incident dated d document R34 was her head by anothe documents a witnes is there any stateme investigation. The incident dated a documents R34 bei	t identified by name, who find her backside. R34 soreness on her right shoulder enol. X-ray was negative for a ation. R34 stated she had a ere snakes in the bed so she There were no interventions 6/14/11 at 8:45 A.M. found on the floor of her room er forehead. Other resident idents kept separate. There is b how the injury occurred and the other resident. R34 sent valuation and treatment but no prmation. 7/22/11 at 2 A.M. documents entified by name, found R34 urse aide helped R34 off the bed. R34 was unable to say here is no account from the nat she witnessed nor is there b why R34 fell. R34, who is d, was instructed to ask for 6/23/11 at 10:40 P.M. 5 punched in the right side of er resident. The report ss but no one is identified nor	F	323			

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		AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG		10/2	5/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	IRSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	seen. The other rest there was no invest was relocated to th The incidents dated 6/24/11 at 4:30 P.M assaulting (2.5 incl hospice nurse for m by her when R34 w station. No investig escalate. The incid R34 scratched E38 re-directed by E38. uncooperative. R34 psychiatric evaluati nor was there an in R34 's erratic beha 8) R33 is a 64 year has a diagnosis that disorder. R33 was radiation treatment A.M. to 10:30 A.M. (nurse), E13 stated treatment that more The incident dated documents R33 as report dated 6/10/1 as disoriented. The dated 6/28/11 at 12 altercations betwee The 5/27/11 inciden about her roommat she was taking a sl backside. The report	mon Bathroom. No injuries sident was not identified and tigation into the incident. R34 e dining room at this time. d 4/15/11 at 11 A.M and 1. document R34 physically h scratch on neck) the a to reason except she walked ras escalating at the nurses ' gation into what caused R34 to lent dated 6/24/11 documents c (staff) when R34 was R34 was aggressive and 4 was sent out to hospital for on. No follow up to the incident vestigation into the cause of	F	323			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	√G		10/2	5/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pa investigation docum	•	F	323			
	another resident we altercation and pulle the other resident s threw a cup at her a intervention is to " medication work-up	6/10/11 documents R33 and ere entangled in a physical ed apart by staff. R33 stated cratched her hand so she and will do it again. The see if R33 could have o on a psychiatric ward " per . There was no documented his intervention.					
	struck in the face by staff. There are no	6/28/11 documents R33 being y R38 and it was witnessed by staff identified and no hat caused the altercation.					
	on the floor. R33 is what happened. Th " watch where she i	7/7/11 at 8 P.M. R33 is found delusional and could not say in intervention was for R33 to is going. " There was no what caused the fall.					
		week, R39 was in the 4th floor ating in and out and Back and					
	9:30 A.M. documen diagnoses to includ schizoaffective disc The 9/13/11 at 9:30 R105 reporting to s fighting in the dayro R146 throw water o threw water on him witness the incident	ent report dated 9/13/11 at hts R39 to be 58 years old with le dementia, bipolar disorder, order and seizure disorder. D A.M incident documents taff that R39 and R146 were bom. R105 stated he saw on R38. R39 stated after R146 , he hit R146. Staff did not t. There was no investigation residents were not supervised					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From pa in the dayroom.	ge 54	F	323	3		
	document R39 was fell straight backwa floor. No injury. It is	8/1/11 at 10:10 P.M. walking out of his room and rds hitting his head on the unclear if it was witnessed. gation into the incident.					
	document R45 was dayroom. R45 is a s diagnoses that inclu bipolar disorder. R4 wheel-chair but not investigation to dete	port dated 7/4/11 at 1:30 P.M. found on the floor of the 50 years old and has ude brain injury, dementia and 45 stated she fell out of her sure how. There was no ermine what happened and vas not supervised. The tnessed.					
	Protocol " document medical causes; the issue. " Under Cau Staff will attempt to within 24 hours of the the fall is unclear, a medical causes suc drug reaction or if the despite attempted in review the situation causes. Under item 3. The situation causes. Under item 3. The situation cause of determined that cau finding the cause wo or the management Treatment/Manage	policy labeled " Falls - Clinical int that falls often have a ey are not just a " nursing use Identification, item 1. " define the possible causes he fall. Item 2. If the cause of and it may be significant ch as stroke or an adverse he resident continues to fall nterventions, a physician will and help identify contributing staff and physician will and evaluate information until falling is identified or it is use cannot be found or that rould not change the outcome t of the falls. Under ment, under item 2., if the annot be identified or					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	corrected, staff will interventions based until the falls reduce identified for its com and Follow-up, und continues to fall, the re-evaluate the situ possible reasons for will re-evaluate the interventions.	try various relevant d on assessment of the fall es or stop or until a reason is ntinuation. Under Monitoring ler item 4., if the individual e staff and physician will nation and consider other or the resident 's falling and continued relevance of current	F	323			
	history of substance admitted to the faci R13 ' s Criminal Recommendation F 8/30/11, indicated t offender, and was a convictions from for vehicle, several dru prostitution. Her ser analysis is, R13 rec more frequent obser routine for most res Regular monitoring behavioral changes closer observation on a limited time ba indicated, that R13 alcohol and had rec R13 ' s nurses m	loses of Bipolar Disorder and e abuse. R13 was initially lity on 7/19/11. History Analysis Security Report ( CHASRR) dated hat R13 is an identified assessed as Moderate Risk for rgery, criminal trespass ug related offenses, to curity recommendation per this quires closer supervision and ervation than standard or sident in the open facility. should be attentive to s that may signal a need for or sustained visual monitoring asis. This assessment also admitted to currently drinking cently snorted cocaine. hotes dated 9/21/11 at 12 AM, was staying with R13's next					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	of kin, Z1, and that in AM. Per nurses r 11:30 (no indication to the facility stating altercation, and that eye is shut, swollen having spasms. R1 swollen and red. R and came back on Review of facility shows no evidence was done, nor was aware of an initial a investigation. During 9/28/11 in Administrator ) said allegation of abuse family or another no Per E8 (case wo at 11:27 AM, R13 re pass on 9/21/11, ar because she had a police initially came upset and did not ta after the police left, the man who hit he R13 again on 9/27/ that she had a phys she knows, and wh the man unexpecte fight ended. E8 said friend and did not s	Z1 said that R13 will be back notes dated 9/21/11 written at n if AM or PM ), R13 returned g that she got into a physical t, a man hit her. R13 ' s right n, very dark and red, and was 3 ' s left eye is also slightly 13 was sent to the hospital	F	323	3		

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 57 F 323 Per R13 's Physician Order Sheet (POS), R13 was placed on restriction for 7 days on both 9/21/11 and 9/22/11.On 9/30/11 at 12:24 PM, Z2 said that the pass restriction for 7 days for R13 is for her own safety, as sometimes, resident don ' t really say who hurt them. Review of R13 's record, showed that as of 9/28/11, the facility has not investigated the allegation of physical abuse. During 9/30/11 interview at 11:15 AM, E3 (Acting Director of Nursing) said that she spoke to R13 only yesterday on 9/29/11. There was no abuse investigation when R13 indicated initially on 9/21/11, that she was hit by a man she knows, with a pole. Per E3. R13 said that the person who hit her was her boyfriend. During 9/30/11 interview however, E8 said that R13's boyfriend is currently incarcerated. Per R13 's record, Z1 is the only man R13 was with as of 9/21/11 at 12 AM. R13 's nurses notes dated 9/21/11 indicated that at 12 AM, Z1 indicated that R13 is coming back to the facility in the morning of 9/21/11. There was no evidence that the facility spoke to Z1 to determine if Z1 was with R13 during the physical abuse incident, or if Z1 was the person being referred to by R13, as the person who hit her with a pole. When E3 was asked on 9/30/11 at 11:15 AM why R13 was allowed to leave the facility and be exposed to potential meeting with the person who physically assaulted her. E3 said that R13 has the right to be out of the community, especially if the physician ordered it. There is no current assessment after the physical abuse allegation incident on 9/21/11 that would indicate that R13 is safe to be outside of the facility by

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR P	OINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	who physically assa caused her injuries. Criminal Assessme risk and needs clos R13 sustained injur assaulted by a pers she was drinking. It 11:45 AM and socia indicated that the al R13 's drinking. R1 also indicated that F using drugs, behavi addressed by the fa she had been doing altercation happene CHASRR and as th involving R13 on 9/2 addressed first prior community unsuper Review of R13 's 9/28/11, Z3 made a may go out of the fa 9/28/11 POS also ir at 3:30 PM, Z3 mad resume community observed leaving th During 9/30/11 in 11:38 PM, E27 said Z3 after R13 went to she is allowed to ha E27 said that Z3 as R13 's pass restrict	urther contact with the man aulted her with a pole, and Added to this, per R13 's nt Analysis, R13 is moderate er supervision, especially that ies after being physically on she knew outside, after nterview on 9/30/11 of E8 at al service notes dated 9/27/11 tercation was the result of 3 's CHASRR on 8/30/11 R13 admitted to drinking and fors that has not been acility after R13 admitted as g (drinking) when the ed. As this was identified in the is was a part of the altercation 21/11, this should have been r to allowing R13 to be in the	F	323			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		145850	B. WI	NG _		10/2	5/2011
	PROVIDER OR SUPPLIER	RSING		5	REET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	that R13 may go or said that she was m came back with eye she does not know E8 said during 9, with Z3 on 9/28/11. what she thought a E8 said that she too have her communit when showed of R has no access to th aware that R13 was Moderate Risk and also said that she is convictions involves drug related offens that she also is not indicated that curre and snorted cocain R13 admitted to E3 her boyfriend. E8 s currently incarcerat that R13 ' s nurses only with Z1 on 9/2 alleged that she wa 9/21/11. When ask recommended to Z for R13 after having said no. E8 said R1 concern. 13) R23 has diagno polyneuropathy. Per record, R23 has	to the community again. E27 to tat the facility when R13 e injuries. E27 also said that who hit R13 up to now. (30/11 interview that she was E8 said that Z3 asked her bout R13 ' s community pass. d Z3 that it is okay for R13 to by pass resumed. However, 13 ' s CHASRR, E8 said she is report previously, and is not s assessed on 8/30/11 as needs closer supervision. E8 s not aware that R13 ' s s criminal trespass, several es, and prostitution. E8 added aware that the CHASRR ntly R13 was using alcohol e. E8 was also not aware that b, that the man who hit her was aid that R13 ' s boyfriend in ed. E8 was also made aware notes indicated that R13 was 1/11 at 12 AM, and that R13 is hit by her boyfriend on ed if she would have 3 to order a community pass g known these information, E8 (3 ' s safety is her first	F	323			

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 60 F 323 on the floor with walker on the floor. 9/6/11 at 5:40 (no indication if AM or PM), R23 was observed as had slipped on the floor. R23 stated his cane was slippery. Review of R23 's care plan dated 6/24/11 showed that the last intervention placed to prevent further falls for R23 was on 3/28/11. R23 ' s care plan indicated that R23 fell also on 3/28/11. Findings include: 14) R18 's Fall Risk assessment dated 6/13/11 (date of admission) shows a score of 19, indicating a high risk for falls. The Care Plan dated 6/19/11 outlines contributing factors such as Seizure Disorder, Dementia, Status Post Cerebro vascular Accident (CVA) and decreased mobility, with generic approaches for fall prevention. Unusual Occurrences Reports for dates 6/19/11 through 9/12/11 shows 5 incidents of fall, all unwitnessed. The fall of 6/19/11 resulted in injury to R18. The facility 's Management Follow-up To Incidents form dated for each fall shows no interdisciplinary team review of the falls. Minimum Data Set (MDS) dated 8/4/11 scores R18 as having moderately impaired cognition and memory deficit. The revised fall Care Plan dated 9/12/11 stated ' remind patient to alert staff to assist with transfer. ' As a result of survey team ' s inquiry, R18 's care plan was revised on 9/28/11 to include referral to rehabilitative services secondary to multiple falls. There is no evidence that post-fall assessments were done

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY	
		145850	B. WI	NG _		- 10/25/2011		
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa following these falls	-	F	323				
F 325 SS=D	and on 7/13/11. Review of R15 ' S r showed that the fac fall risk after each f plan for falls until af when R15 fell while During an interview rehabilitation servic 9/28/11 at 5PM, she hired and was rece 9/1/11. She stated t hasn ' t been able to review his case or of PRSC is no longer was unavailable for Per the facility ' s fa is to be assessed u after a fall. 483.25(i) MAINTAIN UNLESS UNAVOID Based on a resident assessment, the fac resident - (1) Maintains accep status, such as bod unless the resident' demonstrates that t	with R15 's psychiatric ce coordinator (E15) on e stated that she was just ently assigned to R15 on that due to her caseload she to make contact with R15 to care plan. R15 's former employed with the facility and r interview. all policy, a resident 's fall risk upon admission, quarterly and N NUTRITION STATUS DABLE ht's comprehensive cility must ensure that a btable parameters of nutritional dy weight and protein levels, 's clinical condition this is not possible; and rapeutic diet when there is a	F	325				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WIN	G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			325 WEST CERMAK ROAD ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	Continued From pa	ige 62	F3	25			
	by: Based on record refailed to develop intigain and evaluate trinterventions in one residents reviewed sample size of 30 m Findings Include: Record review of quarts and the size of 30 m Findings Include: Record review of quarts and the size of a	e resident (R11) from 14 for weights/nutrition out of a esidents. uarterly nutritional progress denotes R11 weight of 176 reasing gradual monthly, low ied. Record review of notes dated 9-7-11 R11 I/ regular diet. Record review ess notes dated 9-12-11 weight gain increase 13.86 onths. Appetite has been good,					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WING _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325 F 371 SS=F	registered dietician per prescribed diet Record review of nu denotes R11 very ro Resident weight too ideal body weight, r Interview with E2 (E 9-29-11 at 9:55 AM addressing R11 's and dietary notes. 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfac authorities; and (2) Store, prepare, ounder sanitary cond	pounds, probable ween meals. Approach: consult and educate resident orders. utritional notes dated 9-28-11 eceptive with diet counseling. day, 185 pounds weight above nonitor weight and oral intake. Director of Operations) on , states dietary missed weight gain in the care plan ROCURE, /SERVE - SANITARY	F 325			
	by: Based on observat review the facility fa work area as indica The facility also fail storing them on the food items. The fac clean scoop for the cereal, and failed to	tion, interview and record hiled to sanitize dishes, and ted in the facility 's policy. ed to dry dishes prior to shelf, and failed to date open cility also failed to provide large container of open o provide light shields for 3 nits, and failed to ensure there				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	√G		10/2;	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ige 64	F:	371			
	Findings include:						
	manager), the sanit compartment sink v strip to be above 10 was a white sanitizi measured with the and 50 parts per mi red sanitizing bucket	5am along with E5 (dietary tizing sink of the 3 was measured with the test 00 parts per million. There ing bucket the contents was test strip to be between 10 illion, and there was another et that contents were test strip to above 200 parts					
		0am E5 said that the facility sanitizing solution to be 0 part per million.					
	there were 2 floreso dish washing mach observed with no sh	tion on 9/27/11 along with E5 cent lights in the ceiling in the ine room survey team hield or cover, and another r the 3 compartment sink cover.					
		5am E5 said she would make upervisor aware of the missing					
		tion of the kitchen along with less steel pan tops/covers red wet.					
		0am E5 said that staff is les prior to storing them away.					
	During the initial kit	chen observation there was					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WIN	√G		10/2:	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 825 WEST CERMAK ROAD		
CEDAR F	POINTE REHAB & NU	RSING			CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 65	F;	371			
	there was a Styrofo container. During the	r 20 gallon of dry oatmeal, am bowl, inside of the large his observation there was no scoop the dry cereal out of the					
		Dam E5 said that the staff Styrofoam bowls to scoop					
	open box of dry tea on a shelf in dry sto box was opened, th	ur, along with E5 there was an bags observed open sitting orage, with no date when the here was also 2 bowls of dry lastic wrap with no date when					
F 407 SS=F	items are opened s package when it is prepared cereal sta was prepared by sta 483.45(b) REHAB S	SVCS - PHYSICIAN	F،	407			
		tative services must be written order of a physician by					
	by: Based on interview failed to provide doo a full time Psychiatr	NT is not met as evidenced v and record review, the facility cumentation to that there was ric Rehabilitation Service the facility since the departure SD on 9/14/11.					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 407	Continued From pa Findings include:	ge 66	F	407	7		
	approximately 9:15 survey team that the beds with a census and 282 Medicaid). PRSD position has and E6 (Consultant working in an acting PRSD is hired. E1 we documentation for the coverage provided s time is being utilize During a telephone at approximately 1:: PRSD position was she (E6) has been purpose of staff trait development. E6 st direct psychiatric set and family. The facility ' s job d includes the monitod development of eact treatment plan (ITP assure that residen PRSD is also respon provide behavioral in residents. E2 (Consultant, Dire survey team on 9/2 that the social work rehabilitative director position. The facility rehabilitative service	interview with E6 on 9/29/11 25pm, E6 stated that the vacated on 9/14/11, and that in the facility for the sole ining and program ated she has not provided any ervices for facility residents escription for the PRSD oring of the ch resident 's individualized ) and ts ' needs are being met. The					

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 407 Continued From page 67 F 407 psychosocial rehabilitative needs of all 293 residents which translates to a caseload on 59 residents for each PRSC. The facility 's Resident Census and Conditions of Residents form (CMS-672) shows 272 residents in the facility with psychiatric illness. F 441 483.65 INFECTION CONTROL. PREVENT F 441 SS=D SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe. sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WING	G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER		;		EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			25 WEST CERMAK ROAD ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 68	F 4	41			
		ndle, store, process and as to prevent the spread of					
	by: Based on observat review the facility fa of infection control of care for 1 of 4 re	NT is not met as evidenced tion, interview and record hiled to follow current standard practices during the provision sidents (R18) reviewed for a sample of 30 residents.					
	Findings include:						
	awake, alert with in receiving oxygen vi R18 's Respiratory shows a diagnosis the use of a trached Order Sheet (POS)	Assessment dated 7/27/11 of Respiratory Arrest requiring otomy tube. The Physician 's dated 9/1/11 shows a asia which necessitates the					
	R18 's room with s observation of R18 gastrostomy site. E and another infection which she could no of gloves and enter observed surveyor E31 exited R18 's r	om, E31 (Nurse) approached urveyor for the purpose of 's pressure areas and 31 stated that R18 has MRSA ous organism, the name of t remember. E31 put on a pair ed R18 's room. E31 donning gown and gloves and room and herself put on a oned R18 onto his side and					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/2;	5/2011
NAME OF PRO	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD		
CEDAR PC	DINTE REHAB & NU	RSING		_	CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490 SS=D F 490 F 7 F 490 F 7 F 490 F 7 F 7 F 7 F 7 F 7 F 7 F 7 F 7 F 7 F 7	emoved the soiled in place. E31 then r on a clean pair of gl R18 and removing t gastrostomy tube. E between glove char gastrostomy site ca he procedure, prod espiratory secretion protective mask. The facility 's Infect August 2008 states ransmission based prevent spread of ir vashing and use of equipment. R83.75 EFFECTIVE ADMINISTRATION A facility must be ac enables it to use its efficiently to attain of practicable physical vell-being of each r fhis REQUIREMEN by: Based on observat eview, the facility fa administration has the social services for r psychiatric rehability prevention program with falls, and e) ad	tion Control Policy dated that standard precautions and precautions will utilized to freesing protective the dressing covering the and failed to wash her hands ages from perineal care to re. R18 was coughing during lucing a moderate amount of n. E31 failed to wear tion Control Policy dated that standard precautions and precautions will utilized to affection, including hand personal protective compared in a manner that resources effectively and or maintain the highest , mental, and psychosocial		441			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ge 70	F،	490			
		ocial worker, PRSD, and e fall prevention and abuse s.					
	Findings include :						
	1) Abuse :						
	failed to ensure that abuse were investig involved residents were potential abuse for reviewed for allegat sample of 30. As a the perpetrator or a investigated, report allowed outside pass her perpetrator. The IDPH initial and finat During the physical	view and interview, the facility t allegations of and actual gated, reported to IDPH, and vere protected from further 3 residents out of 7 residents ion of abuse (R13, ) in the result of lack of investigation, buser of R13 is not identified, ed to the police, and R13 was as and potential contact with e facility also did not send to al report of this abuse incident. abuse on 9/21/11, R13 eye injuries during the physical					
	Findings include :						
		oses of Bipolar Disorder and e abuse. R13 was initially lity on 7/19/11.					
	Recommendation F 8/30/11, indicated th offender, and was a convictions from for vehicle, several dru	History Analysis Security Report ( CHASRR) dated hat R13 is an identified assessed as Moderate Risk for rgery, criminal trespass g related offenses, to curity recommendation per this					

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		HAND HUMAN SERVICES			FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WING	;	10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	analysis is, R13 rec more frequent observation of routine for most res Regular monitoring behavioral changes closer observation of on a limited time ba- indicated, that R13 alcohol and had rec R13 's nurses n indicated that R13 of f kin, Z1, and that in a.m. Per nurses n 11:30 ( no indication to the facility stating altercation, and that eye is shut, swollen having spasms. R1 swollen and red. R and came back on Review of facility shows no evidence was done, nor was aware of an initial a investigation. During 9/28/11 in Administrator ) said allegation of abuse family or another no Per E8 ( case wo at 11:27 a.m, R13 r community pass on hospital because sh	quires closer supervision and ervation than standard or sident in the open facility. I should be attentive to s that may signal a need for or sustained visual monitoring asis. This assessment also admitted to currently drinking cently snorted cocaine. Notes dated 9/21/11 at 12 AM, was staying with R13 ' s next Z1 said that R13 will be back notes dated 9/21/11 written at in if AM or PM ), R13 returned g that she got into a physical it, a man hit her. R13 ' s right n, very dark and red, and was 3 ' s left eye is also slightly R13 was sent to the hospital	F 49	20		

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NURSING					5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	was upset and did it that after the police knows the man who spoke to R13 again R13 said that she h this guy she knows broken off, the mai pole after the fight of said it was a friend person 's name wa R13 further on 9/21 Per R13 's Phys R13 was placed on 9/21/11 and 9/22/1 said that the pass r for her own safety, really say who hurt Review of R1 9/28/11, the facility allegation of physic interview at 11:15 A Nursing ) said that yesterday on 9/29/1 investigation when 9/21/11, that she w with a pole. Per E3 who hit her was her interview however, is currently incarcer is the only man R13 AM. R13 's nurses that at 12 AM, Z1 ir back to the facility i There was no evide Z1 to determine if Z	not talk to them. E8 continued left, R13 told E8 that she o hit her. E8 said that she o on 9/27/11 and that this time, had a physical altercation with , and when the fight was n unexpectedly hit her with a ended. E8 said that R13 just and did not say what the as. E8 said she did not ask /11. sician Order Sheet (POS), restriction for 7 days on both 1. On 9/30/11 at 12:24 PM, Z2 estriction for 7 days for R13 is as sometimes, resident don ' t	F	490			

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		I AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER	L		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NURSING					825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	being referred to by her with a pole. Wh at 11:15 AM why R facility and be expo the person who phy that R13 has the rig especially if the phy current assessmen allegation incident of that R13 is safe to herself, to prevent to who physically assa caused her injuries Criminal Assessme risk and needs close R13 sustained injur assaulted by a pers she was drinking. I 11:45 AM and social indicated that the a R13 's drinking. R <sup>2</sup> also indicated that using drugs, behav addressed by the fa she had been doing altercation happene CHASRR and as the involving R13 on 9/ addressed first prio community unsupe Review of R13 ' 9/28/11, Z3 made a may go out of the fa 9/28/11 POS also in at 3:30 PM, Z3 made resume community	A R13, as the person who hit ien E3 was asked on 9/30/11 13 was allowed to leave the sed to potential meeting with visically assaulted her, E3 said ght to be out of the community, visician ordered it. There is no t after the physical abuse on 9/21/11 that would indicate be outside of the facility by further contact with the man aulted her with a pole, and . Added to this, per R13 's ent Analysis, R13 is moderate be r supervision, especially that ries after being physically son she knew outside, after interview on 9/30/11 of E8 at al service notes dated 9/27/11 Itercation was the result of 13 's CHASRR on 8/30/11 R13 admitted to drinking and iors that has not been acility after R13 admitted as g (drinking) when the ed. As this was identified in the tis was a part of the altercation 21/11, this should have been r to allowing R13 to be in the	F	490			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/25/2011	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NURSING					825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ige 74	F	490			
	11:38 p.m., E27 sai Z3 after R13 went t she is allowed to ha E27 said that Z3 as R13 ' s pass restric to give R13 another that R13 may go ou said that she was n came back with eye she does not know E8 said during 9/ with Z3 on 9/28/11. what she thought al E8 said that she tol have her communit when showed of R has no access to th aware that R13 was Moderate Risk and also said that she is convictions involves drug related offense that she also is not indicated that curre and snorted cocain R13 admitted to E3 her boyfriend. E8 sa currently incarcerat that R13 ' s nurses only with Z1 on 9/2' alleged that she wa 9/21/11. When ask recommended to Z for R13 after having	hterview of E27 ( nurse ) at id that on 9/28/11, she called to the 5th floor, and said that ave an outside pass again. Sked her what E27 thinks about tion. E27 said that she told Z3 r chance, and that Z3 ordered at to the community again. E27 tot at the facility when R13 e injuries. E27 also said that who hit R13 up to now. /30/11 interview that she was E8 said that Z3 asked her bout R13 ' s community pass. d Z3 that it is okay for R13 to ty pass resumed. However, 13 ' s CHASRR, E8 said she his report previously, and is not s assessed on 8/30/11 as needs closer supervision. E8 s not aware that R13 ' s s criminal trespass, several es, and prostitution. E8 added aware that the CHASRR ontly R13 was using alcohol e. E8 was also not aware that b, that the man who hit her was aid that R13 ' s boyfriend in red. E8 was also made aware notes indicated that R13 was 1/11 at 12 AM, and that R13 is hit by her boyfriend on ed if she would have 3 to order a community pass g known these information, E8 l3 ' s safety is her first					

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		AND HUMAN SERVICES			FORM	02/22/2012 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From pa concern.	ge 75	F	490			
	incident or allegatio mistreatment will re Additionally, this po accused individuals will be denied unsu	use policy and procedure, any on involving abuse or esult in an abuse investigation. licy also indicated that is not employed by the facility pervised access to the e course of investigation.					
	that there is a need residents who are p that social service v social service notes	notes dated 6/7/11 showed to separate R23 from other ohysically attacking R23, and will be made aware. Review of s showed no indication this nvestigated, or results of initial t to IDPH.					
	also indicated that F altercation with ano report and abuse fil an abuse investigat determine abuse. T	otes dated 3/28/11 at 10 AM R23 was involved in a physical other peer. Review of incident les showed no indication that tion was also done to The state department was also investigation related to this.					
	incident or abuse in altercation mention According to this no	' s incident report showed no ovestigation for 11/4/10 ed in social service notes. ote, this occurred in the R23 was hit in the mouth by					
	7:10 AM, R30 push floor and hit the oth incident nor abuse i	rses notes dated 7/31/11, at ed another resident on the er resident with a chair. No investigation was done to or was there notification of					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
-	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		-	5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ge 76	F	490			
	cognitively impaired risk for falls and fail interventions to pre- falls resulting in frac R19 and R44, failed cognitively impaired physical altercation residents and resul investigate and ass cause for falls in 5 of R19, R23) reviewed residents and 8 res R33, R32, R39, R4 Findings include: a) R23 has diagnos polyneuropathy. Per record, R23 ha · 7/11/11 at 6:30 sitting on the floor v · 9/6/11 at 5:40 ( R23 was observed R23 stated his can Review of R23 ' s c showed that the las prevent further falls s care plan indicate 3/28/11. Review of R23 ' s	provide supervision for d individuals assessed as high ed to provide effective vent the numerous falls, some ctures for R2 and sutures for d to provide supervision for d residents who have been in with other cognitively impaired ted in injuries and failed to ess individuals for the root of 13 residents (R2, R15,R18, d for falls in the sample of 30 idents (R34, R44, R38, R36, 5) in the supplemental sample. sis of seizure and s the following falls incident: a.m., R23 was observed with walker on the floor. no indication if AM or PM ), as had slipped on the floor.					

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		I AND HUMAN SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WING	i	10/2	5/2011
NAME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	Review of R23 ' s reindication that an enurse ) on 9/29/11 with PT if R23 had evaluation and treat 9/29/11. c) R23 has diagnost polyneuropathy. Per record, R23 hat is conserved record, R23 has observed R23 stated his candor with wather structure falls s care plan indicate 3/28/11. d) R2 is a wheel-ch who has a diagnost dementia, hyperten Accident per the cu Set (MDS). R2 is di (person, place and 9/14/11 care plan for making. On 9/27/11 at 10 A room, R2 was standing	ecord however showed no valuation was done. Per E29 ( at 11:46 a.m., he will check been seen already. R23 ' s PT tment was only done on sis of seizure and s the following falls incident: AM, R23 was observed sitting lker on the floor. no indication if AM or PM ), as had slipped on the floor.	F 49			

Facility ID: IL6009948

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	
145850 B. WING	- 10/25/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE,	ZIP CODE
CEDAR POINTE REHAB & NURSING       5825 WEST CERMAK ROAD         CICERO, IL 60804	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE A 	ACTION SHOULD BE COMPLÉTION TO THE APPROPRIATE DATE
F 490       Continued From page 78 stated he has a tendency to remove the cast so she is re-applying it. R2 stood up and activated his chair alarm and was re-directed to sit.       F 490         On 9/28/11 at 9:30 A.M., sitting in wheel-chair in the hall near the nurses ' station. R2 's semi-cast and ace bandage were off and his sling around his neck was not in use. R2 's right hand is swollen. E13 (nurse) stated not to know why the cast is off but stated he often removes it and it needs to be replaced. E13 returned and stated the physician 's order has not been changed and R2 needs to keep the semi-cast on at all times. E13 stated the nurse aide stated she could not find the semi-cast in his room. E13 stated she will contact the restorative department. At 10 a.m., R2 removed from the 4th floor dining room to be fitted for a semi-cast. E13 stated since the cast can not be found, R2 will be refitted. At 10:a.m., R2 is back in the dining room. Throughout the week, R2 was in his wheel-chair in the dining room and/or in the hall near nurses ' station. R2 was seen to remove his splint and throw it on the floor. Numerous times resident needed reminders not to get out of his wheel-chair.         R2 is care planned for removing his splint but it is to be re-applied when removed. The cast was not always put back on.         Review of the facility 's incident reports (April ' 11 to September '11) show numerous falls that were not witnessed, many resulting with injuries and no investigation as to how and why the falls occurred.	

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		- 10/25/2011		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR I	POINTE REHAB & NU	RSING		-	825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 490	Continued From pa	ige 79	F	490				
	fall on 6/8/11 at 6:1 room, where R2 is over-bed table brok	ent reports for R2 document a 5 A.M. in the 4th floor dining found on the floor with an ken next to him. It is not nvestigated. R2 was unable to d.						
	document R2 found confused however	es ' notes dated 6/8/11 d on dining room floor. R2 is he interacts with staff. If R2 ifused, he will be sent out to						
	on the floor in the h staff saw him walkin The report does no saw him walking ar have been walking unsteady gait. The	1/11 at 12:15 P.M. when R2 is nall. The report documents that ng down the hall prior to fall. t indicate which staff person nd whether or not be should independently due to his report does not document if ries. It documents 911 was						
	document R2 was went to floor. R2 for right arm and hand pain to head and ar dizziness while star R2 's right side of f R2 was admitted to of Syncope. When	es ' notes dated 6/11/11 walking down hall to lunch and und on his right side with his under him. R2 complained of rm. R2 complained of nding and while on the floor. face was red. 911 was called. the hospital with a diagnosis he returned from the hospital, gnosis of encephalopathy.						
	p.m. where R2 was	ted fall is dated 6/14/11 at 6:30 found on his floor. The report removed from floor and						

Facility ID: IL6009948

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DEPARTMENT OF HEALTH A					FORM	02/22/2012 APPROVED 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	145850	B. WI	NG _		10/2	5/2011
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NUR	ISING		-	825 WEST CERMAK ROAD CICERO, IL 60804		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
injury but there is no determine how and w any follow-up to ensu The next documente 11:40 A.M. where R2 floor. R2 can not say disoriented to all 3 sp reminded to stay in h are to continue to mo evaluate resident for no investigation into f was not effective due facility implemented of frames are unclear a discontinued and the The report dated 8/3 R2 stated another re- a new cut on the righ to cut. There was no other resident identifie The report dated 9/14 documents R2 on flo was asked what hap onto the floor becaus arm cast is with in no edema. It documente this fall and R2 has s incident reports docu a fall. Review of nurses ' n document R2 on the claimed to not fall. Th	r. The report documents no investigation into the fall to why it happened. Nor is there ure there is no injury. ed fall is dated 6/21/11 at 2 is found on the dining room y what happened. R2, who is pheres and confused, was his chair. The interventions onitor resident and to aptop cushion. There was the fall. The laptop cushion e to R2 removing it so the the chair alarm but the time as to when the laptop was e chair alarm implemented. 1/11 at 2:40 p.m. document esident hit him and there was ht cheek. R2 received first aid investigation nor was the fied.	F	490			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	note dated 8/11/11 swollen and R2 corr ordered. There was incident. Review of the porta documents no fract Review of the nurse documents R2 to be was pale in color ar orbital area and ser note dated 9/4/11 a admitted under alte back to the facility of done on 9/6/11 at th documents there is the 5th metacarpal close opposition of no investigation into when and how he fit On 9/29/11 at 11:18 a portable x-ray ma and R2. Z6 stated h R2 ' s right wrist an A.M., E3 (acting dir x-ray was done bed semi-cast. The rest healing. Review of R2 ' s cu 9/19/11 and 9/22/1 with injury. The inc	documents R2 's right wrist mplaining of pain. X-rays were s no investigation into this able x-ray done on 8/11/11 ture. es ' notes dated 9/4/11 e very lethargic and weak. R2 nd had swelling in the right eye nt out to hospital. Nurses ' at 8 P.M. documents R2 was red mental status. R2 returns on 9/6/11 and an x-ray was he hospital. The hospital x-ray a fracture through the neck of of the indeterminate age with fracture fragments. There was o the fracture to determine ractured his 5th metacarpal. 5 A.M., in R2 's room, there is achine and Z6 (a technician) ne was called to do an x-ray on d hand. On 9/30/11 at 9:38 rector of nursing) stated the cause he keeps removing the ults are the fracture is still internet care plan for falls dated 1 document a fall on 9/14/11 ident of 9/14/11 does not to the fall. R2 already had the	F	490			

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		I AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NURSING					825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	On 9/30/11 at 9:55 administration, E3 a stated they are una investigations were physical altercation incidents of unknow hired one month ag Z7 (ex-director of n investigations. E3 s 10/25/10 to 7/29/11 personnel file reflect e) R19 is a 70 year wanders the unit wi extremely thin. At 7 per the 8/24/11 MD spheres, person, pl care plan for orient throughout the wee dining room, reside wears a cervical co care plan document worn at all times. O to 10:35 A.M. durin with E13, E13 state collar due to his nu Review of the incid falls on 7/26/11, 8/ <sup>-</sup> witnessed and 2 of injuries. The incide P.M. documents R <sup>-</sup> resident ' s room. F forehead, above the left and right kneess There was no invest 8/19/11 at 2:45 P.M.	A.M. during daily meeting with and E2 (director of operations) ble to answer why no done into the falls, the s between residents and vn origins. E2 stated she was go and E3 stated she thought ursing) was handling the stated Z7 was employed from when she resigned. The cted the same dates. old, ambulatory male who thout purpose. R19 is tall and 2 inches tall, he weighs 109# S. R19 is disoriented to all 3 ace and time per the current ation. R19 was seen k to wander in and out of nt rooms and in the hall. R19 llar at all times. The current ts the cervical collar is to be in 9/27/11 between 9:50 A.M. g the initial tour of 4th floor ad R19 wears the cervical	F	490			

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SERVICES SERVICES			FORM	02/22/2012 APPROVED 0938-0391
UPPLIER/CLIA (X2) ON NUMBER:		RUCTION	(X3) DATE SURVEY COMPLETED	
<b>I5850</b> B. W	ING		10/25/2011	
DED BY FULL PRE	FIX (EAC	CH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
shoulder and he incident of R19 sitting on hair. No injuries ation done. 0 A.M. ' hit his upper all 1 inch the forehead. 'se aide, no statement ation. An . documents a e R19 od still, lost s left side. R19 s obtained for ff were not ny statements. led or seen. ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	490			
	SERVICES         UPPLIER/CLIA ON NUMBER:       (X2) I A. BL         NUMBER:       B. WI         IS850       B. WI         IENCIES       ID PREI FORMATION)         IENCIES       ID PREI FORMATION)         F       Shoulder and he incident of R19 sitting on hair. No injuries ation done.         0 A.M.       'hit his upper all 1 inch the forehead. 'se aide, no statement ation. An         1 documents a e R19 od still, lost s left side. R19 s obtained for ff were not hy statements. ed or seen.         8/4/11 at 2 nds R19 and each other in tear to the right dent. The other mber but no red. No d and why R19 ructured         r bound male	SERVICES         UPPLIER/CLIA ON NUMBER:       (X2) MULTIPLE CONSTR A. BUILDING         IS850       B. WING         IS850       STREET ADDRES S825 WEST C CICERO, IL         IENCIES       ID PREFIX         IENCIES       ID PREFIX         ICCERO, IL         IENCIES       PREFIX (EAC CROSS         Shoulder and he incident of R19 sitting on hair. No injuries ation done.       F 490         O A.M.       In inch the forehead.         'hit his upper all 1 inch the forehead.       F 490         O A.M.       In inch the forehead.         'se aide, no statement ation. An       Inch the forehead.         'se aide, no statements a e R19       R19 and each other in tear to the right dent. The other mber but no red. No d and why R19 ructured         'r bound male R38 's       I	SERVICES       (X2) MULTIPLE CONSTRUCTION         A BUILDING	SERVICES FORM SERVICES OMB NO. SERVICES OMB NO. SERVICES OMB NO. PPILER/CLIA ON NUMBER: A BUILDING IS850 B. WING IS850 B. WING IS950 B. WING

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		AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG		10/2	5/2011
NAME OF F	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	IRSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	(6/11/11 and 7/5/11 A.M. to 10:30 A.M. R38 was seated in dining room. R38 w street clothes and f Throughout the wey himself throughout and dining rooms. On 9/29/11 at 11:32 environmental tour environmental tour common bathroom opposite side of the wheel-chair in a toil spoken to, R38 did summoned. In the the wheel-chair usi stall, failing to lock rolled backwards. F incontinent brief an was then E13 enter what he was doing response from R38 Review of the curre documents R38 red assistance for toiled bowel and bladder. Review of the incid 2:10 P.M. documer in the 4th floor dinin side of his body an R38 could not say w witnessed it but the	ulsions per incident reports 1). On 9/27/11 between 9:50 during the initial tour with E13, a wheel-chair in the 4th floor /as wearing a winter coat over had long (1 inch) finger nails. ek, R38 was seen propelling the unit, in and out of rooms 5 A.M. during the with E20 (director of ), R38 was in the female , which is located on the e unit. R38 was in his let stall, facing toilet. When not respond. E13, nurse, was meantime, R38 stood up from ng the grab bars in the toilet his wheel-chair, the chair R38 removed his pants and d dropped them to the floor. It red the room and asked R38 in the female bathroom. No a. ent quarterly (7/11/11) MDS quires one person limited t use. R38 is continent of	F	490			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2;	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	and it was negative determine the caus and fall. Review of the incide documents R38 is of 4th floor dining roor incident does not do There is second pa Report (incident rep labeled Manageme There is a section la it documents the sta R38 was unable to stood up after the fa smoke room (the or room). There was n what happened to or report identify the st The incident report documents R38 is of and fell to the floor picked up and place witnessed by a nurse name of this nurse into the fall. R38 wa happened. It is uncl stood up from whee The incident report documents R38 lay and it was not witne he fell. No injuries r wheel-chair. No inve The incident report	<ul> <li>a. There was no investigation to e for R38 to loose his balance</li> <li>ent dated 6/11/11 at 6 P.M. orient times two. R38 fell in the m landing on his left side. The ocument if it was witnessed. ge to the Unusual Occurrence port). The second page is nt Follow-up to Incidents. abeled " interview with staff " aff found R38 on the floor. say what happened. R38 was all and he walked to the utside patio adjacent to dining to investigation to determine cause his fall. Nor does the taff person.</li> <li>date 6/14/11 at 6 P.M. orient times one, loss stability onto his right side. R38 was ed into wheel-chair. This was see on the floor. There is no and there is no investigation as unable to say what lear if R38 was ambulating or el-chair prior to the fall.</li> <li>dated 7/5/11 at 8:35 A.M. ing on the dining room floor essed. R38 could not say how noted and R38 placed in estigation was done.</li> <li>dated 6/28/11 at 12:30 P.M.</li> </ul>	F	490			
		is striking a female resident in					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/2	5/2011	
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD			
CEDAR POINTE REHAB & NURSING				CICERO, IL 60804				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 490	the face with his fis a staff person. No t There was no invest was the female resi The incident report document R38 was forehead by anothe over the peer 's fee peer is identified by other identifier for th identity is unclear. T a nurse aide. This a there a statement fit were re-directed. On 9/30/11 at 9:55 with administration are unable to identi physical altercation witnessed the falls. one month and E3 Director of Nursing g) On 9/27/11 betw A.M during the initia Coordinator/nurse), and asking for mon confused. R44 's d schizoaffective disc disorder per the inc On 9/29/11 at 11:23 environmental tour Maintenance), R44 at the doorway. In t the floor, was a yell	t. This was witnessed by E33, itle was given in the report. stigation into the altercation nor ident identified. dated 8/29/11 at 1:35 P.M. struck in the right side of the r peer because R38 had ran et with his wheel-chair. The room number but there is no his resident. The aggressor 's The incident was witnessed by aide is not identified nor is rom the aide. Both residents A.M. during the daily meeting staff, E2 and E3 stated they fy the residents involved in the s or any staff member who E2 stated to be employed for stated she thought the former was doing the investigations. een the 9:50 A.M. to 10:30 al tour with E13 (MDS R44 was ambulating the unit ey from E13. R44 was very iagnoses include paranoid order, dementia and seizure ident report (7/12/11).	F	490				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/25/2011		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD			
CEDAR	POINTE REHAB & NU	RSING			CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 490	air conditioner unit room, which is not of R44 had a fixed gla answer any questio housekeeper to mo Review of the curred documents R44 red assistance in toilet incontinent of bowe Review of R44 ' s ir 5:30 A.M., 7/12/11 2:30 P.M. documer 7/18/11 resulting in The 6/5/11 incident was found sitting or small amount of blo was unable to say v investigation to dete The witnessed fall of disoriented and he without locking the rolled backwards. F forward hitting his h left eye brow. It req intervention is to ke because he is amb what happened. Th see a neurologist. T 8/12/11 documents with history of Epile " Initial neurological seizures disorder a does not document levels (Valproic acid	he air conditioner units. The in the room next to R44 ' s occupied, smelled of urine. re on his face and would not ns. E20 summoned the p up the spill. ent quarterly 8/11/11 MDS quires one person limited use and occasionally	F	490				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mui A. Build	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		145850	B. WING	3	10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 490	The incident dated was witnessed by E stumbled over his f document the facto and R44 's foot we the unidentified nur floor. h) R36 is a 60 year R36 was confused spheres. Staff woul dining room. At time propel the wheel-ch dementia and schi 4/14/11 incident rep Review of R36 's a documents R36 rec with walking and us The MDS documer lower extremities at mobility. Review of R36 's in 10:30 A.M., 4/29/11 A.M. and 6/20/11 a witnessed falls. The documents during a floor, R36 stood up his right side of the	e witness is not identified. 7/12/11 documents the fall 34, a nurse aide. R44 had eet. The report does not rs such as condition of floor ar. There is no statement from se who assisted R44 off the old, wheel-chair bound male. and not oriented to all 3 d push R36 in and out of the es, R36 would use his feet to hair. R36 ' s diagnoses include zoaffective disorder per the bort. nnual 9/19/11 MDS guires one person assistance les a wheel-chair on the unit. Its he has impairment with his hd requires a wheel-chair for ncident reports dated 4/9/11 at at 2:40 p.m., 5/26/11 at 2:45 t 8:25 A.M. document e incident dated 4/9/11 a group meeting on the second , was unsteady and fell hitting face. R36 stated he	F 49			
	disturbances. The i to check with nurse the floor. R36 has a a wheel-chair when	but denied headache or visual intervention is for activity staff s prior to removing R36 from an unsteady gait and requires leaving floor. There was no rements to determine why R6				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mui A. Build	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WING	j	10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ge 89	F 49	90		
		main seated when he got up				
	a dining room chair unsteady gait acros R36 was asked if h no. " following the documents R36 alw the nurse is the one documents R36 ' s	at documents R36 is sitting in , stood up, walked with as the room and fell. When e was okay, he responded " " no " response, the report vays responds " no " . E35, e who witnessed the fall and gait to be unsteady. The counsel him on safety.				
	aide saw R36 come down the hallway an nurse, who is not id his backside on the R36 stated he was and used his hands investigation to dete The incident dated	6/11 documents E37, nurse e out of his room, stumble nd fall. E37 informed the entified, and she finds R36 on hallway floor. No injuries. going home, stumbled forward to brace his fall. No ermine why he is so unsteady. 6/20/11 documents R36 was				
	carry his own break feet, falling to the fle The intervention we Physical therapy de the floor. There is n continues to fall and interventions in plac The incident dated at 11:45 A.M. and 9 un-witnessed incide documents R36 fac room. R36 was una	fast tray, tripped over his own bor and injuring both knees. ere to check vitals and notify epartment. R36 stated he fell to to investigation as to why he d why there are no ce. 4/14/11 at 7:25 A.M, 8/28/11 9/16/11 at 6:15 A.M. are ents, The 4/14/11 incident the down on the floor in his able to say what happened. one on one monitoring. There				

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	٩G _		10/2	5/2011
NAME OF P	NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NURSING					5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ige 90	F،	490			
	identified, finds R36 stated he was walk nurse aide stated d him on floor and inf not identified. The i the hall rails if nece assistance if neede to determine what of The incident dated was heard and R36 injuries. R36 respon home. The nurse a on the floor. The int wheel-chair but beo from the chair he w	1 documents a nurse aide, not 6 on the floor of his room. R36 ing and lost balance. The furing her rounds she found formed the nurse. The nurse is ntervention is for R36 to use essary and to ask for ed. There was no investigation caused him to fall. 9/16/11 documents a noise 6 found on floor in his room. No nded he was trying to go ide, not identified, found R36 tervention is to place R36 in a cause he continued to get up vas placed at the nurses ' gation as to why he continues					
	i) On 9/28/11 at 11: room, R32 was hold walked because the waist and the length inches too long. R3 dementia secondar subdural hematoma disorder and status per the 6/1/11 incid Review of the annu him to be independ supervision and set The incident dated documents R32 on	al 9/13/11 MDS documents ent for walking but requires t-up for dressing.					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	IG		10/2	5/2011
NAME OF P	NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ige 91	F،	190			
	to say what happer investigation as wh						
	R32 turns around a residents are separ rooms. E30 (nurse resident, who is not and push him again then struck the othe investigation into th was there no imme The intervention wa medication given to does not indicate if medicated or just o to their rooms, not in/out of the dining saying incoherent of room where she wo bed. R34 would we non-skid socks. R3	pushed by a female peer and and hit her in the face. Both rated and re-directed to their aide) stated she saw another t identified, grab R32 ' s collar not the elevator doors. R32 er resident. There is no e physical altercation and why diate intervention/supervision. as to separate the residents, o decrease the agitation but both residents were ne resident and re-direct them a supervised area. week, R34 would ambulate in n to the nurses ' station and room, carrying a bible and gibberish and return to her buld mostly stay, sitting on her ear a house dress and 4 is an 85 year old,					
	s diagnoses include and schizophrenia On 9/29/11 at 11:30 environmental tour maintenance), R34 bible as seen all we She left room and b incoherently and sw the unit and procee	who is very disoriented. R34 ' e dementia, bipolar disorder per the 8/23/11 incident. O A.M. during the with E20 (director of is seated on her bed with her eek. R34 was talking to herself. began to follow us talking vearing. As we left her side of ided back to the nurses ' 12 foot electrical cord for the					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	۱G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	R34 is following us cord. The incident reports documents a loud r nurse aide, both no R34 on the floor on complained about s but refused the Tyle fracture and disloca dream that there we ran to the window. put in place. The incident dated documents R34 is f and has a cut on he re-directed and resi no investigation into it does not identify t out to hospital for e follow-up to this info The incident dated a nurse aide, not id on the floor. The nu floor and onto the b what happened. Th nurse aide as to wh an investigation into cognitively impaired assistance. The incident dated document R34 was her head by anothe	ends the width of the hallway. and needs to step over the s dated 4/29/11 at 2:30 A.M. hoise was heard by nurse and t identified by name, who find her backside. R34 soreness on her right shoulder enol. X-ray was negative for a ation. R34 stated she had a ere snakes in the bed so she There were no interventions 6/14/11 at 8:45 A.M. found on the floor of her room er forehead. Other resident idents kept separate. There is o how the injury occurred and the other resident. R34 sent valuation and treatment but no	F	490			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	is there any statem investigation. The incident dated documents R34 bei was struck in the fa in the female Comm seen. The other rest there was no invest was relocated to the The incidents dated 6/24/11 at 4:30 P.M assaulting ( 2.5 inch hospice nurse for n by her when R34 w station. No investig escalate. The incid R34 scratched E38 re-directed by E38. uncooperative. R34 psychiatric evaluation nor was there an in R34 ' s erratic beha k) R33 is a 64 year has a diagnosis that disorder. R33 was s radiation treatments A.M. to 10:30 A.M. (nurse), E13 stated treatment that morr The incident dated documents R33 as report dated 6/10/1 as disoriented. The	ent. There was no 8/23/11 at 4:10 P.M. ing very upset and stated she ice by another female resident non Bathroom. No injuries sident was not identified and tigation into the incident. R34 e dining room at this time. d 4/15/11 at 11 A.M and 1. document R34 physically h scratch on neck) the a o reason except she walked as escalating at the nurses ' gation into what caused R34 to lent dated 6/24/11 documents (staff) when R34 was R34 was aggressive and was sent out to hospital for on. No follow up to the incident vestigation into the cause of	F	490			

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		I AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI			(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/25/2011	
NAME OF F	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	CEDAR POINTE REHAB & NURSING				5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	The 5/27/11 incider about her roommat she was taking a sh backside. The repo to the aggressor an investigation docum The incident dated another resident dated another resident st threw a cup at her a intervention is to " medication work-up Z3, the psychiatrist. follow through on th The incident dated struck in the face by staff. There are no investigation into wi The incident dated on the floor. R33 is what happened. Th " watch where she i investigation as to v I) Throughout the w dining room ambula forth from his room Review of the incide 9:30 A.M. documen diagnoses to includ schizoaffective disc	<ul> <li>In R33 and other residents.</li> <li>In R33 and other residents.</li> <li>In documents R33 complaining e hitting her in the back when nower. Redness noted on her rt documents that staff spoke id both are separated. No nented.</li> <li>6/10/11 documents R33 and ere entangled in a physical ed apart by staff. R33 stated cratched her hand so she and will do it again. The see if R33 could have o on a psychiatric ward " per . There was no documented his intervention.</li> <li>6/28/11 documents R33 being y R38 and it was witnessed by staff identified and no hat caused the altercation.</li> <li>7/7/11 at 8 P.M. R33 is found delusional and could not say e intervention was for R33 to is going. " There was no what caused the fall.</li> </ul>	F	490			

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 490 Continued From page 95 F 490 R105 reporting to staff that R39 and R146 were fighting in the dayroom. R105 stated he saw R146 throw water on R38. R39 stated after R146 threw water on him, he hit R146. Staff did not witness the incident. There was no investigation or explanation why residents were not supervised in the dayroom. The incident dated 8/1/11 at 10:10 P.M. document R39 was walking out of his room and fell straight backwards hitting his head on the floor. No injury. It is unclear if it was witnessed. There is no investigation into the incident. m) The incident report dated 7/4/11 at 1:30 P.M. document R45 was found on the floor of the dayroom. R45 is a 50 years old and has diagnoses that include brain injury, dementia and bipolar disorder. R45 stated she fell out of her wheel-chair but not sure how. There was no investigation to determine what happened and why the dayroom was not supervised. The incident was not witnessed. n) R15 had fall incidents on 4/29/11, 3/22/11 and on 7/13/11. Review of R15 ' S medical record and care plan, showed that the facility failed to reassess R15 's fall risk after each fall and did not develop a care plan for falls until after R15 's fall on 7/13/11. when R15 fell while out on pass. During an interview with R15's psychiatric rehabilitation service coordinator (E15) on 9/28/11 at 5PM, she stated that she was just hired and was recently assigned to R15 on 9/1/11. She stated that due to her caseload she hasn 't been able to make contact with R15 to review his case or care plan. R15 's former PRSC is no longer employed with the facility and

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		-	825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	was unavailable for o) 14) R18 's Fall F 6/13/11 (date of adri indicating a high ris dated 6/19/11 outlin as Seizure Disorder Cerebro vascular A mobility, with gener prevention. Unusua dates 6/19/11 throu of fall, all unwitness resulted in injury to Management Follow for each fall shows review of the falls. Minimum Data Set R18 as having mod memory deficit. The 9/12/11 stated ' rer assist with transfer. s inquiry, R18 's ca 9/28/11 to include r services secondary evidence that post- following these falls On 9/30/11 at 9:55 administration, E3 a stated they are una investigations were physical altercations incidents of unknow hired one month ag Z7 (ex-director of n investigations. E3 s 10/25/10 to 7/29/11	interview. Risk assessment dated mission) shows a score of 19, k for falls. The Care Plan hes contributing factors such r, Dementia, Status Post accident (CVA) and decreased ic approaches for fall al Occurrences Reports for igh 9/12/11 shows 5 incidents sed. The fall of 6/19/11 R18. The facility ' s w-up To Incidents form dated no interdisciplinary team (MDS) dated 8/4/11 scores lerately impaired cognition and e revised fall Care Plan dated mind patient to alert staff to .' As a result of survey team ' are plan was revised on eferral to rehabilitative to multiple falls. There is no fall assessments were done	F	490			

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	TH AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	145850	B. WI	NG _		10/25	5/2011
NAME OF PROVIDER OR SUPPLIE	3			REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB &	NURSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
PREFIX (EACH DEFICIEI	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
Protocol policy w medical causes; issue. " Under O Staff will attempt within 24 hours of the fall is unclear medical causes a drug reaction or despite attempte review the situati causes. Under item 3. The continue to coller either the cause determined that finding the cause or the managem Treatment/Mana underlying cause corrected, staff w interventions bas until the falls red identified for its of and Follow-up, u continues to fall, re-evaluate the s possible reasons will re-evaluate the interventions. Per the facility ' s fall risk is to be a quarterly and afte evidence to show manner.	page 97 to follow it's "Falls-Clinical hich states that falls often have a they are not just a " nursing Cause Identification, item 1. " to define the possible causes f the fall. Item 2. If the cause of , and it may be significant such as stroke or an adverse f the resident continues to fall d interventions, a physician will on and help identify contributing e staff and physician will thand evaluate information until of falling is identified or it is cause cannot be found or that would not change the outcome ent of the falls. Under gement, under item 2., if the cannot be identified or ill try various relevant ed on assessment of the fall uces or stop or until a reason is ontinuation. Under Monitoring nder item 4., if the individual the staff and physician will ituation and consider other for the resident 's falling and ne continued relevance of current fall policy also states residents ' ssessed upon admission, er a fall. There was insufficient of this being done in a consistent	F	490			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG		10/2	5/2011
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NURSING			-	825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ige 98	F	490			
	review, the facility fa to address mental a residents out of the ) checked for psych program in the sam provide accurate do residents ' assignm psychiatric rehabilit monitor residents ' residents reviewed rehabilitative servic in a sample of 30 a	ion, interview, and record ailed to put in place programs and physical rehabilitation of 3 30 residents (R3, 23, and 30 n and physical rehabilitation hple of 30. The facility failed to occumentation regarding ment to and participation in ation program and failed to attendance for 5 of 21 for SMI psychiatric les (R15, R16, R17, R21, R24) nd 48 residents (R85, R99 he supplemental sample.					
		sis of Manic Depressive dal Ideation and was acility on 6/29/11.					
	that at 3:45 PM, R3 being searched and R3 was also parand of trying to poison a nurses notes indica medications and thi	tes dated 5/18/11 indicated 8 was upset about her purse d threatened to slash her wrist. bid about staff, accusing staff and kill her. R3 ' s 2/19/11 ated that R3 refused her inks that her medications are hore, this nurses notes bontinuously refuses					
	observed in bed, pa	r on 9/27/11 at 10 AM, R3 was aranoid, delusional and talking ng stabbed by staff. Review of					

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		AND HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) N	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDI	NG	COMPLETED		
		145850	B. WI	NG .		10/25/2011		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR F	CEDAR POINTE REHAB & NURSING				5825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
TAG F 490	Continued From pa facility ' s incident re incidents. Review of facility program shows no any program to add and suicidal ideatio During 9/28/11 in case worker ) said that hallucinating, and is said that on 5/18/11 suicidal ideation pe continued that R3 is rehab program and about her suicidal id she tried to ask R3 refused. R3 also do medications includi c) R12 has diagno Disorder. Review of outside attendance sheet in attending his outside 8/27/11. Review of sheet also showed	ge 99 eports indicated no such ' s in house and outside indication that R3 is attending tress her psychiatric issues ns. terview at 11:08 AM, E8 ( that R3 is often delusional, s verbally aggressive. E8 also R3 went to the hospital for r her social service notes. E8 s not attending any psych that E8 has not talked to R3 deation yet. E8 also said that to attend programs but R3 bes not take any of her ng her psych medications. osis of Schizoaffective e program TCOTP ' s indicated that R12 has not been e program starting with the Transportation Tracking no indication that R12 was ing the transportation		490	DEFICIENCY)		DATE	
	During 9/28/11 ir case worker ) said socialization skills a R12 ' s attendance Review of facility ' s also showed no atte	aterview at 11:20 AM, E8 ( that TCOTP is for R12 ' s and independence, but that is not great with TCOTP. program with psychologists endance from R12, although mary indicated that he sees a						

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/25/2011		
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 490	Continued From pa psychologist.	ige 100	F	490				
		nterview with E8 at 11:38 am, hat R12 has not been since 8/27/11.						
	d) R30 has diagno admitted to the facil	osis of Schizophrenia and was lity on 7/12/11.						
		otes dated 7/19/11 indicated ht smoking in the bathroom at						
	no indication that th 7/19/11, even thoug he attended a smol	s social service notes showed his behavior was addressed on gh R30 ' s record shows that king program on 7/18/11 per erations). This inappropriate foccurrence.						
	(Administrator) state rehabilitation progra Abuse, Taking care Association Behavio (ABRS) and 2 psyc 163 residents identi serious mental illne Review of the faciliti (SMI) roster dated 9 R21, R24, R85, R99 assigned to any psy programs. 23 reside reside in the facility Tracking Form inclu and 7 residents who The TCOTP In-Hou	oximately 1:30pm, E1 ed that there are 5 psychiatric ams offered: Substance e of the People (TCOTP), or Rehabilitation Services hotherapy groups. There are ified by the facility as having ess. ty ' s Serious Mental Illness 9/14/11 shows R15, R16, R17, 9 through R145 are not ychiatric rehabilitation ents on the roster no longer t. The TCOTP Day Program udes 1 discharged resident o are not on the SMI roster. use Group includes 3 ts and 20 residents who are						

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WING		10/2	5/2011
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR POINTE REHAB & NURSING				5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	1 discharged reside SMI roster. The Alc Group includes 6 re Of the 59 residents psychotherapy, 32 and 3 no longer res no Psychiatric Reha (PRSD) available f	er. The ABRS roster includes ent and 5 residents not on the ohol and Drug Treatment esidents not on the SMI roster. identified as receiving are not listed on the SMI roster ide in the facility. There was abilitative Services Director or interview during the survey.	F 49	0		
	failed to maintain fu 441 bed facility. Findings include: During the entrance approximately 9:15 survey team that th beds with a census and 282 Medicaid). social worker positi	and record review, the facility ill time social services for its e conference on 9/27/11 at am, E1 (Administrator) told e facility has a total of 441 of 293 residents (11 Medicare E1 stated that the facility ' s on has been vacant since onsultant Social Worker) has				
	social worker is hire documentation of n service coverage p how E6 ' s time was During a telephone	acting position until a full time ed. E1 was not able to provide umber of hours of social rovided by E6, nor details of s utilized. interview with E6 on 9/29/11 25pm, E6 stated that the full				

Facility ID: IL6009948

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WING _		10/25/2011		
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR POINTE REHAB & NURSING			5825 WEST CERMAK ROAD CICERO, IL 60804				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 490	<ul> <li>9/14/11, and that sh for the sole purpose development. E6 has services for facility E2 (Consultant, Dir survey team on 9/2 that the social work rehabilitative directer position. The facility rehabilitative service are responsible to r psychosocial rehabilitative service are responsible to r psychosocial rehabilitative directer for each F</li> <li>3) PRSD</li> <li>Based on interview failed to provide do a full time Psychiate Director (PRSD) in of the previous PRS</li> <li>Findings include:</li> <li>During the entrance approximately 9:15 survey team that the beds with a census and 282 Medicaid).</li> <li>PRSD position has and E6 (Consultant working in an acting PRSD is hired. E1 to documentation for the previous previous</li></ul>	as not provided any direct residents. ector of Operations) told 9/11 at approximately 3:30pm, er and the psychosocial or (PRSD) is a combined job y employs 5 psychosocial e coordinators (PRSC) who neet all social service and ilitative needs of all 293 nslates to a caseload on 59 PRSC. and record review, the facility cumentation to that there was ic Rehabilitation Service the facility since the departure SD on 9/14/11. e conference on 9/27/11 at am, E1 (Administrator) told e facility has a total of 441 of 293 residents (11 Medicare E1 stated that the facility ' s been vacant since 9/20/11 Social Worker) has been g position until a full time was not able to provide he number of hours of PRSD by E6, nor details of how E6 '	F 490				

Facility ID: IL6009948

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		HAND HUMAN SERVICES			FORM	02/22/2012 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WING _				
NAME OF F	PROVIDER OR SUPPLIER	•		REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR	POINTE REHAB & NU	RSING	-	825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 490	Continued From pa	ige 103	F 490				
F9999	at approximately 1: PRSD position was she (E6) has been purpose of staff trai development. E6 st direct psychiatric se and family. The facility ' s job d includes the monito development of eac treatment plan (ITP assure that residen PRSD is also respond provide behavioral residents. E2 (Consultant, Dir survey team on 9/2 that the social work rehabilitative director position. The facility rehabilitative servic are responsible for psychosocial rehab residents for each F The facility ' s Resid Residents form (CM in the facility with ps FINAL OBSERVAT Licensure Violation 300.6251) Section 300.6251) Id	tated she has not provided any ervices for facility residents lescription for the PRSD oring of the ch resident 's individualized 2) and its ' needs are being met. The onsible to intervention and counseling to rector of Operations) told 29/11 at approximately 3:30pm, ter and the psychosocial or (PRSD) is a combined job y employs 5 psychosocial ecoordinators (PRSC) who meeting all social service and oilitative needs of all 293 nslates to a caseload on 59 PRSC. dent Census and Conditions of MS-672) shows 272 residents sychiatric illness. TONS	F9999				

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2;	5/2011
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	ILCS 150/2) or regis sex offender or if th and Recommendat Section 2-201.6(a) identified offender p to others within the required to have his facility subject to the under Section 2-102 2-201.6(d) of the Ad This requirement is Based on observati interview, the facility residents reviewed appropriate private Offender). Findings Include: 9-27-11, observed I another resident. Findicates that R4 is Because of R4 's of have been in a priva E11(Psych Rehab S at 10:00 AM stated a resident who is ar not think that it was room. (B) 300.615b) Section 300.615b)	stered (see 730 ILCS 150/3) ne Identified Offender Report ion prepared pursuant to of the Act reveals that the poses a significant risk of harm facility, the offender shall be s or her own room within the e rights of married residents 8(e) of the Act. (Section	F9	999			
	Screening and Req	uest for Criminal History					

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/25/2011		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR POINTE REHAB & NURSING				5825 WEST CERMAK ROAD CICERO, IL 60804				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999		-	F9	999	9			
	need for nursing far admitted, regardles funding source. (Se screening assessm one of the condition rules of the Departr	cility services prior to being s of income, assets, or ection 2-201.5(a) of the Act) A eent is not required provided as in Section 140.642(c) of the ment of Healthcare and Family ical Payment (89 III. Adm.						
		not met as evidenced by:						
	failed to initiate bac of admission for 8 r R80, R82, R83, R8 supplemental samp initiate background 5 identified offende 30 and 8 residents	view and interview, the facility kground check within 24 hours esidents (R77, R78, R79, 4, R97, R98) in the ble. The facility also failed to check within 24 hours for 2 of rs (R13, R18) in a sample of (R38, R59, R85, R86, R87, he supplemental sample.						
	Findings include:							
	9am that she initiate all new admissions determine if the res and fingerprinting is to 64 years. E36 sta by a contracted age printing . Review of the back	Director) stated on 9/30/11 at es the background check for prior to admission to ident is an indentified offender a done for all residents age 18 ated that fingerprinting is done ency and request for finger ground check findings for since last annual survey ng:						

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 106 F9999 R77 was admitted to the facility on 8/27/11. There was no evidence of background check being done. E36 stated that R77 refused background check and was discharged from the facility on 9/2/11. There was no documented evidence of this presented; R78 was admitted on 9/13/11. The background check was initiated on 9/27/11: R79 was admitted on 9/12/11. R79 was hospitalized on 9/18/11. According to E36, R79 remains on bed hold. A background check has not been initiated; R80 was admitted 9/3/11. R80 was fingerprinted on 9/30/11; R82 was admitted 9/4/11. The background check was initiated 9/9/11; R83 was admitted on 9/16/11. Fingerprinting was done 9/30/11: R84 was admitted 9/10/11. No background check has been done: R97 was admitted on 9/8/11. The background check was initiated on 9/27/11; R98 was admitted 9/8/11. No background check has been done. E36 presented evidence that R78, R80, R83, R84 and R98 signed consents for fingerprinting upon admission. Each of these consents showed appointment date for finger printing of 2/18/11 (prior to admission). Z5 (Representative from finger printing agency) was named as person to obtain fingerprint. E36 stated the appointment date of 2/18/11 means nothing because she had copied an old, previously used form for these residents to sign. R98 's consent was signed by a resident with a different name. E36 stated that she should have corrected this information.

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
145850		145850	B. WI	1G		10/2	5/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	s office fingerprintin surveyor that the fa Wednesday (9/28/7 these residents. Z5 responds to fingerp days. E36 was pres 2).Review of the fa Reporting Form rev R13 was admitted background check R18 was admitted check was initiated R38 was admitted check was initiated R59 was admitted check was initiated R85 was admitted check was initiated R86 was admitted check was initiated R87 was admitted check was initiated R87 was admitted check was initiated R87 was admitted check was initiated R87 was admitted check was initiated R89 was admitted check was initiated R89 was admitted check was initiated R89 was admitted check was initiated check was initiated	om, Z5 was observed in E36 ' ng R78, R80 and R83. Z5 told cility contacted him on 11) to do fingerprinting for stated that he always winning requests within 1-2 sent during this interview. cility 's Identified Offender realed the following: to the facility on 7/19/11. The was initiated 7/28/11; on 6/13/11. The background on 6/30/11; on 1/21/11. The background on 2/17/11; on 1/13/11. The background on 2/11/11; on 3/31/11. The background on 4/8/11; on 5/23/11. The background on 6/30/11; on 3/4/11. The background on 3/15/11; on 3/15/11; on 5/2/11. The background on 6/3/11; on 5/2/11. The background on 6/3/11; on 5/2/11. The background on 6/3/11; on 5/2/11. The background	F9	999			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2;	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	<ul> <li>Subpart S</li> <li>a) The facility shalpsychiatric rehability contract with an outpart of the psychiatric long as individual resubsection (c)(4) is designed to allow a individual therapeut limited to, the follow</li> <li>1) Be adjusted to match residents' tolerance, learning characteristics. Envibe arranged to help resident concentrat (e.g., reduction of dextensive use of suneeded.</li> <li>2) Incentive printerviewing, behav shaping or i reinforcement, and This requirement is Based on record refailed to place three in-house group from reviewed for social residents.</li> </ul>	<ul> <li>(1)2) Psychiatric</li> <li>(ices for Facilities Subject to</li> <li>II develop and implement a ation program. A facility may tside entity to provide all or ric rehabilitation program as esidents' needs are met and met. The program shall be wide array of group and tic activities, including, but not ving:</li> <li>in content, form and duration profiles in terms of stress impairments, and motivational vironmental conditions shall be compensate for deficits in terms of stress impairments, and memory listracting stimuli and upportive reminder cues), as</li> </ul>	F99	999			
		-					

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 109 F9999 also failed to provide accurate documentation regarding residents ' assignment to and participation in psychiatric rehabilitation program and failed to monitor residents ' attendance for 5 of 21 residents reviewed for m psychiatric rehabilitative services (R15, R16, R17, R21, R24) in a sample of 30 and 48 residents (R85, R99 through R145) in the supplemental sample. Based on observation, interview, and record review, the facility also failed to put in place programs to address mental and physical rehabilitation of 3 residents out of the 30 residents (R3, 23, and 30) checked for psych and physical rehabilitation program in the sample of 30. Findings Include: Record review of R10 's physician 's order sheets dated 7-1-11 thru 9-30-11 denotes resident may attend in-house groups. Record review of R10 's care plan denotes goal: the resident will meet with doctor for 1:1 therapy one times a week by 6-22-11. Clinical record review of R11 's physician 's order sheet dated 7-1-11 thru 9-30-11 denotes resident may attend in-house groups. Record review of R11 's interagency certification of screening results determination, social services: mental health rehabilitation activities, aggression/anger management. Record review of R11 's care plan- substance abuse denotes the resident will attend in-house group program four times a week by 7-16-11. Record review of facility 's attendance sheet for in-house groups do not have any documentation that R10 and R11 have attended in-house groups

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/22/2012

		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/25	5/2011	
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR I	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	from 6-1-11 thru 9-3 Interview with E9 (F Services Coordinate states she did not h to accurately review E9 states she now f group for R10 and F others were brough and now are being being updated. Clinical review of R form for psycho soor review of R10 's ph 9-29-11 denotes res psychosocial group treatment. Clinical review of R form for psycho soor review of R11 's ph 9-29-11 denotes res psychosocial group psychiatric treatment a) R3 has diagnos Disorder and Suicio readmitted to the fa R3 's nurses no that at 3:45 PM, R3 being searched and R3 was also parand of trying to poison a nurses notes indica and thinks that her	30-11. Psychiatric Rehabilitation for) on 9-29-11 at 11:45 a.m. have the opportunity and time w R10s' and R11's charts. made the referral to in-house R11. E9 states this issue and ht to her attention yesterday addressed and care plans are 210's programming referral cial dated 9-28-11. Record hysician's order sheet dated isident may attend o for psychosocial/psychiatric 211's programming referral cial dated 9-28-11. Record hysician's order sheet dated isident may attend o for psychosocial and nt. sis of Manic Depressive dal Ideation and was acility on 6/29/11. bes dated 5/18/11 indicated 8 was upset about her purse d threatened to slash her wrist. oid about staff, accusing staff and kill her. R3's 2/19/11 ated that R3 refused her meds meds are poisoned. hurses notes indicated that R3	F9	999				

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/25	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD		
CEDAR I	POINTE REHAB & NU	RSING			CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	During initial tou observed in bed, pa about residents bein facility ' s incident re- incidents. Review of facility program shows no any program to add and suicidal ideation During 9/28/11 in case worker ) said th hallucinating, and is said that on 5/18/11 suicidal ideation per continued that R3 is rehab program and about her suicidal id she tried to ask R3 refused. R3 also do medications includin b) R12 has diagno Disorder. Review of outsid attendance sheet in attending his outsid 8/27/11. Review for sheet also showed gpoing to TCOTP u arranged for by the During 9/28/11 in case worker ) said to socialization skills a	r on 9/27/11 at 10 AM, R3 was aranoid, delusional and talking ng stabbed by staff. Review of eports indicated no such y ' s inhouse and outside indication that R3 is attending lress her psychiatric issues ns. nterview at 11:08 a.m., E8 ( that R3 is often delusional, s verbally aggressive. E8 also I R3 went to the hospital for r her social service notes. E8 s not attending any psych that E8 has not talked to R3 deation yet. E8 also said that to attend programs but R3 bes not take any of her ng her psych meds. osis of Schizoaffective de program TCOTP ' s ndicated that R12 has not been le program starting with the Transportation Tracking no indication that R12 was using the transportation	F9	999			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR P	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR( DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	also showed no atte 6/2/11 Annual Sum psychologist. During 9/29/11 in E8 was not aware to attending TCOTP s c) R30 has diagno admitted to the facil R30 ' s nurses n that R30 was caugh 11 AM. Review of R30 ' no indication that th 7/19/11, even thoughe attended a smok E2 ( Director of Ope smoking is a new o During 9/28/1 case worker ) said th hallucinating, and is confirmed R3 never involved in any prog R3 went to the hosp said she has not tal suicidal ideation. E8 R3 does not like to 1) R12 has diagno	s program with psychologists endance from R12, although mary indicated that he sees a nterview with E8 at 11:38 am, that R12 has not been since 8/27/11. bosis of Schizophrenia and was lity on 7/12/11. notes dated 7/19/11 indicated ht smoking in the bathroom at s social service notes showed his behavior was addressed on gh R30 ' s record shows that king program on 7/18/11 per erations). This inappropriate	F99	999			

		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
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		145850	B. WI	NG		10/2;	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING		-	825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	attendance notes w last participated in a as had attended the Transportation trac name. Review of ps showed that R12 w though social servic 6/2/11 says R12 se monthly. During 9/29/11 i not aware that R12 8/17/11. No commu was in charge of R <sup>2</sup> could be addressed not had any program after 8/17/11. 2) R30 was admitt diagnosis of Schizo s psychiatric notes impulsiveness, delu nurse ' s notes date caught smoking in f was given a PRN, a s social service not behavior was addre During daily status a smoking program on 7/18/11. When R <sup>2</sup> program prior to thi smoking in inappro to provide further in On 9/27/11 at appro	with above group indicated he 8/17/11. R12 has not signed e TCOTP starting 8/27/11. king also did not show R12 ' s sychologists sign in sheet also ras not in their group even ce annual summary dated res an psychiatrist/psychologist nterview at 11:38 AM, E8 was had not attended after unication was given to E8 who 12 ' s case so non- attendance d. In the meantime, R12 has m to address his mental health ted to facility on 7/12/11 with ophrenia Paranoid Type. R30 ' dated 7/13/11 indicated usional, and with lability. Per ed 7/19/11 at 11 AM, R30 was the bathroom. Although R30 and counseled, review of R30 ' res showed no indication this resed. on 9/29/11, E2 said he was in and had attended a session asked what did the facility do 30 who was in a smoking is behavior was caught priate places, E2 was not able	F99	999			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         145950		(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
	Rovider or Supplier	RSING		5	REET ADDRESS, CITY, STATE, ZIP CODE 1825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	rehabilitation progra Abuse, Taking care Association Behavi (ABRS) and 2 psyc 163 residents ident serious mental illne Review of the facil (SMI) roster dated R21, R24, R85, R9 assigned to any psy programs. 23 resid reside in the facility Tracking Form incli and 7 residents whi The TCOTP In-Hou discharged residen not on the SMI rost 1 discharged residen SMI roster. The Alc Group includes 6 re Of the 59 residents psychotherapy, 32 and 3 no longer residents psychotherapy, 32 and 3 no longer residents psychotherapy, 32 and 3 no longer residents (PRSD) available f 300.4060b Section 300.4060b Section 300.4060b Mithin one discharge, preparation	ams offered: Substance e of the People (TCOTP), or Rehabilitation Services hotherapy groups. There are ified by the facility as having ess. ity 's Serious Mental Illness 9/14/11 shows R15, R16, R17, 9 through R145 are not ychiatric rehabilitation ents on the roster no longer . The TCOTP Day Program udes 1 discharged resident o are not on the SMI roster. use Group includes 3 ts and 20 residents who are er. The ABRS roster includes ent and 5 residents not on the cohol and Drug Treatment esidents not on the SMI roster. identified as receiving are not listed on the SMI roster side in the facility. There was abilitative Services Director for interview during the survey. (B)	F9	999			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WIN	G		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			325 WEST CERMAK ROAD ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa community provide	-	F99	99			
		d initiation and compliance services while in the facility;					
	3) Use of com	munity mental health services;					
	4) Assistance housing; and	with locating and securing					
	5) Assistance and securing finance	with identification, application ial resources.					
	This requirement is	not met as evidenced by:					
	failed to provide dis resident (R11) out o	view and interview facility charge planning to one of 25 residents reviewed for a sample size of 30 residents.					
	Findings Include:						
	states he informed quit that he wanted states that after his (Psychiatric Rehabi from the 7th floor th R11 states he E11 the housing list but Interview with E11 of R11 acquired about independent living, but didn ' t do it but (Psychiatric Rehabi Interview with E# of she does not know	on 9-29-11 at 12:00 PM, his social worker before she to seek senior housing. R11 social worker quit he told E11 litation Services Coordinator) hat he wanted senior housing. told him that he placed him on never did. on 9-29-11 at 12:10 PM, states thousing for assistance with E11 states he was told by R11 rather delegated it to E8 litation Services Coordinator). In 9-29-11 at 12:20 PM, states that R11. E8 doesn ' t recall st R11 with placement for					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	assessment, review denotes discharge R11 's comprehens discharge dated 4-7 favor discharge ever extensive physical a Goal: resident will r and significant other needs by 7-16-11. Interview with E9 (F Services Coordinat states she did not h to accurately review charts. E9 states th brought to attention addressed and care Record review of R plan; anticipating di Interventions: conta services. Contact p nurse. Meet with re help with mental pro- 300.4030h)	11's discharge potential v and plan dated 4-13-11 is uncertain. Record review of sive care plan; anticipating 16-11 denotes the resident en though the resident requires and/or mental heath service. meet with social worker, nurse er(s) to identify post-discharge Psychiatric Rehabilitation or) on 9-29-11 at 11:45 AM have the opportunity and time v R11s' chart and other his issue and others were n yesterday and now are being e plans are being updated. 11's comprehensive care ischarge dated 9-28-11 act department of human hysician for home health sident on a regular basis to eparation for discharge. (B)	F9!	999			
	for Residents with S Residing in Facilitie	ndividualized Treatment Plan Serious Mental Illness es Subject to Subpart S all be reviewed by the IDT					
	quarterly and in res	ponse to significant changes nptoms, behavior or					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145850	B. WIN	1G		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	functioning; sustain resident's refusal to the treatment plan; readiness for discha discharge; or the re goals in the treatme This requirement is Based on record re failed to review and to minimize the risk (R15, R16, R18, R2 out of sample size of revise the nutritiona (R11) out of 14 revi of a sample size of Findings Include: Record review of R vital record denotes 183 pounds and in Record review of qu note dated 7-6-11 of pounds, weight incr sodium diet continu nutritional progress re-admitted general of nutritional progres denotes significant pounds in three mo general diet no den s care plan therape 9-7-11, Goal: will in fluids. Approach: pr	<ul> <li>and lack of progress; the participate or cooperate with the resident's potential arge and actual planned esident's achievement of the ent plan.</li> <li>a not met as evidenced by:</li> <li>eview and interview facility revise care plan interventions a for falls for four residents 20) out of 13 reviewed for falls of 30 and failed to review and al care plan for one resident iewed for weights/nutrition out 30.</li> <li>and 's monthly weights and s in July 176 pounds, August September 189 pounds.</li> <li>anterly nutritional progress denotes R11 weight of 176 reasing gradual monthly, low ued. Record review of a notes dated 9-7-11 R11 l/ regular diet. Record review ess notes dated 9-12-11 weight gain increase 13.86 onths. Appetite has been good, tures. Record review of R11' eutic diet dated 7-13-11 and gest adequate nutrition and rovide diet as ordered, monitor</li> </ul>	F99	999			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SU COMPLE	
		145850	B. WI	٩G _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD		
CEDAR F	POINTE REHAB & NU	RSING			CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	<ul> <li>9-28-11 at 11:50 AM the issue in the diet</li> <li>E12 states she will was missed.</li> <li>Interview with E2 (E</li> <li>9-29-11 at 9:55 AM addressing R11 's and dietary notes.</li> <li>Record review of R plan dated 9-27-11, gain increase 13.8 p snacking/eating bet registered dietician per prescribed diet</li> <li>300.610a) 300.1210a) 300.1210b)5) 300.1210b)5) 300.1210b)5) 300.1210b)5) 300.3240a)</li> <li>Section 300.610 Re a) The facility shall procedures, govern the facility which sh Resident Care Polic least the administrat the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility</li> </ul>	M states we did not address tary notes or in the care plan. address it now, not sure how it Director of Operations) on , states dietary missed weight gain in the care plan 11 's therapeutic diet care , problem: resident with weight pounds, probable tween meals. Approach: consult and educate resident orders. (B) esident Care Policies have written policies and hing all services provided by all be formulated by a cy Committee consisting of at ator, the advisory physician or ry committee and hursing and other services in policies shall be in compliance rules promulgated thereunder. ies shall be followed in y and shall be reviewed at	F9	999			
	These written polici operating the facility least annually by the	es shall be followed in					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE		
		145850	B. WI	NG _		- 10/25/2011		
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	Nursing and Person a) Comprehensive with the participatio resident's guardian applicable, must de comprehensive car includes measurable meet the resident's and psychosocial n resident's compreh- allow the resident to provide for discharg restrictive setting ban needs. The assess the active participat resident's guardian applicable. (Section b) The facility shall and services to attap practicable physica well-being of the resident's com plan. Adequate and care and personal of resident to meet the care needs of the resident shall include, at a m procedures: 5) All nursing perso encourage resident transfer activities as effort to help them of practicable level of d) Pursuant to subs	Seneral Requirements for nal Care Resident Care Plan. A facility, n of the resident and the or representative, as velop and implement a e plan for each resident that e objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care ment shall be developed with ion of the resident and the or representative, as a 3-202.2a of the Act) provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with hprehensive resident care properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative measures ninimum, the following nnel shall assist and s with ambulation and safe s often as necessary in an retain or maintain their highest	F9	9999				

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/25	5/2011
NAME OF PROVID	DER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POIN	ITE REHAB & NUI	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
and sev 3) C resi em deta furti mad resi 6) <i>A</i> ass as f nurs that and Sec a) <i>A</i> age resi Cog risk inte falls R19 cog phy resi inve cau R15 san R44 sup	ven-day-a-week b Dbjective observation, otional changes, ermining care re- cher medical eval de by nursing sta- ident's medical re- all necessary pre- sure that the resid free of accident h sing personnel s t each resident re- d assistance to pi- ction 300.3240 A An owner, license ent of a facility sh- ident. sed on observation iew, the facility fa- gnitively impaired c for falls and failed reventions to pre- s resulting in frace 9 and R44, failed pitively impaired c for falls and result estigate and asse- use for falls in 6 c 5,R18, R19, R23 nple of 30 reside	eed on a 24-hour, basis: rations of changes in a , including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the record. ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents. Abuse and Neglect ee, administrator, employee or hall not abuse or neglect a ons, interview and record ailed to provide supervision for d individuals assessed as high led to provide effective vent the numerous falls, some ctures for R2 and sutures for d to provide supervision for d residents who have been in with other cognitively impaired ted in injuries and failed to ess individuals for the root of 13 residents (R2, R13, B) reviewed for falls in the ents and 8 residents (R34, 3, R32, R39, R45) in the ole.	F99	999			

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	√G _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ıge 121	F9	999			
	who has a diagnose dementia, hyperten Accident per the cu Set (MDS). R2 is di (person, place and 9/14/11 care plan for making. On 9/27/11 at 10 a. R2 was seated in w was standing along semi-cast and wrap stated he has a ten she is re-applying it his chair alarm and On 9/28/11 at 9:30 the hall near the nu semi-cast and ace around his neck wa is swollen. E13 (nut the cast is off but st it needs to be repla the physician ' s oro R2 needs to keep th E13 stated the nurs find the semi-cast in contact the restorat R2 removed from th fitted for a semi-cast can not be found, F A.M., R2 is back in	hair bound, 67 year old male es of alcohol abuse related hair bound, 67 year old male es of alcohol abuse related hair and Cerebral Vascular inrent 6/20/11 Minimum Data isoriented by all 3 spheres time) per the 5/9/11 and or memory and decision- 					
	Rehabilitation Servi	P.R.S.C. (Psychiatric ice Counselor) were circulating out the week, R2 was in his					

I

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
_	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD		
CEDAR I	POINTE REHAB & NU	RSING		-	CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	near nurses ' static splint and throw it o resident needed rer wheel-chair. R2 is care planned to be re-applied wha always put back on Review of the facilit 11 to September ' were not witnessed and no investigation occurred. Review of the incide fall on 6/8/11 at 6:1 room, where R2 is f over-bed table brok witnessed nor is it it say what happened Review of the nurse document R2 found confused however I becomes more con hospital. The next fall is 6/11 on the floor in the h staff saw him walking nhave been walking unsteady gait. The	ining room and/or in the hall on. R2 was seen to remove his in the floor. Numerous times minders not to get out of his for removing his splint but it is en removed. The cast was not ry 's incident reports (April ' 11) show numerous falls that , many resulting with injuries in as to how and why the falls ent reports for R2 document a 5 A.M. in the 4th floor dining found on the floor with an .en next to him. It is not nvestigated. R2 was unable to	F9	999			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2;	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 123	F9	999			
	document R2 was ween to floor. R2 for right arm and hand pain to head and ard dizziness while star R2 's right side of f R2 was admitted to of Syncope. When he had another diag The next document p.m. where R2 was documents he was placed in wheel-chainjury but there is not determine how and any follow-up to ens The next document 11:40 A.M. where F floor. R2 can not sid disoriented to all 3 s reminded to stay in are to continue to m evaluate resident for no investigation into was not effective du facility implemented frames are unclear discontinued and th The report dated 8/ R2 stated another r a new cut on the rig	es' notes dated 6/11/11 walking down hall to lunch and und on his right side with his under him. R2 complained of m. R2 complained of nding and while on the floor. Face was red. 911 was called. the hospital with a diagnosis he returned from the hospital, gnosis of encephalopathy. ted fall is dated 6/14/11 at 6:30 a found on his floor. The report removed from floor and air. The report documents no o investigation into the fall to why it happened. Nor is there sure there is no injury. ted fall is dated 6/21/11 at R2 is found on the dining room ay what happened. R2, who is spheres and confused, was his chair. The interventions nonitor resident and to or laptop cushion. There was o the fall. The laptop cushion ue to R2 removing it so the d the chair alarm but the time as to when the laptop was ne chair alarm implemented. (31/11 at 2:40 p.m. document resident hit him and there was ght cheek. R2 received first aid to investigation nor was the tified.					

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING		_	825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 124	F9	999			
	documents R2 on f was asked what ha onto the floor becau arm cast is with in r edema. It document this fall and R2 has incident reports doc a fall. Review of nurses ' document R2 on th claimed to not fall.' seen or any investig note dated 8/11/11 swollen and R2 cor ordered. There wa incident. Review of the porta documents no fract Review of the nurse documents R2 to b was pale in color ar orbital area and ser note dated 9/4/11 a admitted under alte back to the facility of done on 9/6/11 at th documents there is the 5th metacarpal close opposition of no investigation into when and how he facility of	<ul> <li>14/11 at 10:30 P.M.</li> <li>loor next to bed. When R2 ppened, he stated he rolled use it feels better. R2 's right normal limits with some ited the cast is not related to soft cast to arm. None of the cument fracture resulting from</li> <li>note dated 8/10/11 at 6 A.M.</li> <li>e floor sitting Indian-style. R2 There is no incident report gation into it. The nurses ' documents R2 's right wrist nplaining of pain. X-rays were s no investigation into this</li> <li>able x-ray done on 8/11/11 every lethargic and weak. R2 nd had swelling in the right eye nt out to hospital. Nurses ' it 8 P.M. documents R2 was red mental status. R2 returns on 9/6/11 and an x-ray was he hospital. The hospital x-ray a fracture through the neck of of the indeterminate age with fracture fragments. There was on the fracture to determine ractured his 5th metacarpal.</li> <li>5 A.M., in R2 's room, there is</li> </ul>					

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145850 10/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CEDAR POINTE REHAB & NURSING CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 125 F9999 a portable x-ray machine and Z6 (a technician) and R2. Z6 stated he was called to do an x-ray on R2 's right wrist and hand. On 9/30/11 at 9:38 A.M., E3 (acting director of nursing) stated the x-ray was done because he keeps removing the semi-cast. The results are the fracture is still healing. Review of R2 's current care plan for falls dated 9/19/11 and 9/22/11 document a fall on 9/14/11 with injury. The incident of 9/14/11 does not document an injury to the fall. R2 already had the injury prior to 9/14/11. On 9/30/11 at 9:55 A.M. during daily meeting with administration, E3 and E2 (director of operations) stated they are unable to answer why no investigations were done into the falls, the physical altercations between residents and incidents of unknown origins. E2 stated she was hired one month ago and E3 stated she thought Z7 (ex-director of nursing) was handling the investigations. E3 stated Z7 was employed from 10/25/10 to 7/29/11 when she resigned. The personnel file reflected the same dates. 2) R19 is a 70 year old, ambulatory male who wanders the unit without purpose. R19 is tall and extremely thin. At 72 inches tall, he weighs 109# per the 8/24/11 MDS. R19 is disoriented to all 3 spheres, person, place and time per the current care plan for orientation. R19 was seen throughout the week to wander in and out of dining room, resident rooms and in the hall. R19 wears a cervical collar at all times. The current care plan documents the cervical collar is to be worn at all times. On 9/27/11 between 9:50 A.M.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR I	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	to 10:35 A.M. during with E13, E13 state collar due to his num Review of the incide falls on 7/26/11, 8/1 witnessed and 2 of injuries. The incider P.M. documents R resident 's room. R forehead, above the left and right knees There was no inves 8/19/11 at 2:45 P.M underneath a dress room. R19 sustaine the left elbow. No in 7/26/11 at 10:40 A. the floor in the hallw were documented a The incidents dated document R19 fell f left orbital area " su wound. R19 require The reports docum witnessed the incide from her nor was the incident dated 5/29, housekeeper and a ambulating in the d balance and fell. R 's left elbow is swo an x-ray to entire le identified by name f	g the initial tour of 4th floor ed R19 wears the cervical merous falls. ent reports for R19 document 14/11, 8/19/11 which were not the incidents resulted in nt report dated 8/14/11 at 2:50 19 sitting on floor of another R19 sustained a 2 inch cuts to e right eye, the lip, left eye lid, a. R19 was sent out to hospital. stigation. The incident dated A. document R19 face down ser in another resident 's ed a cut to the shoulder and nvestigation. The incident of M. documents R19 sitting on way next to a chair. No injuries and no investigation done. d 7/18/11 at 4:20 A.M. from bed and " hit his upper ustaining a small 1 inch ed 4 sutures to the forehead. ents E32, a nurse aide, lent but there is no statement here an investigation. An 1/11 at 1:15 P.M. documents a a nurse aide see R19 ining room, stood still, lost 19 landed on his left side. R19 ollen. An order is obtained for eft arm. The staff were not nor are there any statements. by results provided or seen.	F9	999	9		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WI	NG _		10/2	5/2011
	Rovider or supplier Pointe Rehab & NU	RSING			TREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F9999	<ul> <li>P.M. documents whanother resident was the hallway. R19 survist area. No injuri resident was identifiname. Both separar investigation as to vand other resident was identification as to vand other resident vactivity.</li> <li>3) R38 is a 57 year who is confused and diagnoses include a dementia and conv (6/11/11 and 7/5/11 A.M. to 10:30 A.M. R38 was seated in dining room. R38 was seated in dining rooms.</li> <li>On 9/29/11 at 11:38 environmental tour environmental tour common bathroom, opposite side of the wheel-chair in a toil spoken to, R38 did summoned. In the r the wheel-chair using stall, failing to lock frolled backwards. Fincontinent brief and the spoken to for the wheel-chair using stall, failing to lock frolled backwards. Fincontinent brief and the spoken to for the spoken to</li></ul>	t for R19 dated 8/4/11 at 2 hile making rounds R19 and ere swinging at each other in listained a skin tear to the right es to other resident. The other ied by room number but no ted and monitored. No why it happened and why R19 were not in a structured old, wheel-chair bound male d disoriented. R38 ' s schizoaffective disorder, ulsions per incident reports ). On 9/27/11 between 9:50 during the initial tour with E13, a wheel-chair in the 4th floor ras wearing a winter coat over had long (1 inch) finger nails. ek, R38 was seen propelling the unit, in and out of rooms	F9	999	9		

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PRINTED: 02/22/2012

		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR F	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa what he was doing response from R38 Review of the curre documents R38 red assistance for toilet bowel and bladder. Review of the incide 2:10 P.M. document in the 4th floor dinint side of his body and R38 could not say w witnessed it but the from the person. Ar and it was negative determine the caus and fall. Review of the incide documents R38 is of 4th floor dining roor incident does not do There is second pa Report (incident rep labeled Manageme There is a section la it documents the sta R38 was unable to stood up after the fa smoke room (the our room). There was rep	age 128 in the female bathroom. No 3. ent quarterly (7/11/11) MDS quires one person limited t use. R38 is continent of ent report dated 5/24/11 at nt R38 lost his balance and fell ng room, landing on his left d hitting his head on the floor. what happened. A nurse aide ere is no name or statement in x-ray was done on left hand a. There was no investigation to be for R38 to loose his balance ent dated 6/11/11 at 6 P.M. orient times two. R38 fell in the m landing on his left side. The ocument if it was witnessed. age to the Unusual Occurrence port). The second page is ent Follow-up to Incidents. abeled " interview with staff " aff found R38 on the floor. say what happened. R38 was all and he walked to the utside patio adjacent to dining no investigation to determine		999	DEFICIENCY)		
	report identify the s The incident report documents R38 is o	cause his fall. Nor does the taff person. date 6/14/11 at 6 P.M. orient times one, loss stability onto his right side. R38 was					

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145850	B. WING	G		10/2	5/2011
NAME OF F	ROVIDER OR SUPPLIER		:		EET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			25 WEST CERMAK ROAD CERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	witnessed by a nurs name of this nurse into the fall. R38 wa happened. It is uncl stood up from whee The incident report documents R38 lay and it was not witne he fell. No injuries r wheel-chair. No inv The incident report documents R38 wa the face with his fis a staff person. No t There was no inves was the female resi The incident report document R38 was forehead by anothe over the peer 's fee peer is identified by other identifier for th identity is unclear. Ta a nurse aide. This a there a statement fivere re-directed. On 9/30/11 at 9:55 with administration are unable to identii physical altercation witnessed the falls. one month and E3	ed into wheel-chair. This was se on the floor. There is no and there is no investigation as unable to say what lear if R38 was ambulating or el-chair prior to the fall. dated 7/5/11 at 8:35 A.M. ring on the dining room floor essed. R38 could not say how noted and R38 placed in estigation was done. dated 6/28/11 at 12:30 P.M. s striking a female resident in t. This was witnessed by E33, itle was given in the report. etigation into the altercation nor	F99	99			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		145850	B. WING	G	10/2	5/2011
NAME OF F	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CEDAR	POINTE REHAB & NU	RSING		5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 130	F999	99		
	4) On 9/27/11 betw A.M during the initia Coordinator/nurse), and asking for mon confused. R44 's d schizoaffective disc disorder per the inc On 9/29/11 at 11:23 environmental tour Maintenance), R44 at the doorway. In t the floor, was a yell like urine. E20 state on the floor and in t air conditioner unit room, which is not of R44 had a fixed gla answer any question housekeeper to mon Review of the current documents R44 rect assistance in toilet incontinent of bower Review of R44 's in 5:30 A.M., 7/12/11 2:30 P.M. documer 7/18/11 resulting in The 6/5/11 incident was found sitting or small amount of blow was unable to say v investigation to deta The witnessed fall of	een the 9:50 A.M. to 10:30 al tour with E13 (MDS R44 was ambulating the unit ey from E13. R44 was very iagnoses include paranoid order, dementia and seizure ident report (7/12/11). B A.M during the with E20 (Director of was standing inside his room he hall outside of his room, on ow-pooled liquid that looked ed R44 has a habit of urinating he air conditioner units. The in the room next to R44 ' s occupied, smelled of urine. re on his face and would not ns. E20 summoned the p up the spill. nt quarterly 8/11/11 MDS quires one person limited use and occasionally				

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR	POINTE REHAB & NU	RSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	without locking the rolled backwards. F forward hitting his h left eye brow. It req intervention is to ke because he is ambut what happened. Th see a neurologist. T 8/12/11 documents with history of Epile " Initial neurological seizures disorder a does not document levels (Valproic acid (routine labs) in 2 m investigation and th The incident dated was witnessed by E stumbled over his f document the facto and R44 's foot we the unidentified nur floor. 5) R36 is a 60 year R36 was confused spheres. Staff woul dining room. At time propel the wheel-ch dementia and schiz 4/14/11 incident rep Review of R36 's a documents R36 rec with walking and us The MDS document	brakes and the wheel-chair R44 lost his balance and fell nead causing a cut above the uired 3 sutures. The eep him out of any wheel-chair ulatory. R44 was unable to say here was an order for R44 to The neurologist 's report dated a R44 is a 56 year old male opsy. The chief complaint listed I exam. The patient has nd dementia. " The report any test done. Recommends d and Dilantin) and RTL nonths. There was no ne witness is not identified. 7/12/11 documents the fall E34, a nurse aide. R44 had eet. The report does not or such as condition of floor har. There is no statement from rea who assisted R44 off the old, wheel-chair bound male. and not oriented to all 3 id push R36 in and out of the es, R36 would use his feet to hair. R36 's diagnoses include zoaffective disorder per the	F9	999			

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
	145850	B. WI	NG		10/2	5/2011
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NU	RSING		-	825 WEST CERMAK ROAD CICERO, IL 60804		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999 Continued From pa mobility.	ge 132	F9!	999			
Review of R36 ' s in 10:30 A.M., 4/29/11 A.M. and 6/20/11 at witnessed falls. The documents during a floor, R36 stood up his right side of the remembers falling b disturbances. The in to check with nurse the floor. R36 has a a wheel-chair when investigation or stat was not asked to re from chair with unst The 4/29/11 incider a dining room chair unsteady gait acros R36 was asked if he no. " following the documents R36 alw the nurse is the one documents R36 ' s intervention was to The incident of 5/26 aide saw R36 come down the hallway at nurse, who is not id his backside on the R36 stated he was and used his hands investigation to dete	Acident reports dated 4/9/11 at at 2:40 p.m., 5/26/11 at 2:45 t 8:25 A.M. document incident dated 4/9/11 a group meeting on the second , was unsteady and fell hitting face. R36 stated he out denied headache or visual intervention is for activity staff s prior to removing R36 from an unsteady gait and requires leaving floor. There was no ements to determine why R6 emain seated when he got up teady gait. At documents R36 is sitting in , stood up, walked with is the room and fell. When e was okay, he responded " " no " response, the report vays responds " no " . E35, e who witnessed the fall and gait to be unsteady. The counsel him on safety. 6/11 documents E37, nurse e out of his room, stumble nd fall. E37 informed the entified, and she finds R36 on hallway floor. No injuries. going home, stumbled forward is to brace his fall. No ermine why he is so unsteady. 6/20/11 documents R36 was					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SL COMPLE	
		145850	B. WI	NG _		10/2	5/2011
NAME OF PROVIDER OR SUPP	LIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB	& Nl	IRSING			5825 WEST CERMAK ROAD CICERO, IL 60804		
PREFIX (EACH DEFIC	IENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
feet, falling to The intervention Physical thera the floor. Ther continues to fa interventions in The incident d at 11:45 A.M. un-witnessed documents R3 room. R36 wa The intervention was no investi The incident 8 identified, finds stated he was nurse aide sta him on floor ar not identified. the hall rails if assistance if m to determine w The incident d was heard and injuries. R36 m home. The nu on the floor. T wheel-chair bu from the chair station. No inv to fall. 6) On 9/28/11	breal be find by de- by de- de- by de- by de- de- de- de- de- de- de- de- de- de-	cfast tray, tripped over his own oor and injuring both knees. ere to check vitals and notify epartment. R36 stated he fell to no investigation as to why he d why there are no ce. 4/14/11 at 7:25 A.M, 8/28/11 9/16/11 at 6:15 A.M. are ents, The 4/14/11 incident ce down on the floor in his able to say what happened. one on one monitoring. There	F9	999	9		

DEPAR <sup>-</sup> CENTE	PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	ILDI		(X3) DATE SURVEY COMPLETED	
		145850	B. WI	NG _		10/2	5/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR POINTE REHAB & NURSING					5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	walked because the waist and the length inches too long. R3 dementia secondar subdural hematoma disorder and status per the 6/1/11 incid Review of the annu him to be independ supervision and set The incident dated documents R32 on room floor. It was n to say what happen investigation as why The incident dated documents R32 is p R32 turns around a residents are separ rooms. E30 (nurse resident, who is not and push him again then struck the othe investigation into th was there no imme The intervention wa medicated or just o to their rooms, not a 7) Throughout the w and out of her room in/out of the dining	<ul> <li>e pants were too big in the h of the pants were several 2' s diagnoses include y to the traumatic brain injury, a, bipolar disorder, seizure post shunt and craniotomy ent report.</li> <li>al 9/13/11 MDS documents ent for walking but requires t-up for dressing.</li> <li>6/1/11 at 2:30 P.M. his buttocks on the dining not witnessed. R32 was unable ned. There was no y he fell.</li> <li>8/27/1 at 9:50 A.M. pushed by a female peer and and hit her in the face. Both rated and re-directed to their aide) stated she saw another t identified, grab R32 ' s collar nest the elevator doors. R32 er resident. There is no he physical altercation and why diate intervention/supervision. as to separate the residents, o decrease the agitation but both residents were ne resident and re-direct them</li> </ul>	F9	9999	9		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		145850	B. WI	NG _		10/25/2011		
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR POINTE REHAB & NURSING					5825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	bed. R34 would we non-skid socks. R3 ambulatory female s diagnoses include and schizophrenia p On 9/29/11 at 11:30 environmental tour maintenance), R34 bible as seen all we She left room and b incoherently and sw the unit and procee station. There is a f floor buffer that exte R34 is following us cord. The incident reports documents a loud r nurse aide, both no R34 on the floor on complained about s but refused the Tyle fracture and dislocat dream that there we ran to the window. put in place. The incident dated documents R34 is fa and has a cut on he re-directed and resi no investigation inte it does not identify f	<ul> <li>a house dress and</li> <li>4 is an 85 year old,</li> <li>who is very disoriented. R34 'e</li> <li>e dementia, bipolar disorder</li> <li>ber the 8/23/11 incident.</li> <li>D A.M. during the</li> <li>with E20 (director of</li> <li>is seated on her bed with her</li> <li>began to follow us talking</li> <li>vearing. As we left her side of</li> <li>ded back to the nurses '</li> <li>12 foot electrical cord for the</li> <li>ends the width of the hallway.</li> <li>and needs to step over the</li> </ul> S dated 4/29/11 at 2:30 A.M. noise was heard by nurse and t identified by name, who find her backside. R34 soreness on her right shoulder enol. X-ray was negative for a ation. R34 stated she had a ere snakes in the bed so she There were no interventions 6/14/11 at 8:45 A.M. found on the floor of her room er forehead. Other resident dents kept separate. There is o how the injury occurred and he other resident. R34 sent valuation and treatment but no	F9	999				

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		AND HUMAN SERVICES			FORM	: 02/22/2012 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL A. BUILD	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		145850	B. WING	3	10/25/2011	
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CEDAR POINTE REHAB & NURSING				5825 WEST CERMAK ROAD CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 136	F999	99		
	a nurse aide, not id on the floor. The nu floor and onto the b what happened. Th nurse aide as to wh an investigation into cognitively impaired assistance. The incident dated document R34 was her head by anothe documents a witnes is there any statem investigation. The incident dated documents R34 be was struck in the fai in the female Comr seen. The other res there was no invest was relocated to the The incidents dated 6/24/11 at 4:30 P.M assaulting ( 2.5 incl hospice nurse for n by her when R34 w station. No investig escalate. The incid R34 scratched E38 re-directed by E38. uncooperative. R34 psychiatric evaluation	7/22/11 at 2 A.M. documents lentified by name, found R34 urse aide helped R34 off the bed. R34 was unable to say here is no account from the nat she witnessed nor is there o why R34 fell. R34, who is d, was instructed to ask for 6/23/11 at 10:40 P.M. 6 punched in the right side of er resident. The report ss but no one is identified nor ent. There was no 8/23/11 at 4:10 P.M. ing very upset and stated she ace by another female resident mon Bathroom. No injuries sident was not identified and tigation into the incident. R34 e dining room at this time. d 4/15/11 at 11 A.M and A. document R34 physically h scratch on neck) the a to reason except she walked vas escalating at the nurses ' gation into what caused R34 to dent dated 6/24/11 documents a (staff) when R34 was R34 was aggressive and 4 was sent out to hospital for on. No follow up to the incident vestigation into the cause of				

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145850	B. WI	NG _		10/25/2011		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR POINTE REHAB & NURSING					5825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	Continued From pa R34 ' s erratic beha	-	F9	999	)			
	has a diagnosis tha disorder. R33 was s radiation treatments A.M. to 10:30 A.M. (nurse), E13 stated treatment that morr The incident dated documents R33 as report dated 6/10/1 as disoriented. The dated 6/28/11 at 12	old, ambulatory female who it includes schizoaffective seen mostly in the bed due to s. On 9/27/11 between 9:50 during initial tour with E13 R33 was receiving radiation ning and was out of facility. 5/27/11 at 10:35 P.M. oriented and the incident 1 at 2:30 P.M. document her se two incidents and incidents 1:30 P.M are all physical in R33 and other residents.						
	The 5/27/11 incider about her roommat she was taking a sh backside. The repo	nt documents R33 complaining e hitting her in the back when nower. Redness noted on her rt documents that staff spoke id both are separated. No						
	another resident we altercation and pulle the other resident s threw a cup at her a intervention is to " medication work-up	6/10/11 documents R33 and ere entangled in a physical ed apart by staff. R33 stated cratched her hand so she and will do it again. The see if R33 could have o on a psychiatric ward " per . There was no documented his intervention.						
	struck in the face by staff. There are no	6/28/11 documents R33 being y R38 and it was witnessed by staff identified and no hat caused the altercation.						

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
				ILDIN	IG			
		145850	B. WI	NG _		10/25/2011		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR I	POINTE REHAB & NU	RSING		-	CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	on the floor. R33 is what happened. Th " watch where she i investigation as to v 9) Throughout the v dining room ambula forth from his room Review of the incide 9:30 A.M. documen diagnoses to includ schizoaffective diso The 9/13/11 at 9:30 R105 reporting to s fighting in the dayro R146 throw water o threw water on him witness the incident or explanation why in the dayroom. The incident dated document R39 was fell straight backwa floor. No injury. It is There is no investig 10) The incident rep document R45 was dayroom. R45 is a s diagnoses that inclu bipolar disorder. R4 wheel-chair but not investigation to deter	7/7/11 at 8 P.M. R33 is found delusional and could not say e intervention was for R33 to s going. " There was no what caused the fall. week, R39 was in the 4th floor ating in and out and Back and the report dated 9/13/11 at the R39 to be 58 years old with e dementia, bipolar disorder, order and seizure disorder. A.M incident documents taff that R39 and R146 were from. R105 stated he saw on R38. R39 stated after R146 , he hit R146. Staff did not t. There was no investigation residents were not supervised 8/1/11 at 10:10 P.M. walking out of his room and rds hitting his head on the unclear if it was witnessed. tation into the incident.	F9	999				

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		145850	B. WI	NG _		10/25/2011		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR POINTE REHAB & NURSING					825 WEST CERMAK ROAD CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	Continued From pa	ıge 139	F9	999				
	Protocol " docume medical causes; the issue. " Under Cau Staff will attempt to within 24 hours of the the fall is unclear, a medical causes suc drug reaction or if the despite attempted i review the situation causes. Under item 3. The situation causes. Under item 3. The situation causes. Under item 3. The situation causes of determined that cau finding the cause of determined that cau finding the cause w or the managemen Treatment/Manage underlying cause ca corrected, staff will interventions based until the falls reduced identified for its com and Follow-up, und continues to fall, the re-evaluate the situ possible reasons for	policy labeled " Falls - Clinical nt that falls often have a ey are not just a " nursing use Identification, item 1. " o define the possible causes he fall. Item 2. If the cause of and it may be significant ch as stroke or an adverse he resident continues to fall interventions, a physician will and help identify contributing staff and physician will and evaluate information until falling is identified or it is use cannot be found or that yould not change the outcome t of the falls. Under ement, under item 2., if the annot be identified or try various relevant d on assessment of the fall es or stop or until a reason is ntinuation. Under Monitoring ler item 4., if the individual e staff and physician will vation and consider other or the resident 's falling and continued relevance of current (B)						

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