STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification. Licensure Survey for Subpart S: SMI Complaint investigations 1191983/IL53508 - no deficiencies 1192320/IL53905 - no deficiencies 1192718/IL54375 - no deficiencies An extended survey was done.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident rights to 1 of 30 sampled residents (R14) by failing to honor the resident ' s right to refuse psychotropic medications. Findings include: Review of R14 ' s Physician Order Sheet and Psychotropic consent form indicated that there was no signed consent for Haloperidol concentrate. Attached to the outside of R14 ' s medical record, was a note, informing nursing staff, that if R14 refuses his medication, it may be put into his food. A physician ' s order form was located in R14 ' s chart indicating that Haloperidol concentrate may	F 155		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 1 be mix in R14 ' s food. R14 ' s medication administration record, show initialed boxes, indicating, Haloperidol had been given to R14 from 9/22/11 thru 9/27/11. Interviews: On 9/28/11 at 1015 AM, R14 ' s PRSC (E7) stated that, to his knowledge R14 has been refusing all psychotropic medications and says he was unaware that medications were being put in R14 ' s food, until it was brought to his attention by the survey team and after seeing the note attached to the cover of the R14 ' s chart on 9/28/11. On 9/29/11 at 1045 AM, R14 stated, he doesn ' t take any psychotropic medications and refuses to do so. On 9/27/11 at 1240 PM, E23 (LPN) a regular nurse on the 8th floor and the facility ' s psychotropic nurse (E24), admitted that R14 ' s meds were being mixed in with his food. On 9/28/11 at 4PM, E25 (LPN) a full time nurse on the evening shiift, verified her initials on the medication administration record and admitted to putting Haloperidol concentrate in R14 ' S coffee.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2	F 157		

significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
A. Based on closed record review and interview, the facility failed to notify the family of one resident (R30) in a sample of 30 residents, regarding transfer to the hospital.

Findings include:

After having a physical altercation with another resident on 7/31/11 at 7:10 AM, R30 was sent to the hospital on 8/1/11. However, nurses notes showed no evidence that R30 ' s family was notified of his transfer.

During 9/29/11 interview of E23 (nurse) at 3:41 PM, E23 is unable to recall if she called R30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 ' s family about his hospital transfer. During 9/27/11 interview at 11:46 AM, Z4 said the facility did not notify her that R30 was gone from the facility. B. Based on record review and interview, the facility failed to notify the physician of refusal of lab draws involving 1 of 3 residents reviewed for lab orders (R9), in a sample of 30. Findings Include: 1) Review of R9 ' s lab reports dated 7-27-11 and 9-22-11, both indicate that the resident refused the labs to be drawn. Review of nursing notes dated July and September of 2011 does not indicate that the physician was notified. Interview with R9 on 9-27-11 at 1:00 PM stated to the surveyor that he does not like needles and that " no one is going to stick me. " On 9-28-11 at 4:30 PM, during the daily status meeting, the facility was informed of the concerns.	F 157		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 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. The findings include:	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 1. The incident report dated 6/8/11 at 10 P.M. document R34, an 85 year old ambulatory female with diagnoses that includes severe bipolar disorder, dementia and schizophrenia. R34's top lip was swollen and R34 was unable to say what happened. There was no investigation in to the injury nor was this incident reported to the State of Illinois as an alleged abuse. 2. The incident report dated 4/25/11 at 10:30 P.M. document R44, a 56 year old ambulatory male with diagnoses that includes schizoaffective disorder and seizures, approached the nurses ' station and he had a small wound in the upper arc of the left eye. R56 was unable to say what happened. There was no investigation into the incident nor was it reported to the State of Illinois as an alleged abuse.. 3. R13 has diagnoses of Bipolar Disorder and history of substance abuse. R13 was initially admitted to the facility on 7/19/11. R13 ' s Criminal History Analysis Security Recommendation Report (CHASRR) dated 8/30/11, indicated that R13 is an identified offender, and was assessed as Moderate Risk for convictions from forgery, criminal trespass vehicle, several drug related offenses, to prostitution. Her security recommendation per this analysis is, R13 requires closer supervision and more frequent observation than standard or routine for most resident in the open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6	F 225		

on a limited time basis. This assessment also indicated, that R13 admitted to currently drinking alcohol and had recently snorted cocaine.

R13 ' s nurses notes dated 9/21/11 at 12 AM, indicated that R13 was staying with R13 's next of kin, Z1, and that Z1 said that R13 will be back in AM. Per nurses notes dated 9/21/11 written at 11:30 (no indication if AM or PM), R13 returned to the facility stating that she got into a physical altercation, and that, a man hit her. R13 ' s right eye is shut, swollen, very dark and red, and was having spasms. R13 ' s left eye is also slightly swollen and red. R13 was sent to the hospital and came back on 9/22/11 at 4 AM.

Review of facility ' s abuse investigations shows no evidence that an abuse investigation was done, nor was the state department made aware of an initial and final result of the investigation.

During 9/28/11 interview at 1:50 PM, E1 (Administrator) said that he is not aware of any allegation of abuse involving a resident and a family or another non-resident from the outside.

Per E8 (case worker) during 9/28/11 interview at 11:27 AM, R13 returned late after a community pass on 9/21/11, and was sent to the hospital because she had a black eye. E8 said that the police initially came to the facility, but R13 was upset and did not talk to them. E8 continued that after the police left, R13 told E8 that she knows the man who hit her. E8 said that she spoke to R13 again on 9/27/11 and that this time, R13 said that she had a physical altercation with this guy she knows, and when the fight was broken off,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7	F 225		

the man unexpectedly hit her with a pole after the fight ended. E8 said that R13 just said it was a friend and did not say what the person ' s name was. E8 said she did not ask R13 further on 9/21/11.

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 in the community,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 8	F 225		

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 herself, to prevent further contact with the man who physically assaulted her with a pole, and caused her injuries. Added to this, per R13 ' s Criminal Assessment Analysis, R13 is moderate risk and needs closer supervision, especially that R13 sustained injuries after being physically assaulted by a person she knew outside, after she was drinking. Interview on 9/30/11 of E8 at 11:45 AM and social service notes dated 9/27/11 indicated that the altercation was the result of R13 ' s drinking. R13 ' s CHASRR on 8/30/11 also indicated that R13 admitted to drinking and using drugs, behaviors that has not been addressed by the facility after R13 admitted as she had been doing (drinking) when the altercation happened. As this was identified in the CHASRR and as this was a part of the altercation involving R13 on 9/21/11, this should have been addressed first prior to allowing R13 to be in the community unsupervised.

Review of R13 ' s POS indicated that on 9/28/11, Z3 made a telephone order, that R13 may go out of the facility with activity staff. 9/28/11 POS also indicated in another sheet, that at 3:30 PM, Z3 made another telephone order to resume community pass. On 9/28/11, R13 was observed leaving the facility at 4:02 PM.

During 9/30/11 interview of E27 (nurse) at 11:38 PM, E27 said that on 9/28/11, she called Z3 after R13 went to the 5th floor, and said that she is allowed to have an outside pass again. E27 said that Z3 asked her what E27 thinks about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 9 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	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10 social service notes showed no indication this was addressed or investigated, or results of initial and final report sent to IDPH. Social service notes dated 3/28/11 at 10 AM also indicated that R23 was involved in a physical altercation with another peer. Review of incident report and abuse files showed no indication that an abuse investigation was also done to determine abuse. The state department was also not notified of any investigation related to this. Review of facility ' s incident report showed no incident or abuse investigation for 11/4/10 altercation mentioned in social service notes. According to this note, this occurred in the smoking room and R23 was hit in the mouth by another resident. 5. Per R30's nurses notes dated 7/31/11, at 7:10 AM, R30 pushed another resident on the floor and hit the other resident with a chair. No incident nor abuse investigation was done to determine abuse, nor was there notification of IDPH. 6. According to the nursing notes 6/22/11 3:20pm R16 was found on the floor in her room against the bedpost, R16's nose was noted as bleeding, and when asked R16 said that she was hit in the nose by a co-peer. The note indicates that R16's physician was notified and ice applied. According to the facility ' s accident and incident reports there were no reports noted on the log, and no report was found after review of all	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 11	F 225		

incident reports for June, 2011. According to the abuse investigations provided by the facility there were no investigations noted with the allegations made by R16 that another resident hit her in the nose.

On 9/28/11 at 4:00pm during the daily status meeting E2 (acting administrator), E3 (director of nursing), both said that she couldn't locate any abuse investigations, and therefore the allegations of abuse made by R16 was not reported to the state agency.

According to the facility ' s policy on external reporting of potential abuse indicates if mistreatment has occurred the state survey agency will be informed immediately.

7. R69 sustained a fracture to the left wrist as evidenced by an Unusual Occurrence Report dated 7/14/11. The Report states R69 self reported a fall which was unwitnessed by staff. There was no evidence that an investigation was done to rule out abuse. R69 received ice pack to the injured hand and a portable X-Ray done on 7/14/11. The X-Ray results showed no evidence of fracture nor dislocation. The Report states that after 2 days R69 continued to experience severe pain and was sent out to the hospital where a repeat X-Ray showed a fracture of the left wrist. E3 (Director of Nursing) told survey team that the incident was not investigated and neither was the injury reported to the State agency.

8. Review of R4's record indicates that on 10-16 -10, R4 slapped a male peer in the face following an argument. On 5-4-11, R4, following an argument, struck a male peer in the face. Review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12	F 225		

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.

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.

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 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.

The facility ' s policy on Abuse Prevention Program instructs employees to report any incident, allegation or suspicion of potential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 result in an abuse investigation. An initial report of 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.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. 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 in grooming and dressing for 4 of 9 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: 1. On 9/27/11 between 9:50 a.m. to 10:35 a.m. with E13 (nurse/MDS coordinator), in the 4th floor	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 14	F 241		

dining room, R38, a male, has long (one inch)finger nails and wearing a winter coat, R31, a male, has long (one inch), curved finger nails and the right thumb nail is brown- discolored and thick. R54, a male was wandering the unit and noted with the same clothes on for 3 days. Room 426 was open and the room was in disarray. Residents clothing and belongings were spewed all over the room. E13 stated the clothes are for residents on the floor and the room should have been locked.

2. On 9/27/11 at 11:47 A.M., E16 (nurse aide) pushed R2 in his wheel-chair out of the dining room to room 406, which is not his room. This room is across from the Men ' s common bathroom. E16 went to the closet of bed 2 and grabbed some pants from it. E16 stated when she starts her shift, she will go to room 426 to gather clothes she will need for her assigned residents and puts them in 406 bed 2 ' s closet. E16 stated it is more convenient to use room 406 which is resident room to R61, R62, R66 and R67. E16 stated the clothes are used, laundered and returned to the room 406 for storage. The clothes are not labeled with residents ' names and given to resident when worn.

3. On 9/27/11 at 11:45 A.M., R40 was in the dining room wandering the room while holding up his pants which were several sizes too big in the waist and legs. R19 ambulating the dining room and halls. R19 ' s pant legs are several sizes to wide and the waist of the pants is cinched with belt due to waist being too big for R19.

4. On 9/28/11 at 9:36 A.M., R44 was wandering the unit, his zipper was busted and there was gap

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 15 in the groin area. 5. On 9/28/11 at 11:54 A.M. in the 4th floor dining room, R36 was served his noon meal on disposable dinner-ware, cups and plastic utensils. E18 (nurse aide), E13 and other nurse aides present were unable to say why he received his meal on disposable dinner-ware. E26 (Dietary Technician) stated it was a mistake. E26 asked surveyor should she send him another noon meal on regular dish-ware. 6. On 9/28/11, all day, in the 4th floor dining room, R37 was seated on an extensively cracked seat cushion in his wheel-chair. R42 is wearing black sweat pants with a quarter-size hole on buttocks area exposing her skin when she bent over. At one point, when she was bent over at the nurses ' station after the noon meal, R54 was attempting to touch R42 ' s buttocks area when E17 (activity aide) re-directed him and had R42 sit down on chair. R42 ' s pants remained on her all day. Other residents with ill-fitting clothes are R7 with sweat pants above her ankles. R40 is wearing tight pants that were above his ankles. R32 was holding up his pants when he walked the unit and the length was several inches too long and dragging when he walked. R39 was wearing the same clothes for 2 days and holding the pants up while walking due to waist too big. R19 was wearing a shirt several sizes too big. R44 was assisted by E17 (activity aide) from the dining room to a chair at the nurses ' station and his back-side of his pants were visibly wet. The hem was folded up due to being too long. R38 was wearing pants several sizes too big. The legs were extremely wide and the length was several	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 16	F 241		

inches long. R31 was noted with long, curved discolored finger nails. He stated he would like them cut. R31 ' s hair was greasy and slick back. R43 ' s speech was gurgling when she spoke to E15 at 12:20 p.m. and again at 3:45 P.M. and was never instructed to clear her throat. R43 also had the same clothes on for 2 days.

7. On 9/29/11 at 11:38 A.M. with E20 (Maintenance Director), R55 was seated in his wheel-chair, very disoriented with garbled speech. R55 ' s pants zipper was unfastened. E20 summoned nurse aide to help fasten his pants.

8. On 9/29/11 at 12:45 P.M. in front of the nurses ' station, the residents were seated in chairs and/or wheel-chairs. R39 was wearing the same pants for two days, R43 was wearing the same outfit for 3 days and is still gurgling when she spoke. R2 was wearing the same football jersey for 2 days. R42 was wearing the same black and white shirt with emblem on front for 2 days. R34 was seated in the dining room eating, talking incoherently and coughing due to talking while eating. No re-direction was given by staff present.

All these residents (exception R55) reside on the 4th floor, which is the dementia floor, a closed, secured unit. Review of the current Minimum Data Set for R42, R41, R37 requires extensive assistance by staff for dressing; R31, R34, R35, R36, R38, R43, R44 require limited assistance by staff for dressing; and R32, R33, R39, R40 require supervision and set-up for dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 17 9. On 3 of 4 days of the survey(9-27-11 thru 9-29-11), observed R9 walking on the unit. Surveyor noted that R9 ' s hair appeared to be unkempt, wearing of the same shirt which showed dried food stains, pants extremely loose and pulled up over the stomach and shoes that are damaged. The bottom portion of the shoes is separated from the upper portion of the shoe, resulting in the flapping appearance as the resident walks. Interview with R9 on 9-29-11 at 10:00 AM stated that the shoes are worn and a little difficult to walk in, but otherwise ok. Interview with E19(Activity Director) on 9-28-11 at 11:00 AM stated that she is aware of the condition of the shoes and that next week, there is a scheduled trip to the thrift store, where at that time, R9 ' s shoes will be replaced.	F 241		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that family were notified prior to a room change involving 1 of 3 residents reviewed for family notification(R4), in a sample of 30. Findings Include: Review of R4 ' s record indicates that on 9-27-11, R4 was moved to another room. Review of the psych social progress notes dated 9-27-11, does not indicate that the family was notified.	F 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 18 Review of the face sheet indicates that R4 has a state appointed guardian. Interview with E11(Psych Rehab Social Coordinator) on 9-28-11 at 10:30 AM stated that he notified the resident prior to the room transfer, but did not notify the guardian.	F 247		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility's social service department failed to address the illlicit drug use for one resident (R16) reviewed for social services in a sample of 30. Findings include: According to the clinical record laboratory results dated 7/11/11 R16 tested positive for benzodiazepine, and cocaine. According to the psychosocial progress notes there were no entries, or documentation related to R16 ' s testing positive for benzodiazepine and cocaine. According to R16 ' s current plan of care there was no care plan identifying R16 ' s behavior of the use of benzodiazepine, and cocaine.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 19 According to the substance abuse and alcohol therapeutic group R16 was not referred or attending the group. On 9/28/11 at 1:30pm E7 (social service), said that he was unaware of R16 ' s testing positive for benzodiazepine, and cocaine, and said that there should have been some behavior modifications put into place. E7 said that R16 ' s was new to his case-load. E7 said that he reviewed R16 ' s clinical record upon taking R16 in his case-load, but didn ' t review the laboratory results indicating that R16 tested positive for benzodiazepine, and cocaine. B. Based on observation, record review, and interview, the facility failed to ensure that 1 of 3 residents reviewed for abuse(R4), was in the appropriated private room(Registered Sex Offender), and failed to provide behavior services for 1 of 3 residents reviewed for behavior services(R8), in a sample of 30. Findings Include: 9-27-11, observed R4 in a room shared with another resident. Review of R4 ' s record indicates that R4 is a Registered Sex Offender. Because of R4 ' s conviction status, R4 should have been in a private room. Interview with E11(Psych Rehab Social Coordinator) on 9-27-11 at 10:00 AM stated that R4 shared the room with a resident who is an Identified Offender, thus, did not think that it was required to be in a private room. The state guidelines indicate that all Registered/Convicted Sex Offenders that resides in nursing homes are to be in a private room,	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 20 close to the nursing station, and to have a private bathroom. Review of R8 ' s record indicates that R8 medical diagnosis includes a history of alcohol abuse. Review of the facility ' s behavior group related to substance abuse, does not list R8 as a member. Interview with E11 further stated that R8 is not involved in a group related to substance abuse, but has not displayed any behaviors of alcohol usage. C. Based on record review and interview facility failed to provide discharge planning to one resident (R11) out of 25 residents reviewed for social services in a sample size of 30 residents. Findings Include: Interview with R11 on 9-29-11 at 12:00 PM, states he informed his social worker before she quit that he wanted to seek senior housing. R11 states that after his social worker quit he told E11 (Psychiatric Rehabilitation Services Coordinator) from the 7th floor that he wanted senior housing. R11 states he (E11) told him that he placed him on the housing list but never did. Interview with E11 on 9-29-11 at 12:10 PM, states R11 inquired about housing for seniors. E11 states he was told by R11 but didn't do it but rather delegated it to E8 (Psychiatric Rehabilitation Services Coordinator). Interview with E9 on 9-29-11 at 12:20 PM, states she does not know R11. E8 doesn't recall being asked to assist R11 with placement for housing. Record review of R11 ' s discharge potential assessment, review and plan dated 4-13-11 denotes discharge is uncertain. Record review of	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 21 R11 ' s comprehensive care plan; anticipating discharge dated 4-16-11 denotes the resident favor discharge even though the resident requires extensive physical and/or mental heath service. Goal: resident will meet with social worker, nurse and significant other(s) to identify post-discharge needs by 7-16-11. Interview with E9 (Psychiatric Rehabilitation Services Coordinator) on 9-29-11 at 11:45 AM states she did not have the opportunity and time to accurately review R11s ' chart and other charts. E9 states this issue and others were brought to attention yesterday and now are being addressed and care plans are being updated.	F 250		
F 251 SS=F	483.15(g)(2)&(3) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain full time social services for its 441 bed facility. Findings include:	F 251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 22 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 251		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE 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.	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the environment was safe, clean, and homelike involving 7 supplemental residents(R70-R76), in a sample of 30. Findings Include: On 9-27-11 at 9:45 AM during the 7th floor initial tour, accompanied by E22(Licensed Practical Nurse), the following were observed: 1. Room 701 involving R70-R73, the air conditioner unit front cover not secured to the unit resulting in the inside mechanical parts exposed and the window curtain not secured to the curtain rod. 2. Room 702 involving R74-R76, the air conditioner unit front cover loose resulting in the inside mechanical parts exposed. The inside mechanical parts are saturated with large amount of dust. 3. Mens Bathroom/Shower Room is with strong pervasive urine/musty odors, mold like substance on shower stall floor # 1, and mold like substance on the ceiling of shower stall # 2. On 9-28-11 at 4:30 PM, during the daily status meeting, the facility was notified of the findings. Interview with E2(Director Of Operations) on 9-30-11 at 9:30 AM stated that some, but not all environmental concerns were addressed, and that it will take some time to correct all of the surveyor ' s concerns.	F 252		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 24 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to put in place care plans based on resident assessment instrument (RAI) for 5 residents out of 16 residents reviewed for care plans (R3, R8, R9,13, 16) in the sample of 30. Findings include : 1) R3 has diagnoses of Manic depressive Disorder and has history of Suicidal Ideation. R3 ' s last suicidal ideation that resulted to her hospitalization was 6/20/11 per hospital record. R3 ' s nurses notes dated 5/18/11 indicated that at 3:45 PM, R3 was upset about her purse being	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 25 searched and verbalized that she is going to slash her wrist. R3 was also paranoid about staff trying to poison and kill her. Review of R3 ' s care plan showed no evidence of any care plan for suicidal ideation. Her care plan was finally updated on 9/28/11 by E8 (case worker). Per E8 during 9/28/11 interview at 11:08 AM, her care plan was updated on 9/28/11 as there was no previous care plan about suicidal ideation previously. 2) R13 has diagnosis of Bipolar Disorder. Per R3 ' s Criminal History Analysis security Recommendation Report, R3 is an identified offender for forgery, criminal trespass, drug related offenses, and prostitution. Review of R3 ' s care plan showed no care plan for her diagnosis of severe mental illness, nor of her drug use and being an identified offended. Per E8 (case worker) during 9/28/11 interview at 11:27 AM, R3 ' s care plan was updated only on 9/27/11. R3 has been in the facility since 7/19/11. 3. According to the clinical record laboratory results dated 7/11/11 R16 tested positive for benzodiazepine, and cocaine. According to the psychosocial progress notes there were no entries, or documentation related	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 26 to R16 ' s testing positive for benzodiazepine and cocaine. According to R16 ' s current plan of care there was no care plan identifying R16 ' s behavior of the use of benzodiazepine, and cocaine. According to the substance abuse and alcohol therapeutic group R16 was not referred or attending the group. On 9/28/11 at 1:30pm E7 (social service), said that he was unaware of R16 ' s testing positive for benzodiazepine, and cocaine, and said that there should have been some behavior modifications put into place. E7 said that R16 ' s was new to his case-load. E7 said that he reviewed R16 ' s clinical record upon taking R16 in his case-load, but didn ' t review the laboratory results indicating that R16 tested positive for benzodiazepine, and cocaine. 4) Review of R8 ' s record indicates a history of alcohol abuse. Review of R8 ' s care plan does not address the history of alcohol abuse. Interview with E11(Psych Rehab Social Coordinator) on 9-28-11 at 10:00 AM stated that R8 has not displayed any behaviors associated with alcohol abuse. 5) Review of R9 ' s lab reports dated 7-27-11 and 9-22-11, both indicate that the resident refused the lab to be drawn. Review of R8 ' s care plans does not address the behavior. Interview with R9 on 9-27-11 at 1:00 PM stated that he does not like needles and that " no one is going to stick	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 27 me. " On 9-28-11 at 4:30 PM, during the daily status meeting, the facility was informed of the concerns	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to update a fall care plan and fall risk assessment for 3 of 13 sampled residents (R11, R15, R16) reviewed for falls in a sample of 30. Findings include: 1. According to the nurses notes 7/6/11 8:00pm	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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. According to the facility ' s incident and accident reports there were no incident report completed noting R16 ' s fall incident on 7/6/11. 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. 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. 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	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 29 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	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 30 no substance abuse care plan in R15 ' s medical record, although R15 has a history of substance abuse and has returned to the facility intoxicated on numerous occasions. 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. A newly created substance abuse care plan was provided to the survey team on 9/29/11 during the daily status meeting. R15 ' s former PRSC is no longer employed with the facility and was unavailable for interview. Per the facility ' s fall policy, a resident ' s fall risk is to be assessed upon admission, quarterly and after a fall. The resident ' s care plan is to be developed and revised based on assessed needs.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their incident report policy and complete an incident report form for 1 of 30 residents R16, and R69 of the supplemental sample. Findings include:	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 31	F 281		

1. According to the nursing notes 6/22/11 3:20pm R16 was found on the floor in her room against the bedpost, R16 ' s nose was noted as bleeding, and when asked R16 said that she was it in the nose by a co-peer. The note indicates that R16 ' s physician was notified and ice applied.

According to the facility ' s accident and incident reports there were no reports noted on the log,, and no report was found after review of all incident reports for June, 2011. According to the abuse investigations files provided by the facility there were no investigations noted with the allegations made by R16 that another resident hit her in the nose.

On 9/28/11 at 4:00pm during the daily status meeting E2 (acting administrator), E3 (director of nursing), both said that she couldn't locate the incident report and/or abuse investigations.

According to the nurses notes 7/6/11 8:00pm 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.

According to the facility ' s incident and accident reports there were no incident report completed noting R16 ' s fall incident on 7/6/11.

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.

According to the facility ' s incident / accident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 32 report protocol, indicates to document all incidents and accidents, and that the completed incident form should forwarded to the director of nursing. 2. R69 sustained a fracture to the left wrist as evidenced by an Unusual Occurrence Report dated 7/14/11. The Report states R69 self reported a fall which was unwitnessed by staff. There was no evidence that an investigation was done to rule out abuse. R69 received ice pack to the injured hand and a portable X-Ray done on 7/14/11. The X-Ray results showed no evidence of fracture nor dislocation. The Report states that after 2 days R69 continued to experience severe pain and was sent out to the hospital where a repeat X-Ray showed a fracture of the left wrist. E3 (Director of Nursing) told survey team that the incident was not investigated and neither was the injury reported to the State agency.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that lab tests were followed up and done for 2(13, R13) residents out of 5	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33 residents reviewed for lab tests in the sample of 30. Findings include : 1) R13 has diagnoses of Breast cancer, History of Substance Abuse and Asthma. Per R13 ' s Physician Order Sheet (POS) dated 8/22/11, a stool specimen for C. Difficile x 2 was ordered. Only one result was in the record dated 8/25/11. R13 ' s POS also indicated that Hepatitis B RNA was ordered on 9/23/11, yet as of 9/29/11, no Hepatitis RNA was done. R13 ' s Hepatitis B core antibodies was tested positive. 2) R12 has diagnoses of Hypertension, BPH, and Gastric Ulcer. R12 ' s POS indicated that a stool for occult blood, Urinalysis for micro-albumin, and EKG were ordered every 6 months. There were no results of these tests in R12 ' s record. Per E2 (Director of Operations) during 9/29/11 during daily status meeting at 10 AM, R12 ' s EKG will be done on 9/29/11.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide physician ordered wound treatment for 3 days for 1 of 30 residents R26, identified with pressure ulcers. Findings include: According to the clinical record nurse notes dated 9/2/11 3:25pm R26 was admitted to the facility. According to the admitting physician orders sheet dated 9/2/11 indicates wound treatment orders to include; right lateral leg cleanse with normal saline, apply Hydrogel, dry dressing every other day and as needed until healed, right lateral foot cleanse with normal saline apply dry dressing every three days and as needed, right gluteal cleanse with normal saline apply non-adhesive foam, dry dressing daily and as needed until healed, coccyx cleanse with normal saline, apply non-adhesive dressing foam, dry dressing daily as needed until healed. According to the wound treatment notes R26 wounds wasn't assessed and measured until 9/5/11. The note included the first description of R26 ' s wound; the note indicates that the physician orders were carried out. According to the treatment administration record, 9/5/2011 was the first treatment administered to R26. The orders on the treatment administration record orders include: right lateral leg cleanse	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35 with normal saline, apply Hydrogel, dry dressing every other day and as needed until healed, right lateral foot cleanse with normal saline apply dry dressing every three days and as needed, right gluteal cleanse with normal saline apply non-adhesive foam, dry dressing daily and as needed until healed, coccyx cleanse with normal saline, apply non-adhesive dressing foam, dry dressing daily as needed until healed. The same orders that given at admission on 9/2/11. The treatment administration record was blank for 9/2/11, 9/3/11, and 9/4/11. On 9/30/11 at 10:45am E21 (treatment nurse), was unable to verbalize why R26 didn ' t receive any wound treatment for 3 days, however E21 said that she wasn't employed by the facility at the time of the missed treatments. E21 said that the former treatment nurse was no longer employed by the facility. E21 said that when wound nurse is not available it up to the primary nurse make the assessment of residents wounds and administer treatments.	F 314		
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 36	F 323		

review, the facility failed to provide supervision for cognitively impaired individuals assessed as high risk for falls and failed to provide effective interventions to prevent the numerous falls, some falls resulting in fractures for R2 and sutures for R19 and R44, failed to provide supervision for cognitively impaired residents who have been in physical altercation with other cognitively impaired residents and resulted in injuries and failed to investigate and assess individuals for the root cause for falls in 6 of 13 residents (R2, R13, R15,R18, R19, R23) reviewed for falls in the sample of 30 residents and 8 residents (R34, R44, R38, R36, R33, R32, R39, R45) in the supplemental sample.

The findings include:

1) R2 is a wheel-chair bound, 67 year old male who has a diagnoses of alcohol abuse related dementia, hypertension and Cerebral Vascular Accident per the current 6/20/11 Minimum Data Set (MDS). R2 is disoriented by all 3 spheres (person, place and time) per the 5/9/11 and 9/14/11 care plan for memory and decision-making.

On 9/27/11 at 10 A.M. in the 4th floor dining room, R2 was seated in wheel-chair. E16 (nurse aide) was standing along side him, re-applying his semi-cast and wrap to his right hand/wrist. E16 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 37	F 323		

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 10:55 A.M., R2 is back in the dining room. The semi-splint is off and on the floor. E17 (activity aide) and E15, the P.R.S.C. (Psychiatric Rehabilitation Service Counselor) were circulating the 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.

Review of the incident reports for R2 document a fall on 6/8/11 at 6:15 A.M. in the 4th floor dining room, where R2 is found on the floor with an over-bed table broken next to him. It is not witnessed nor is it investigated. R2 was unable to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 38	F 323		

say what happened.

Review of the nurses ' notes dated 6/8/11 document R2 found on dining room floor. R2 is confused however he interacts with staff. If R2 becomes more confused, he will be sent out to hospital.

The next fall is 6/11/11 at 12:15 P.M. when R2 is on the floor in the hall. The report documents that staff saw him walking down the hall prior to fall. The report does not indicate which staff person saw him walking and whether or not be should have been walking independently due to his unsteady gait. The report does not document if there were any injuries. It documents 911 was called.

Review of the nurses ' notes dated 6/11/11 document R2 was walking down hall to lunch and went to floor. R2 found on his right side with his right arm and hand under him. R2 complained of pain to head and arm. R2 complained of dizziness while standing and while on the floor. R2 ' s right side of face was red. 911 was called. R2 was admitted to the hospital with a diagnosis of Syncope. When he returned from the hospital, he had another diagnosis of encephalopathy.

The next documented fall is dated 6/14/11 at 6:30 p.m. where R2 was found on his floor. The report documents he was removed from floor and placed in wheel-chair. The report documents no injury but there is no investigation into the fall to determine how and why it happened. Nor is there any follow-up to ensure there is no injury.

The next documented fall is dated 6/21/11 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 39	F 323		

11:40 A.M. where R2 is found on the dining room floor. R2 can not say what happened. R2, who is disoriented to all 3 spheres and confused, was reminded to stay in his chair. The interventions are to continue to monitor resident and to evaluate resident for laptop cushion. There was no investigation into the fall. The laptop cushion was not effective due to R2 removing it so the facility implemented the chair alarm but the time frames are unclear as to when the laptop was discontinued and the chair alarm implemented.

The report dated 8/31/11 at 2:40 p.m. document R2 stated another resident hit him and there was a new cut on the right cheek. R2 received first aid to cut. There was no investigation nor was the other resident identified.

The report dated 9/14/11 at 10:30 P.M. documents R2 on floor next to bed. When R2 was asked what happened, he stated he rolled onto the floor because it feels better. R2 ' s right arm cast is with in normal limits with some edema. It documented the cast is not related to this fall and R2 has soft cast to arm. None of the incident reports document fracture resulting from a fall.

Review of nurses ' note dated 8/10/11 at 6 A.M. document R2 on the floor sitting Indian-style. R2 claimed to not fall. There is no incident report seen or any investigation into it. The nurses ' note dated 8/11/11 documents R2 ' s right wrist swollen and R2 complaining of pain. X-rays were ordered. There was no investigation into this incident.

Review of the portable x-ray done on 8/11/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 40 documents no fracture. Review of the nurses ' notes dated 9/4/11 documents R2 to be very lethargic and weak. R2 was pale in color and had swelling in the right eye orbital area and sent out to hospital. Nurses ' note dated 9/4/11 at 8 P.M. documents R2 was admitted under altered mental status. R2 returns back to the facility on 9/6/11 and an x-ray was done on 9/6/11 at the hospital. The hospital x-ray documents there is a fracture through the neck of the 5th metacarpal of the indeterminate age with close opposition of fracture fragments. There was no investigation into the fracture to determine when and how he fractured his 5th metacarpal. On 9/29/11 at 11:15 A.M., in R2 ' s room, there is 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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 41 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. to 10:35 A.M. during the initial tour of 4th floor with E13, E13 stated R19 wears the cervical collar due to his numerous falls. Review of the incident reports for R19 document falls on 7/26/11, 8/14/11, 8/19/11 which were not witnessed and 2 of the incidents resulted in injuries. The incident report dated 8/14/11 at 2:50 P.M. documents R19 sitting on floor of another resident ' s room. R19 sustained a 2 inch cuts to forehead, above the right eye, the lip, left eye lid, left and right knees. R19 was sent out to hospital. There was no investigation. The incident dated 8/19/11 at 2:45 P.M. document R19 face down underneath a dresser in another resident ' s room. R19 sustained a cut to the shoulder and the left elbow. No investigation. The incident of 7/26/11 at 10:40 A.M. documents R19 sitting on the floor in the hallway next to a chair. No injuries were documented and no investigation done.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 42	F 323		

The incidents dated 7/18/11 at 4:20 A.M. document R19 fell from bed and " hit his upper left orbital area " sustaining a small 1 inch wound. R19 required 4 sutures to the forehead. The reports documents E32, a nurse aide, witnessed the incident but there is no statement from her nor was there an investigation. An incident dated 5/29/11 at 1:15 P.M. documents a housekeeper and a nurse aide see R19 ambulating in the dining room, stood still, lost balance and fell. R19 landed on his left side. R19 ' s left elbow is swollen. An order is obtained for an x-ray to entire left arm. The staff were not identified by name nor are there any statements. There were no x-ray results provided or seen. This incident was not investigated.

There is an incident for R19 dated 8/4/11 at 2 P.M. documents while making rounds R19 and another resident were swinging at each other in the hallway. R19 sustained a skin tear to the right wrist area. No injuries to other resident. The other resident was identified by room number but no name. Both separated and monitored. No investigation as to why it happened and why R19 and other resident were not in a structured activity.

3) R38 is a 57 year old, wheel-chair bound male who is confused and disoriented. R38 ' s diagnoses include schizoaffective disorder, dementia and convulsions per incident reports (6/11/11 and 7/5/11). On 9/27/11 between 9:50 A.M. to 10:30 A.M. during the initial tour with E13, R38 was seated in a wheel-chair in the 4th floor dining room. R38 was wearing a winter coat over street clothes and had long (1 inch) finger nails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 43	F 323		

Throughout the week, R38 was seen propelling himself throughout the unit, in and out of rooms and dining rooms.

On 9/29/11 at 11:35 A.M. during the environmental tour with E20 (director of environmental tour), R38 was in the female common bathroom, which is located on the opposite side of the unit. R38 was in his wheel-chair in a toilet stall, facing toilet. When spoken to, R38 did not respond. E13, nurse, was summoned. In the meantime, R38 stood up from the wheel-chair using the grab bars in the toilet stall, failing to lock his wheel-chair, the chair rolled backwards. R38 removed his pants and incontinent brief and dropped them to the floor. It was then E13 entered the room and asked R38 what he was doing in the female bathroom. No response from R38.

Review of the current quarterly (7/11/11) MDS documents R38 requires one person limited assistance for toilet use. R38 is continent of bowel and bladder.

Review of the incident report dated 5/24/11 at 2:10 P.M. document R38 lost his balance and fell in the 4th floor dining room, landing on his left side of his body and hitting his head on the floor. R38 could not say what happened. A nurse aide witnessed it but there is no name or statement from the person. An x-ray was done on left hand and it was negative. There was no investigation to determine the cause for R38 to loose his balance and fall.

Review of the incident dated 6/11/11 at 6 P.M. documents R38 is orient times two. R38 fell in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 44	F 323		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 45	F 323		

document R38 was struck in the right side of the forehead by another peer because R38 had ran over the peer ' s feet with his wheel-chair. The peer is identified by room number but there is no other identifier for this resident. The aggressor ' s identity is unclear. The incident was witnessed by a nurse aide. This aide is not identified nor is there a statement from the aide. Both residents were re-directed.

On 9/30/11 at 9:55 A.M. during the daily meeting with administration staff, E2 and E3 stated they are unable to identify the residents involved in the physical altercations or any staff member who witnessed the falls. E2 stated to be employed for one month and E3 stated she thought the former Director of Nursing was doing the investigations.

4) On 9/27/11 between the 9:50 A.M. to 10:30 A.M during the initial tour with E13 (MDS Coordinator/nurse), R44 was ambulating the unit and asking for money from E13. R44 was very confused. R44 ' s diagnoses include paranoid schizoaffective disorder, dementia and seizure disorder per the incident report (7/12/11).

On 9/29/11 at 11:23 A.M during the environmental tour with E20 (Director of Maintenance), R44 was standing inside his room at the doorway. In the hall outside of his room, on the floor, was a yellow-pooled liquid that looked like urine. E20 stated R44 has a habit of urinating on the floor and in the air conditioner units. The air conditioner unit in the room next to R44 ' s room, which is not occupied, smelled of urine. R44 had a fixed glare on his face and would not answer any questions. E20 summoned the housekeeper to mop up the spill.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 46	F 323		

Review of the current quarterly 8/11/11 MDS documents R44 requires one person limited assistance in toilet use and occasionally incontinent of bowel and bladder.

Review of R44 ' s incident reports dated 6/5/11 at 5:30 A.M., 7/12/11 at 12:30 A.M. and 7/18/11 at 2:30 P.M. documents all falls with the incident of 7/18/11 resulting in sutures to the left eye brow. The 6/5/11 incident was not witnessed and R44 was found sitting on the floor next to bed with a small amount of blood on the right cheek. R44 was unable to say what happened. There was no investigation to determine what caused the fall. The witnessed fall of 7/18/11 documents R44 as disoriented and he got up from his wheel-chair without locking the brakes and the wheel-chair rolled backwards. R44 lost his balance and fell forward hitting his head causing a cut above the left eye brow. It required 3 sutures. The intervention is to keep him out of any wheel-chair because he is ambulatory. R44 was unable to say what happened. There was an order for R44 to see a neurologist. The neurologist ' s report dated 8/12/11 documents R44 is a 56 year old male with history of Epilepsy. The chief complaint listed " Initial neurological exam. The patient has seizures disorder and dementia. " The report does not document any test done. Recommends levels (Valproic acid and Dilantin) and RTL (routine labs) in 2 months. There was no investigation and the witness is not identified.

The incident dated 7/12/11 documents the fall was witnessed by E34, a nurse aide. R44 had stumbled over his feet. The report does not document the factors such as condition of floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 47 and R44 ' s foot wear. There is no statement from the unidentified nurse who assisted R44 off the floor. 5) R36 is a 60 year old, wheel-chair bound male. R36 was confused and not oriented to all 3 spheres. Staff would push R36 in and out of the dining room. At times, R36 would use his feet to propel the wheel-chair. R36 ' s diagnoses include dementia and schizoaffective disorder per the 4/14/11 incident report. Review of R36 ' s annual 9/19/11 MDS documents R36 requires one person assistance with walking and uses a wheel-chair on the unit. The MDS documents he has impairment with his lower extremities and requires a wheel-chair for mobility. Review of R36 ' s incident reports dated 4/9/11 at 10:30 A.M., 4/29/11 at 2:40 p.m., 5/26/11 at 2:45 A.M. and 6/20/11 at 8:25 A.M. document witnessed falls. The incident dated 4/9/11 documents during a group meeting on the second floor, R36 stood up, was unsteady and fell hitting his right side of the face. R36 stated he remembers falling but denied headache or visual disturbances. The intervention is for activity staff to check with nurses prior to removing R36 from the floor. R36 has an unsteady gait and requires a wheel-chair when leaving floor. There was no investigation or statements to determine why R6 was not asked to remain seated when he got up from chair with unsteady gait. The 4/29/11 incident documents R36 is sitting in a dining room chair, stood up, walked with unsteady gait across the room and fell. When	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 48	F 323		

R36 was asked if he was okay, he responded " no. " following the " no " response, the report documents R36 always responds " no " . E35, the nurse is the one who witnessed the fall and documents R36 ' s gait to be unsteady. The intervention was to counsel him on safety.

The incident of 5/26/11 documents E37, nurse aide saw R36 come out of his room, stumble down the hallway and fall. E37 informed the nurse, who is not identified, and she finds R36 on his backside on the hallway floor. No injuries. R36 stated he was going home, stumbled forward and used his hands to brace his fall. No investigation to determine why he is so unsteady.

The incident dated 6/20/11 documents R36 was carry his own breakfast tray, tripped over his own feet, falling to the floor and injuring both knees. The intervention were to check vitals and notify Physical therapy department. R36 stated he fell to the floor. There is no investigation as to why he continues to fall and why there are no interventions in place.

The incident dated 4/14/11 at 7:25 A.M, 8/28/11 at 11:45 A.M. and 9/16/11 at 6:15 A.M. are un-witnessed incidents, The 4/14/11 incident documents R36 face down on the floor in his room. R36 was unable to say what happened. The intervention is one on one monitoring. There was no investigation into the fall.

The incident 8/28/11 documents a nurse aide, not identified, finds R36 on the floor of his room. R36 stated he was walking and lost balance. The nurse aide stated during her rounds she found him on floor and informed the nurse. The nurse is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 49	F 323		

not identified. The intervention is for R36 to use the hall rails if necessary and to ask for assistance if needed. There was no investigation to determine what caused him to fall.

The incident dated 9/16/11 documents a noise was heard and R36 found on floor in his room. No injuries. R36 responded he was trying to go home. The nurse aide, not identified, found R36 on the floor. The intervention is to place R36 in a wheel-chair but because he continued to get up from the chair he was placed at the nurses ' station. No investigation as to why he continues to fall.

6) On 9/28/11 at 11:58 A.M. in the 4th floor dining room, R32 was holding up his pants while he walked because the pants were too big in the waist and the length of the pants were several inches too long. R32 ' s diagnoses include dementia secondary to the traumatic brain injury, subdural hematoma, bipolar disorder, seizure disorder and status post shunt and craniotomy per the 6/1/11 incident report.

Review of the annual 9/13/11 MDS documents him to be independent for walking but requires supervision and set-up for dressing.

The incident dated 6/1/11 at 2:30 P.M. documents R32 on his buttocks on the dining room floor. It was not witnessed. R32 was unable to say what happened. There was no investigation as why he fell.

The incident dated 8/27/1 at 9:50 A.M. documents R32 is pushed by a female peer and R32 turns around and hit her in the face. Both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 50	F 323		

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 and push him against the elevator doors. R32 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.

7) Throughout the week, R34 would ambulate in and out of her 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 wear 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.

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.

The incident reports dated 4/29/11 at 2:30 A.M. documents a loud noise was heard by nurse and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 51	F 323		

nurse aide, both not identified by name, who find R34 on the floor on her backside. R34 complained about soreness on her right shoulder but refused the Tylenol. X-ray was negative for a fracture and dislocation. R34 stated she had a dream that there were snakes in the bed so she ran to the window. There were no interventions put in place.

The incident dated 6/14/11 at 8:45 A.M. documents R34 is found on the floor of her room and has a cut on her forehead. Other resident re-directed and residents kept separate. There is no investigation into how the injury occurred and it does not identify the other resident. R34 sent out to hospital for evaluation and treatment but no follow-up to this information.

The incident dated 7/22/11 at 2 A.M. documents a nurse aide, not identified by name, found R34 on the floor. The nurse aide helped R34 off the floor and onto the bed. R34 was unable to say what happened. There is no account from the nurse aide as to what she witnessed nor is there an investigation into why R34 fell. R34, who is cognitively impaired, was instructed to ask for assistance.

The incident dated 6/23/11 at 10:40 P.M. document R34 was punched in the right side of her head by another resident. The report documents a witness but no one is identified nor is there any statement. There was no investigation.

The incident dated 8/23/11 at 4:10 P.M. documents R34 being very upset and stated she was struck in the face by another female resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 52	F 323		

in the female Common Bathroom. No injuries seen. The other resident was not identified and there was no investigation into the incident. R34 was relocated to the dining room at this time.

The incidents dated 4/15/11 at 11 A.M and 6/24/11 at 4:30 P.M. document R34 physically assaulting (2.5 inch scratch on neck) the a hospice nurse for no reason except she walked by her when R34 was escalating at the nurses ' station. No investigation into what caused R34 to escalate. The incident dated 6/24/11 documents R34 scratched E38 (staff) when R34 was re-directed by E38. R34 was aggressive and uncooperative. R34 was sent out to hospital for psychiatric evaluation. No follow up to the incident nor was there an investigation into the cause of R34 ' s erratic behavior.

8) R33 is a 64 year old, ambulatory female who has a diagnosis that includes schizoaffective disorder. R33 was seen mostly in the bed due to radiation treatments. On 9/27/11 between 9:50 A.M. to 10:30 A.M. during initial tour with E13 (nurse), E13 stated R33 was receiving radiation treatment that morning and was out of facility.

The incident dated 5/27/11 at 10:35 P.M. documents R33 as oriented and the incident report dated 6/10/11 at 2:30 P.M. document her as disoriented. These two incidents and incidents dated 6/28/11 at 12:30 P.M are all physical altercations between R33 and other residents. The 5/27/11 incident documents R33 complaining about her roommate hitting her in the back when she was taking a shower. Redness noted on her backside. The report documents that staff spoke to the aggressor and both are separated. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 53	F 323		

investigation documented.

The incident dated 6/10/11 documents R33 and another resident were entangled in a physical altercation and pulled apart by staff. R33 stated the other resident scratched her hand so she threw a cup at her and will do it again. The intervention is to " see if R33 could have medication work-up on a psychiatric ward " per Z3, the psychiatrist. There was no documented follow through on this intervention.

The incident dated 6/28/11 documents R33 being struck in the face by R38 and it was witnessed by staff. There are no staff identified and no investigation into what caused the altercation.

The incident dated 7/7/11 at 8 P.M. R33 is found on the floor. R33 is delusional and could not say what happened. The intervention was for R33 to " watch where she is going. " There was no investigation as to what caused the fall.

9) Throughout the week, R39 was in the 4th floor dining room ambulating in and out and Back and forth from his room.

Review of the incident report dated 9/13/11 at 9:30 A.M. documents R39 to be 58 years old with diagnoses to include dementia, bipolar disorder, schizoaffective disorder and seizure disorder. The 9/13/11 at 9:30 A.M incident documents 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 54 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. 10) 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. 11) The facility ' s policy labeled " Falls - Clinical Protocol " document that falls often have a medical causes; they are not just a " nursing issue. " Under Cause Identification, item 1. " Staff will attempt to define the possible causes within 24 hours of the fall. Item 2. If the cause of the fall is unclear, and it may be significant medical causes such as stroke or an adverse drug reaction or if the resident continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. Under item 3. The staff and physician will continue to collect and evaluate information until either the cause of falling is identified or it is determined that cause cannot be found or that finding the cause would not change the outcome or the management of the falls. Under Treatment/Management, under item 2., if the underlying cause cannot be identified or	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 55	F 323		

corrected, staff will try various relevant interventions based on assessment of the fall until the falls reduces or stop or until a reason is identified for its continuation. Under Monitoring and Follow-up, under item 4., if the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident ' s falling and will re-evaluate the continued relevance of current interventions.

12) R13 has diagnoses of Bipolar Disorder and history of substance abuse. R13 was initially admitted to the facility on 7/19/11.

R13 ' s Criminal History Analysis Security Recommendation Report (CHASRR) dated 8/30/11, indicated that R13 is an identified offender, and was assessed as Moderate Risk for convictions from forgery, criminal trespass vehicle, several drug related offenses, to prostitution. Her security recommendation per this analysis is, R13 requires closer supervision and more frequent observation than standard or routine for most resident in the open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a limited time basis. This assessment also indicated, that R13 admitted to currently drinking alcohol and had recently snorted cocaine.

R13 ' s nurses notes dated 9/21/11 at 12 AM, indicated that R13 was staying with R13 ' s next

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 56	F 323		

of kin, Z1, and that Z1 said that R13 will be back in AM. Per nurses notes dated 9/21/11 written at 11:30 (no indication if AM or PM), R13 returned to the facility stating that she got into a physical altercation, and that, a man hit her. R13 ' s right eye is shut, swollen, very dark and red, and was having spasms. R13 ' s left eye is also slightly swollen and red. R13 was sent to the hospital and came back on 9/22/11 at 4 AM.

Review of facility ' s abuse investigations shows no evidence that an abuse investigation was done, nor was the state department made aware of an initial and final result of the investigation.

During 9/28/11 interview at 1:50 PM, E1 (Administrator) said that he is not aware of any allegation of abuse involving a resident and a family or another non-resident from the outside.

Per E8 (case worker) during 9/28/11 interview at 11:27 AM, R13 returned late after a community pass on 9/21/11, and was sent to the hospital because she had a black eye. E8 said that the police initially came to the facility, but R13 was upset and did not talk to them. E8 continued that after the police left, R13 told E8 that she knows the man who hit her. E8 said that she spoke to R13 again on 9/27/11 and that this time, R13 said that she had a physical altercation with this guy she knows, and when the fight was broken off, the man unexpectedly hit her with a pole after the fight ended. E8 said that R13 just said it was a friend and did not say what the person ' s name was. E8 said she did not ask R13 further on 9/21/11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 57 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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 58 herself, to prevent further contact with the man who physically assaulted her with a pole, and caused her injuries. Added to this, per R13 ' s Criminal Assessment Analysis, R13 is moderate risk and needs closer supervision, especially that R13 sustained injuries after being physically assaulted by a person she knew outside, after she was drinking. Interview on 9/30/11 of E8 at 11:45 AM and social service notes dated 9/27/11 indicated that the altercation was the result of R13 ' s drinking. R13 ' s CHASRR on 8/30/11 also indicated that R13 admitted to drinking and using drugs, behaviors that has not been addressed by the facility after R13 admitted as she had been doing (drinking) when the altercation happened. As this was identified in the CHASRR and as this was a part of the altercation involving R13 on 9/21/11, this should have been addressed first prior to allowing R13 to be in the community unsupervised. Review of R13 ' s POS indicated that on 9/28/11, Z3 made a telephone order, that R13 may go out of the facility with activity staff. 9/28/11 POS also indicated in another sheet, that at 3:30 PM, Z3 made another telephone order to resume community pass. On 9/28/11, R13 was observed leaving the facility at 4:02 PM. During 9/30/11 interview of E27 (nurse) at 11:38 PM, E27 said that on 9/28/11, she called Z3 after R13 went to the 5th floor, and said that she is allowed to have an outside pass again. E27 said that Z3 asked her what E27 thinks about R13 ' s pass restriction. E27 said that she told Z3 to give R13 another chance, and that Z3 ordered	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 59	F 323		

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 in 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 these information, E8 said no. E8 said R13 ' s safety is her first concern.

13) R23 has diagnosis of seizure and polyneuropathy.

Per record, R23 has the following falls incident:

· 7/11/11 at 6:30 AM, R23 was observed sitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 60 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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 61 following these falls. 15) 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 was unavailable for interview. Per the facility ' s fall policy, a resident ' s fall risk is to be assessed upon admission, quarterly and after a fall.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 62	F 325		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview facility failed to develop interventions to prevent weight gain and evaluate the effectiveness of interventions in one resident (R11) from 14 residents reviewed for weights/nutrition out of a sample size of 30 residents.

Findings Include:

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 denotes significant weight gain increase 13.86 pounds in three months. Appetite has been good, general diet no dentures.
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 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.
Record review of R11 ' s therapeutic diet care plan dated 9-27-11, problem: resident with weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 63 gain increase 13.8 pounds, probable snacking/eating between meals. Approach: registered dietician consult and educate resident per prescribed diet orders. Record review of nutritional notes dated 9-28-11 denotes R11 very receptive with diet counseling. Resident weight today, 185 pounds weight above ideal body weight, monitor weight and oral intake. 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.	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to sanitize dishes, and work area as indicated in the facility ' s policy. The facility also failed to dry dishes prior to storing them on the shelf, and failed to date open food items. The facility also failed to provide clean scoop for the large container of open cereal, and failed to provide light shields for 3 florescent lighting units, and failed to ensure there were no flying insects in the kitchen.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 64 Findings include: On 9/27/11 at 10:15am along with E5 (dietary manager), the sanitizing sink of the 3 compartment sink was measured with the test strip to be above 100 parts per million. There was a white sanitizing bucket the contents was measured with the test strip to be between 10 and 50 parts per million, and there was another red sanitizing bucket that contents were measured with the test strip to above 200 parts per million. On 9/27/11 at 10:30am E5 said that the facility policy requires the sanitizing solution to be between 50 and 100 part per million. During the observation on 9/27/11 along with E5 there were 2 florescent lights in the ceiling in the dish washing machine room survey team observed with no shield or cover, and another florescent light over the 3 compartment sink without a shield or cover. On 9/27/11 at 10:25am E5 said she would make the maintenance supervisor aware of the missing light covers. During the observation of the kitchen along with E5 there were stainless steel pan tops/covers observed to be stored wet. On 9/27/11 at 10:30am E5 said that staff is required to dry dishes prior to storing them away. During the initial kitchen observation there was	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 65 one large, container 20 gallon of dry oatmeal, there was a Styrofoam bowl, inside of the large container. During this observation there was no scoop available to scoop the dry cereal out of the container. On 9/27/11 at 10:30am E5 said that the staff should not use the Styrofoam bowls to scoop cereal. During the initial tour, along with E5 there was an open box of dry tea bags observed open sitting on a shelf in dry storage, with no date when the box was opened, there was also 2 bowls of dry cereal covered in plastic wrap with no date when they were prepared. On 9/27/11 at 10:30am E5 said that when food items are opened staff is required to date the package when it is opened, and the bowls of prepared cereal staff are required to date when it was prepared by staff.	F 371		
F 407 SS=F	483.45(b) REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation to that there was a full time Psychiatric Rehabilitation Service Director (PRSD) in the facility since the departure of the previous PRSD on 9/14/11.	F 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 407	Continued From page 66 Findings include: 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 PRSD position has been vacant since 9/20/11 and E6 (Consultant Social Worker) has been working in an acting position until a full time PRSD is hired. E1 was not able to provide documentation for the number of hours of PRSD coverage provided by E6, nor details of how E6 ' s time is being utilized. During a telephone interview with E6 on 9/29/11 at approximately 1:25pm, E6 stated that the PRSD 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 stated she has not provided any direct psychiatric services for facility residents and family. The facility ' s job description for the PRSD includes the monitoring of the development of each resident ' s individualized treatment plan (ITP) and assure that residents ' needs are being met. The PRSD is also responsible to provide behavioral intervention and counseling to 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 for meeting all social service and	F 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 407	Continued From page 67 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 407		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 68 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow current standard of infection control practices during the provision of care for 1 of 4 residents (R18) reviewed for infection control in a sample of 30 residents. Findings include: On 9/27/11 at 9:30 am, R18 was observed in bed, awake, alert with intelligible speech. R18 was receiving oxygen via a tracheotomy. R18 ' s Respiratory Assessment dated 7/27/11 shows a diagnosis of Respiratory Arrest requiring the use of a tracheotomy tube. The Physician ' s Order Sheet (POS) dated 9/1/11 shows a diagnosis of Dysphasia which necessitates the use of a gastric tube. On 9/27/11 at 1:10pm, E31 (Nurse) approached R18 ' s room with surveyor for the purpose of observation of R18 ' s pressure areas and gastrostomy site. E31 stated that R18 has MRSA and another infectious organism, the name of which she could not remember. E31 put on a pair of gloves and entered R18 ' s room. E31 observed surveyor donning gown and gloves and E31 exited R18 ' s room and herself put on a gown. E31 repositioned R18 onto his side and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 69 found R18 to be incontinent of urine. E31 removed the soiled diaper and put a clean diaper in place. E31 then removed the soiled glove, put on a clean pair of glove, proceeded to lean over R18 and removing the dressing covering the gastrostomy tube. E31 failed to wash her hands between glove changes from perineal care to gastrostomy site care. R18 was coughing during the procedure, producing a moderate amount of respiratory secretion. E31 failed to wear protective mask. The facility ' s Infection Control Policy dated August 2008 states that standard precautions and transmission based precautions will utilized to prevent spread of infection, including hand washing and use of personal protective equipment.	F 441		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that administration has been managed in areas of a) social services for residents with SMI, b) psychiatric rehabilitation program, c) abuse prevention program, d) supervision of residents with falls, and e) administrative personnel entrusted to run these programs. These resulted	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 70 from the lack of a social worker, PRSD, and administration of the fall prevention and abuse prevention programs. Findings include : 1) Abuse : Based on record review and interview, the facility failed to ensure that allegations of and actual abuse were investigated, reported to IDPH, and involved residents were protected from further potential abuse for 3 residents out of 7 residents reviewed for allegation of abuse (R13,) in the sample of 30. As a result of lack of investigation, the perpetrator or abuser of R13 is not identified, investigated, reported to the police, and R13 was allowed outside pass and potential contact with her perpetrator. The facility also did not send to IDPH initial and final report of this abuse incident. During the physical abuse on 9/21/11, R13 sustained multiple eye injuries during the physical abuse. Findings include : a) R13 has diagnoses of Bipolar Disorder and history of substance abuse. R13 was initially admitted to the facility on 7/19/11. R13 ' s Criminal History Analysis Security Recommendation Report (CHASRR) dated 8/30/11, indicated that R13 is an identified offender, and was assessed as Moderate Risk for convictions from forgery, criminal trespass vehicle, several drug related offenses, to prostitution. Her security recommendation per this	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 71	F 490		

analysis is, R13 requires closer supervision and more frequent observation than standard or routine for most resident in the open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a limited time basis. This assessment also indicated, that R13 admitted to currently drinking alcohol and had recently snorted cocaine.

R13 ' s nurses notes dated 9/21/11 at 12 AM, indicated that R13 was staying with R13 ' s next of kin, Z1, and that Z1 said that R13 will be back in a.m. Per nurses notes dated 9/21/11 written at 11:30 (no indication if AM or PM), R13 returned to the facility stating that she got into a physical altercation, and that, a man hit her. R13 ' s right eye is shut, swollen, very dark and red, and was having spasms. R13 ' s left eye is also slightly swollen and red. R13 was sent to the hospital and came back on 9/22/11 at 4 a.m.

Review of facility ' s abuse investigations shows no evidence that an abuse investigation was done, nor was the state department made aware of an initial and final result of the investigation.

During 9/28/11 interview at 1:50 p.m., E1 (Administrator) said that he is not aware of any allegation of abuse involving a resident and a family or another non-resident from the outside.

Per E8 (case worker) during 9/28/11 interview at 11:27 a.m, R13 returned late after a community pass on 9/21/11, and was sent to the hospital because she had a black eye. E8 said that the police initially came to the facility, but R13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 72	F 490		

was upset and did not talk to them. E8 continued that after the police left, R13 told E8 that she knows the man who hit her. E8 said that she spoke to R13 again on 9/27/11 and that this time, R13 said that she had a physical altercation with this guy she knows, and when the fight was broken off, the man unexpectedly hit her with a pole after the fight ended. E8 said that R13 just said it was a friend and did not say what the person ' s name was. E8 said she did not ask R13 further on 9/21/11.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 73 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 herself, to prevent further contact with the man who physically assaulted her with a pole, and caused her injuries. Added to this, per R13 ' s Criminal Assessment Analysis, R13 is moderate risk and needs closer supervision, especially that R13 sustained injuries after being physically assaulted by a person she knew outside, after she was drinking. Interview on 9/30/11 of E8 at 11:45 AM and social service notes dated 9/27/11 indicated that the altercation was the result of R13 ' s drinking. R13 ' s CHASRR on 8/30/11 also indicated that R13 admitted to drinking and using drugs, behaviors that has not been addressed by the facility after R13 admitted as she had been doing (drinking) when the altercation happened. As this was identified in the CHASRR and as this was a part of the altercation involving R13 on 9/21/11, this should have been addressed first prior to allowing R13 to be in the community unsupervised. Review of R13 ' s POS indicated that on 9/28/11, Z3 made a telephone order, that R13 may go out of the facility with activity staff. 9/28/11 POS also indicated in another sheet, that at 3:30 PM, Z3 made another telephone order to resume community pass. On 9/28/11, R13 was observed leaving the facility at 4:02 PM.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 74 During 9/30/11 interview of E27 (nurse) at 11:38 p.m., E27 said that on 9/28/11, she called Z3 after R13 went to the 5th floor, and said that she is allowed to have an outside pass again. E27 said that Z3 asked her what E27 thinks about 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 in 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 these information, E8 said no. E8 said R13 ' s safety is her first	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 75 concern. Per facility ' s abuse policy and procedure, any incident or allegation involving abuse or mistreatment will result in an abuse investigation. Additionally, this policy also indicated that accused individuals not employed by the facility will be denied unsupervised access to the residents during the course of investigation. b) 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 social service notes showed no indication this was addressed or investigated, or results of initial and final report sent to IDPH. Social service notes dated 3/28/11 at 10 AM also indicated that R23 was involved in a physical altercation with another peer. Review of incident report and abuse files showed no indication that an abuse investigation was also done to determine abuse. The state department was also not notified of any investigation related to this. Review of facility ' s incident report showed no incident or abuse investigation for 11/4/10 altercation mentioned in social service notes. According to this note, this occurred in the smoking room and R23 was hit in the mouth by another resident. c) Per R30 ' s nurses notes dated 7/31/11, at 7:10 AM, R30 pushed another resident on the floor and hit the other resident with a chair. No incident nor abuse investigation was done to determine abuse, nor was there notification of	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 76 IDPH. 2)Falls and Supervision: The facility failed to provide supervision for cognitively impaired individuals assessed as high risk for falls and failed to provide effective interventions to prevent the numerous falls, some falls resulting in fractures for R2 and sutures for R19 and R44, failed to provide supervision for cognitively impaired residents who have been in physical altercation with other cognitively impaired residents and resulted in injuries and failed to investigate and assess individuals for the root cause for falls in 5 of 13 residents (R2, R15,R18, R19, R23) reviewed for falls in the sample of 30 residents and 8 residents (R34, R44, R38, R36, R33, R32, R39, R45) in the supplemental sample. Findings include: a) R23 has diagnosis of seizure and polyneuropathy. Per record, R23 has the following falls incident: · 7/11/11 at 6:30 a.m., R23 was observed sitting 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. Review of R23 ' s POS shows that Physical Therapy was ordered on both 9/6/11 and 9/22/11.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 77 Review of R23 ' s record however showed no indication that an evaluation was done. Per E29 (nurse) on 9/29/11 at 11:46 a.m., he will check with PT if R23 had been seen already. R23 ' s PT evaluation and treatment was only done on 9/29/11. c) R23 has diagnosis of seizure and polyneuropathy. Per record, R23 has the following falls incident: · 7/11/11 at 6:30 AM, R23 was observed sitting 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. d) R2 is a wheel-chair bound, 67 year old male who has a diagnoses of alcohol abuse related dementia, hypertension and Cerebral Vascular Accident per the current 6/20/11 Minimum Data Set (MDS). R2 is disoriented by all 3 spheres (person, place and time) per the 5/9/11 and 9/14/11 care plan for memory and decision-making. On 9/27/11 at 10 A.M. in the 4th floor dining room, R2 was seated in wheel-chair. E16 (nurse aide) was standing along side him, re-applying his semi-cast and wrap to his right hand/wrist. E16	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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. 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. The semi-splint is off and on the floor. E17 (activity aide) and E15, the P.R.S.C. (Psychiatric Rehabilitation Service Counselor) were circulating the 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.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 79 Review of the incident reports for R2 document a fall on 6/8/11 at 6:15 A.M. in the 4th floor dining room, where R2 is found on the floor with an over-bed table broken next to him. It is not witnessed nor is it investigated. R2 was unable to say what happened. Review of the nurses ' notes dated 6/8/11 document R2 found on dining room floor. R2 is confused however he interacts with staff. If R2 becomes more confused, he will be sent out to hospital. The next fall is 6/11/11 at 12:15 P.M. when R2 is on the floor in the hall. The report documents that staff saw him walking down the hall prior to fall. The report does not indicate which staff person saw him walking and whether or not be should have been walking independently due to his unsteady gait. The report does not document if there were any injuries. It documents 911 was called. Review of the nurses ' notes dated 6/11/11 document R2 was walking down hall to lunch and went to floor. R2 found on his right side with his right arm and hand under him. R2 complained of pain to head and arm. R2 complained of dizziness while standing and while on the floor. R2 ' s right side of face was red. 911 was called. R2 was admitted to the hospital with a diagnosis of Syncope. When he returned from the hospital, he had another diagnosis of encephalopathy. The next documented fall is dated 6/14/11 at 6:30 p.m. where R2 was found on his floor. The report documents he was removed from floor and	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 80	F 490		

placed in wheel-chair. The report documents no injury but there is no investigation into the fall to determine how and why it happened. Nor is there any follow-up to ensure there is no injury.

The next documented fall is dated 6/21/11 at 11:40 A.M. where R2 is found on the dining room floor. R2 can not say what happened. R2, who is disoriented to all 3 spheres and confused, was reminded to stay in his chair. The interventions are to continue to monitor resident and to evaluate resident for laptop cushion. There was no investigation into the fall. The laptop cushion was not effective due to R2 removing it so the facility implemented the chair alarm but the time frames are unclear as to when the laptop was discontinued and the chair alarm implemented.

The report dated 8/31/11 at 2:40 p.m. document R2 stated another resident hit him and there was a new cut on the right cheek. R2 received first aid to cut. There was no investigation nor was the other resident identified.

The report dated 9/14/11 at 10:30 P.M. documents R2 on floor next to bed. When R2 was asked what happened, he stated he rolled onto the floor because it feels better. R2 ' s right arm cast is with in normal limits with some edema. It documented the cast is not related to this fall and R2 has soft cast to arm. None of the incident reports document fracture resulting from a fall.

Review of nurses ' note dated 8/10/11 at 6 A.M. document R2 on the floor sitting Indian-style. R2 claimed to not fall. There is no incident report seen or any investigation into it. The nurses '

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 81 note dated 8/11/11 documents R2 ' s right wrist swollen and R2 complaining of pain. X-rays were ordered. There was no investigation into this incident. Review of the portable x-ray done on 8/11/11 documents no fracture. Review of the nurses ' notes dated 9/4/11 documents R2 to be very lethargic and weak. R2 was pale in color and had swelling in the right eye orbital area and sent out to hospital. Nurses ' note dated 9/4/11 at 8 P.M. documents R2 was admitted under altered mental status. R2 returns back to the facility on 9/6/11 and an x-ray was done on 9/6/11 at the hospital. The hospital x-ray documents there is a fracture through the neck of the 5th metacarpal of the indeterminate age with close opposition of fracture fragments. There was no investigation into the fracture to determine when and how he fractured his 5th metacarpal. On 9/29/11 at 11:15 A.M., in R2 ' s room, there is 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.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 82 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. e) 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. to 10:35 A.M. during the initial tour of 4th floor with E13, E13 stated R19 wears the cervical collar due to his numerous falls. Review of the incident reports for R19 document falls on 7/26/11, 8/14/11, 8/19/11 which were not witnessed and 2 of the incidents resulted in injuries. The incident report dated 8/14/11 at 2:50 P.M. documents R19 sitting on floor of another resident ' s room. R19 sustained a 2 inch cuts to forehead, above the right eye, the lip, left eye lid, left and right knees. R19 was sent out to hospital. There was no investigation. The incident dated 8/19/11 at 2:45 P.M. document R19 face down underneath a dresser in another resident ' s	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 83	F 490		

room. R19 sustained a cut to the shoulder and the left elbow. No investigation. The incident of 7/26/11 at 10:40 A.M. documents R19 sitting on the floor in the hallway next to a chair. No injuries were documented and no investigation done.

The incidents dated 7/18/11 at 4:20 A.M. document R19 fell from bed and " hit his upper left orbital area " sustaining a small 1 inch wound. R19 required 4 sutures to the forehead. The reports documents E32, a nurse aide, witnessed the incident but there is no statement from her nor was there an investigation. An incident dated 5/29/11 at 1:15 P.M. documents a housekeeper and a nurse aide see R19 ambulating in the dining room, stood still, lost balance and fell. R19 landed on his left side. R19 ' s left elbow is swollen. An order is obtained for an x-ray to entire left arm. The staff were not identified by name nor are there any statements. There were no x-ray results provided or seen. This incident was not investigated.

There is an incident for R19 dated 8/4/11 at 2 P.M. documents while making rounds R19 and another resident were swinging at each other in the hallway. R19 sustained a skin tear to the right wrist area. No injuries to other resident. The other resident was identified by room number but no name. Both separated and monitored. No investigation as to why it happened and why R19 and other resident were not in a structured activity.

f) R38 is a 57 year old, wheel-chair bound male who is confused and disoriented. R38 ' s diagnoses include schizoaffective disorder,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 84	F 490		

dementia and convulsions per incident reports (6/11/11 and 7/5/11). On 9/27/11 between 9:50 A.M. to 10:30 A.M. during the initial tour with E13, R38 was seated in a wheel-chair in the 4th floor dining room. R38 was wearing a winter coat over street clothes and had long (1 inch) finger nails. Throughout the week, R38 was seen propelling himself throughout the unit, in and out of rooms and dining rooms.

On 9/29/11 at 11:35 A.M. during the environmental tour with E20 (director of environmental tour), R38 was in the female common bathroom, which is located on the opposite side of the unit. R38 was in his wheel-chair in a toilet stall, facing toilet. When spoken to, R38 did not respond. E13, nurse, was summoned. In the meantime, R38 stood up from the wheel-chair using the grab bars in the toilet stall, failing to lock his wheel-chair, the chair rolled backwards. R38 removed his pants and incontinent brief and dropped them to the floor. It was then E13 entered the room and asked R38 what he was doing in the female bathroom. No response from R38.

Review of the current quarterly (7/11/11) MDS documents R38 requires one person limited assistance for toilet use. R38 is continent of bowel and bladder.

Review of the incident report dated 5/24/11 at 2:10 P.M. document R38 lost his balance and fell in the 4th floor dining room, landing on his left side of his body and hitting his head on the floor. R38 could not say what happened. A nurse aide witnessed it but there is no name or statement from the person. An x-ray was done on left hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 85	F 490		

and it was negative. There was no investigation to determine the cause for R38 to loose his balance and fall.

Review of the incident dated 6/11/11 at 6 P.M. documents R38 is orient times two. R38 fell in the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 86	F 490		

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. document R38 was struck in the right side of the forehead by another peer because R38 had ran over the peer ' s feet with his wheel-chair. The peer is identified by room number but there is no other identifier for this resident. The aggressor ' s identity is unclear. The incident was witnessed by a nurse aide. This aide is not identified nor is there a statement from the aide. Both residents were re-directed.

On 9/30/11 at 9:55 A.M. during the daily meeting with administration staff, E2 and E3 stated they are unable to identify the residents involved in the physical altercations or any staff member who witnessed the falls. E2 stated to be employed for one month and E3 stated she thought the former Director of Nursing was doing the investigations.

g) On 9/27/11 between the 9:50 A.M. to 10:30 A.M during the initial tour with E13 (MDS Coordinator/nurse), R44 was ambulating the unit and asking for money from E13. R44 was very confused. R44 ' s diagnoses include paranoid schizoaffective disorder, dementia and seizure disorder per the incident report (7/12/11).

On 9/29/11 at 11:23 A.M during the environmental tour with E20 (Director of Maintenance), R44 was standing inside his room at the doorway. In the hall outside of his room, on the floor, was a yellow-pooled liquid that looked like urine. E20 stated R44 has a habit of urinating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 87	F 490		

on the floor and in the air conditioner units. The air conditioner unit in the room next to R44 ' s room, which is not occupied, smelled of urine. R44 had a fixed glare on his face and would not answer any questions. E20 summoned the housekeeper to mop up the spill.

Review of the current quarterly 8/11/11 MDS documents R44 requires one person limited assistance in toilet use and occasionally incontinent of bowel and bladder.

Review of R44 ' s incident reports dated 6/5/11 at 5:30 A.M., 7/12/11 at 12:30 A.M. and 7/18/11 at 2:30 P.M. documents all falls with the incident of 7/18/11 resulting in sutures to the left eye brow. The 6/5/11 incident was not witnessed and R44 was found sitting on the floor next to bed with a small amount of blood on the right cheek. R44 was unable to say what happened. There was no investigation to determine what caused the fall. The witnessed fall of 7/18/11 documents R44 as disoriented and he got up from his wheel-chair without locking the brakes and the wheel-chair rolled backwards. R44 lost his balance and fell forward hitting his head causing a cut above the left eye brow. It required 3 sutures. The intervention is to keep him out of any wheel-chair because he is ambulatory. R44 was unable to say what happened. There was an order for R44 to see a neurologist. The neurologist ' s report dated 8/12/11 documents R44 is a 56 year old male with history of Epilepsy. The chief complaint listed " Initial neurological exam. The patient has seizures disorder and dementia. " The report does not document any test done. Recommends levels (Valproic acid and Dilantin) and RTL (routine labs) in 2 months. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 88 investigation and the witness is not identified. The incident dated 7/12/11 documents the fall was witnessed by E34, a nurse aide. R44 had stumbled over his feet. The report does not document the factors such as condition of floor and R44 ' s foot wear. There is no statement from the unidentified nurse who assisted R44 off the floor. h) R36 is a 60 year old, wheel-chair bound male. R36 was confused and not oriented to all 3 spheres. Staff would push R36 in and out of the dining room. At times, R36 would use his feet to propel the wheel-chair. R36 ' s diagnoses include dementia and schizoaffective disorder per the 4/14/11 incident report. Review of R36 ' s annual 9/19/11 MDS documents R36 requires one person assistance with walking and uses a wheel-chair on the unit. The MDS documents he has impairment with his lower extremities and requires a wheel-chair for mobility. Review of R36 ' s incident reports dated 4/9/11 at 10:30 A.M., 4/29/11 at 2:40 p.m., 5/26/11 at 2:45 A.M. and 6/20/11 at 8:25 A.M. document witnessed falls. The incident dated 4/9/11 documents during a group meeting on the second floor, R36 stood up, was unsteady and fell hitting his right side of the face. R36 stated he remembers falling but denied headache or visual disturbances. The intervention is for activity staff to check with nurses prior to removing R36 from the floor. R36 has an unsteady gait and requires a wheel-chair when leaving floor. There was no investigation or statements to determine why R6	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 89 was not asked to remain seated when he got up from chair with unsteady gait. The 4/29/11 incident documents R36 is sitting in a dining room chair, stood up, walked with unsteady gait across the room and fell. When R36 was asked if he was okay, he responded " no. " following the " no " response, the report documents R36 always responds " no " . E35, the nurse is the one who witnessed the fall and documents R36 ' s gait to be unsteady. The intervention was to counsel him on safety. The incident of 5/26/11 documents E37, nurse aide saw R36 come out of his room, stumble down the hallway and fall. E37 informed the nurse, who is not identified, and she finds R36 on his backside on the hallway floor. No injuries. R36 stated he was going home, stumbled forward and used his hands to brace his fall. No investigation to determine why he is so unsteady. The incident dated 6/20/11 documents R36 was carry his own breakfast tray, tripped over his own feet, falling to the floor and injuring both knees. The intervention were to check vitals and notify Physical therapy department. R36 stated he fell to the floor. There is no investigation as to why he continues to fall and why there are no interventions in place. The incident dated 4/14/11 at 7:25 A.M, 8/28/11 at 11:45 A.M. and 9/16/11 at 6:15 A.M. are un-witnessed incidents, The 4/14/11 incident documents R36 face down on the floor in his room. R36 was unable to say what happened. The intervention is one on one monitoring. There was no investigation into the fall.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 90 The incident 8/28/11 documents a nurse aide, not identified, finds R36 on the floor of his room. R36 stated he was walking and lost balance. The nurse aide stated during her rounds she found him on floor and informed the nurse. The nurse is not identified. The intervention is for R36 to use the hall rails if necessary and to ask for assistance if needed. There was no investigation to determine what caused him to fall. The incident dated 9/16/11 documents a noise was heard and R36 found on floor in his room. No injuries. R36 responded he was trying to go home. The nurse aide, not identified, found R36 on the floor. The intervention is to place R36 in a wheel-chair but because he continued to get up from the chair he was placed at the nurses ' station. No investigation as to why he continues to fall. i) On 9/28/11 at 11:58 A.M. in the 4th floor dining room, R32 was holding up his pants while he walked because the pants were too big in the waist and the length of the pants were several inches too long. R32 ' s diagnoses include dementia secondary to the traumatic brain injury, subdural hematoma, bipolar disorder, seizure disorder and status post shunt and craniotomy per the 6/1/11 incident report. Review of the annual 9/13/11 MDS documents him to be independent for walking but requires supervision and set-up for dressing. The incident dated 6/1/11 at 2:30 P.M. documents R32 on his buttocks on the dining room floor. It was not witnessed. R32 was unable	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 91 to say what happened. There was no investigation as why he fell. The incident dated 8/27/1 at 9:50 A.M. documents R32 is pushed by a female peer and R32 turns around and hit her in the face. Both 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 and push him against the elevator doors. R32 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. j) Throughout the week, R34 would ambulate in and out of her 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 wear 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. 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	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 92	F 490		

floor buffer that extends the width of the hallway. R34 is following us and needs to step over the cord.

The incident reports dated 4/29/11 at 2:30 A.M. documents a loud noise was heard by nurse and nurse aide, both not identified by name, who find R34 on the floor on her backside. R34 complained about soreness on her right shoulder but refused the Tylenol. X-ray was negative for a fracture and dislocation. R34 stated she had a dream that there were snakes in the bed so she ran to the window. There were no interventions put in place.

The incident dated 6/14/11 at 8:45 A.M. documents R34 is found on the floor of her room and has a cut on her forehead. Other resident re-directed and residents kept separate. There is no investigation into how the injury occurred and it does not identify the other resident. R34 sent out to hospital for evaluation and treatment but no follow-up to this information.

The incident dated 7/22/11 at 2 A.M. documents a nurse aide, not identified by name, found R34 on the floor. The nurse aide helped R34 off the floor and onto the bed. R34 was unable to say what happened. There is no account from the nurse aide as to what she witnessed nor is there an investigation into why R34 fell. R34, who is cognitively impaired, was instructed to ask for assistance.

The incident dated 6/23/11 at 10:40 P.M. document R34 was punched in the right side of her head by another resident. The report documents a witness but no one is identified nor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 93 is there any statement. There was no investigation. The incident dated 8/23/11 at 4:10 P.M. documents R34 being very upset and stated she was struck in the face by another female resident in the female Common Bathroom. No injuries seen. The other resident was not identified and there was no investigation into the incident. R34 was relocated to the dining room at this time. The incidents dated 4/15/11 at 11 A.M and 6/24/11 at 4:30 P.M. document R34 physically assaulting (2.5 inch scratch on neck) the a hospice nurse for no reason except she walked by her when R34 was escalating at the nurses ' station. No investigation into what caused R34 to escalate. The incident dated 6/24/11 documents R34 scratched E38 (staff) when R34 was re-directed by E38. R34 was aggressive and uncooperative. R34 was sent out to hospital for psychiatric evaluation. No follow up to the incident nor was there an investigation into the cause of R34 ' s erratic behavior. k) R33 is a 64 year old, ambulatory female who has a diagnosis that includes schizoaffective disorder. R33 was seen mostly in the bed due to radiation treatments. On 9/27/11 between 9:50 A.M. to 10:30 A.M. during initial tour with E13 (nurse), E13 stated R33 was receiving radiation treatment that morning and was out of facility. The incident dated 5/27/11 at 10:35 P.M. documents R33 as oriented and the incident report dated 6/10/11 at 2:30 P.M. document her as disoriented. These two incidents and incidents dated 6/28/11 at 12:30 P.M are all physical	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 94	F 490		

altercations between R33 and other residents. The 5/27/11 incident documents R33 complaining about her roommate hitting her in the back when she was taking a shower. Redness noted on her backside. The report documents that staff spoke to the aggressor and both are separated. No investigation documented.

The incident dated 6/10/11 documents R33 and another resident were entangled in a physical altercation and pulled apart by staff. R33 stated the other resident scratched her hand so she threw a cup at her and will do it again. The intervention is to " see if R33 could have medication work-up on a psychiatric ward " per Z3, the psychiatrist. There was no documented follow through on this intervention.

The incident dated 6/28/11 documents R33 being struck in the face by R38 and it was witnessed by staff. There are no staff identified and no investigation into what caused the altercation.

The incident dated 7/7/11 at 8 P.M. R33 is found on the floor. R33 is delusional and could not say what happened. The intervention was for R33 to " watch where she is going. " There was no investigation as to what caused the fall.

l) Throughout the week, R39 was in the 4th floor dining room ambulating in and out and Back and forth from his room.

Review of the incident report dated 9/13/11 at 9:30 A.M. documents R39 to be 58 years old with diagnoses to include dementia, bipolar disorder, schizoaffective disorder and seizure disorder. The 9/13/11 at 9:30 A.M incident documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 95 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	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 96 was unavailable for interview. o) 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 following these falls. 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.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 97 The facility failed to follow it's "Falls-Clinical Protocol policy which states that falls often have a medical causes; they are not just a " nursing issue. " Under Cause Identification, item 1. " Staff will attempt to define the possible causes within 24 hours of the fall. Item 2. If the cause of the fall is unclear, and it may be significant medical causes such as stroke or an adverse drug reaction or if the resident continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. Under item 3. The staff and physician will continue to collect and evaluate information until either the cause of falling is identified or it is determined that cause cannot be found or that finding the cause would not change the outcome or the management of the falls. Under Treatment/Management, under item 2., if the underlying cause cannot be identified or corrected, staff will try various relevant interventions based on assessment of the fall until the falls reduces or stop or until a reason is identified for its continuation. Under Monitoring and Follow-up, under item 4., if the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident ' s falling and will re-evaluate the continued relevance of current interventions. Per the facility ' s fall policy also states residents ' fall risk is to be assessed upon admission, quarterly and after a fall. There was insufficient evidence to show this being done in a consistent manner. 3) Psychiatric Rehab Program :	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 98 Based on observation, interview, and record review, the facility 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. The facility 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 SMI psychiatric rehabilitative services (R15, R16, R17, R21, R24) in a sample of 30 and 48 residents (R85, R99 through R145) in the supplemental sample. Findings include : b) R3 has diagnosis of Manic Depressive Disorder and Suicidal Ideation and was readmitted to the facility on 6/29/11. R3 ' s nurses notes dated 5/18/11 indicated that at 3:45 PM, R3 was upset about her purse being searched and threatened to slash her wrist. R3 was also paranoid about staff, accusing staff of trying to poison and kill her. R3 ' s 2/19/11 nurses notes indicated that R3 refused her medications and thinks that her medications are poisoned. Furthermore, this nurses notes indicated that R3 continuously refuses medications. During initial tour on 9/27/11 at 10 AM, R3 was observed in bed, paranoid, delusional and talking about residents being stabbed by staff. Review of	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 99 facility ' s incident reports indicated no such incidents. Review of facility ' s in house and outside program shows no indication that R3 is attending any program to address her psychiatric issues and suicidal ideations. During 9/28/11 interview at 11:08 AM, E8 (case worker) said that R3 is often delusional, hallucinating, and is verbally aggressive. E8 also said that on 5/18/11 R3 went to the hospital for suicidal ideation per her social service notes. E8 continued that R3 is not attending any psych rehab program and that E8 has not talked to R3 about her suicidal ideation yet. E8 also said that she tried to ask R3 to attend programs but R3 refused. R3 also does not take any of her medications including her psych medications. c) R12 has diagnosis of Schizoaffective Disorder. Review of outside program TCOTP ' s attendance sheet indicated that R12 has not been attending his outside program starting with 8/27/11. Review of the Transportation Tracking sheet also showed no indication that R12 was going to TCOTP using the transportation arranged for by the facility. During 9/28/11 interview at 11:20 AM, E8 (case worker) said that TCOTP is for R12 ' s socialization skills and independence, but that R12 ' s attendance is not great with TCOTP. Review of facility ' s program with psychologists also showed no attendance from R12, although 6/2/11 Annual Summary indicated that he sees a	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 100 psychologist. During 9/29/11 interview with E8 at 11:38 am, E8 was not aware that R12 has not been attending TCOTP since 8/27/11. d) R30 has diagnosis of Schizophrenia and was admitted to the facility on 7/12/11. R30 ' s nurses notes dated 7/19/11 indicated that R30 was caught smoking in the bathroom at 11 AM. Review of R30 ' s social service notes showed no indication that this behavior was addressed on 7/19/11, even though R30 ' s record shows that he attended a smoking program on 7/18/11 per E2 (Director of Operations). This inappropriate smoking is a new occurrence. On 9/27/11 at approximately 1:30pm, E1 (Administrator) stated that there are 5 psychiatric rehabilitation programs offered: Substance Abuse, Taking care of the People (TCOTP), Association Behavior Rehabilitation Services (ABRS) and 2 psychotherapy groups. There are 163 residents identified by the facility as having serious mental illness. Review of the facility ' s Serious Mental Illness (SMI) roster dated 9/14/11 shows R15, R16, R17, R21, R24, R85, R99 through R145 are not assigned to any psychiatric rehabilitation programs. 23 residents on the roster no longer reside in the facility. The TCOTP Day Program Tracking Form includes 1 discharged resident and 7 residents who are not on the SMI roster. The TCOTP In-House Group includes 3 discharged residents and 20 residents who are	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 101 not on the SMI roster. The ABRS roster includes 1 discharged resident and 5 residents not on the SMI roster. The Alcohol and Drug Treatment Group includes 6 residents not on the SMI roster. Of the 59 residents identified as receiving psychotherapy, 32 are not listed on the SMI roster and 3 no longer reside in the facility. There was no Psychiatric Rehabilitative Services Director (PRSD) available for interview during the survey. 2) Social Service and Social Worker: Based on interview and record review, the facility failed to maintain full time social services for its 441 bed facility. Findings include: 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	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 102 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. 3) PRSD Based on interview and record review, the facility failed to provide documentation to that there was a full time Psychiatric Rehabilitation Service Director (PRSD) in the facility since the departure of the previous PRSD on 9/14/11. Findings include: 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 PRSD position has been vacant since 9/20/11 and E6 (Consultant Social Worker) has been working in an acting position until a full time PRSD is hired. E1 was not able to provide documentation for the number of hours of PRSD coverage provided by E6, nor details of how E6 ' s time is being utilized.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 103 During a telephone interview with E6 on 9/29/11 at approximately 1:25pm, E6 stated that the PRSD 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 stated she has not provided any direct psychiatric services for facility residents and family. The facility ' s job description for the PRSD includes the monitoring of the development of each resident ' s individualized treatment plan (ITP) and assure that residents ' needs are being met. The PRSD is also responsible to provide behavioral intervention and counseling to 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 for meeting all social service and 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 490		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.6251) Section 300.625l) Identified Offenders l) If the identified offender is a convicted (see 730	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 104 ILCS 150/2) or registered (see 730 ILCS 150/3) sex offender or if the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-201.6(d) of the Act) This requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that 1 of 3 residents reviewed for abuse(R4), was in the appropriate private room(Registered Sex Offender). Findings Include: 9-27-11, observed R4 in a room shared with another resident. Review of R4 ' s record indicates that R4 is a Registered Sex Offender. Because of R4 ' s conviction status, R4 should have been in a private room. Interview with E11(Psych Rehab Social Coordinator) on 9-27-11 at 10:00 AM stated that R4 shared the room with a resident who is an Identified Offender, thus, did not think that it was required to be in a private room. (B) 300.615b) Section 300.615b) Determination of Need Screening and Request for Criminal History	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 105 Record Information b) All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. (Section 2-201.5(a) of the Act) A screening assessment is not required provided one of the conditions in Section 140.642(c) of the rules of the Department of Healthcare and Family Services titled Medical Payment (89 Ill. Adm. Code 140.642(c)) is met. This requirement is not met as evidenced by: Based on record review and interview, the facility failed to initiate background check within 24 hours of admission for 8 residents (R77, R78, R79, R80, R82, R83, R84, R97, R98) in the supplemental sample. The facility also failed to initiate background check within 24 hours for 2 of 5 identified offenders (R13, R18) in a sample of 30 and 8 residents (R38, R59, R85, R86, R87, R88, R89, R90) in the supplemental sample. Findings include: 1)E36 (Admissions Director) stated on 9/30/11 at 9am that she initiates the background check for all new admissions prior to admission to determine if the resident is an indentified offender and fingerprinting is done for all residents age 18 to 64 years. E36 stated that fingerprinting is done by a contracted agency and request for finger printing . Review of the background check findings for residents admitted since last annual survey revealed the following:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 106 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.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 107 On 9/30/11 at 1:30pm, Z5 was observed in E36 ' s office fingerprinting R78, R80 and R83. Z5 told surveyor that the facility contacted him on Wednesday (9/28/11) to do fingerprinting for these residents. Z5 stated that he always responds to fingerprinting requests within 1-2 days. E36 was present during this interview. 2).Review of the facility ' s Identified Offender Reporting Form revealed the following: R13 was admitted to the facility on 7/19/11. The background check was initiated 7/28/11; R18 was admitted on 6/13/11. The background check was initiated on 6/30/11; R38 was admitted on 1/21/11. The background check was initiated on 2/17/11; R59 was admitted on 1/13/11. The background check was initiated on 2/11/11; R85 was admitted on 3/31/11. The background check was initiated on 4/8/11; R86 was admitted on 5/23/11. The background check was initiated on 6/3/11; R87 was admitted on 6/9/11. The background check was initiated on 6/30/11; R88 was admitted on 3/4/11. The background check was initiated on 3/15/11; R89 was admitted on 5/2/11. The background check was initiated on 6/3/11; R90 was admitted on 5/20/11. The background check was initiated on 6/3/11. E2 (Consultant/Director of Operations) stated on 9/30/11 at 2:30pm, that she will investigate this. (B) 300.4050a)1)2)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 108 Section 300.4050a)1)2) Psychiatric Rehabilitation Services for Facilities Subject to Subpart S a) The facility shall develop and implement a psychiatric rehabilitation program. A facility may contract with an outside entity to provide all or part of the psychiatric rehabilitation program as long as individual residents' needs are met and subsection (c)(4) is met. The program shall be designed to allow a wide array of group and individual therapeutic activities, including, but not limited to, the following: 1) Be adjusted in content, form and duration to match residents' profiles in terms of stress tolerance, learning impairments, and motivational characteristics. Environmental conditions shall be arranged to help compensate for deficits in resident concentration, attention, and memory (e.g., reduction of distracting stimuli and extensive use of supportive reminder cues), as needed. 2) Incentive programs, such as motivational interviewing, behavioral contracting, shaping or individual positive reinforcement, and token economy. This requirement is not met as evidenced by: Based on record review and interview facility failed to place three residents (R10, R11) in-house group from a sample of 25 residents reviewed for social service out a sample of 30 residents. Based on record review and interview, the facility	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 109 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 110	F9999		

from 6-1-11 thru 9-30-11.
Interview with E9 (Psychiatric Rehabilitation Services Coordinator) on 9-29-11 at 11:45 a.m. states she did not have the opportunity and time to accurately review R10s ' and R11 ' s charts. E9 states she now made the referral to in-house group for R10 and R11. E9 states this issue and others were brought to her attention yesterday and now are being addressed and care plans are being updated.
Clinical review of R10 ' s programming referral form for psycho social dated 9-28-11. Record review of R10 ' s physician ' s order sheet dated 9-29-11 denotes resident may attend psychosocial group for psychosocial/psychiatric treatment.
Clinical review of R11 ' s programming referral form for psycho social dated 9-28-11. Record review of R11 ' s physician ' s order sheet dated 9-29-11 denotes resident may attend psychosocial group for psychosocial and psychiatric treatment.

a) R3 has diagnosis of Manic Depressive Disorder and Suicidal Ideation and was readmitted to the facility on 6/29/11.

R3 ' s nurses notes dated 5/18/11 indicated that at 3:45 PM, R3 was upset about her purse being searched and threatened to slash her wrist. R3 was also paranoid about staff, accusing staff of trying to poison and kill her. R3 ' s 2/19/11 nurses notes indicated that R3 refused her meds and thinks that her meds are poisoned. Furthermore, this nurses notes indicated that R3 continuously refuses meds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 111	F9999		

During initial tour on 9/27/11 at 10 AM, R3 was observed in bed, paranoid, delusional and talking about residents being stabbed by staff. Review of facility ' s incident reports indicated no such incidents.

Review of facility ' s inhouse and outside program shows no indication that R3 is attending any program to address her psychiatric issues and suicidal ideations.

During 9/28/11 interview at 11:08 a.m., E8 (case worker) said that R3 is often delusional, hallucinating, and is verbally aggressive. E8 also said that on 5/18/11 R3 went to the hospital for suicidal ideation per her social service notes. E8 continued that R3 is not attending any psych rehab program and that E8 has not talked to R3 about her suicidal ideation yet. E8 also said that she tried to ask R3 to attend programs but R3 refused. R3 also does not take any of her medications including her psych meds.

b) R12 has diagnosis of Schizoaffective Disorder.

Review of outside program TCOTP ' s attendance sheet indicated that R12 has not been attending his outside program starting with 8/27/11. Review fo the Transportation Tracking sheet also showed no indication that R12 was gpoing to TCOTP using the transportation arranged for by the facility.

During 9/28/11 interview at 11:20 AM, E8 (case worker) said that TCOTP is for R12 ' s socialization skills and independence, but that R12 ' s attendance is not great with TCOTP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 112	F9999		

Review of facility ' s program with psychologists also showed no attendance from R12, although 6/2/11 Annual Summary indicated that he sees a psychologist.

During 9/29/11 interview with E8 at 11:38 am, E8 was not aware that R12 has not been attending TCOTP since 8/27/11.

c) R30 has diagnosis of Schizophrenia and was admitted to the facility on 7/12/11.

R30 ' s nurses notes dated 7/19/11 indicated that R30 was caught smoking in the bathroom at 11 AM.

Review of R30 ' s social service notes showed no indication that this behavior was addressed on 7/19/11, even though R30 ' s record shows that he attended a smoking program on 7/18/11 per E2 (Director of Operations). This inappropriate smoking is a new occurrence.

During 9/28/11 interview at 11:08 AM, E8 (case worker) said that R3 is often delusional, hallucinating, and is verbally aggressive. E8 confirmed R3 never takes her pills and is not involved in any program. E8 said that on 5/8/11, R3 went to the hospital for suicidal ideation. E8 said she has not talked to R3 about R3 ' s suicidal ideation. E8 said that she is new and that R3 does not like to talk and just sways E8 away.

1) R12 has diagnosis of Schizoaffective Disorder.

Per record review, R12 was placed in an outside program called TCOTP. Review of R12 ' s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 113	F9999		

attendance notes with above group indicated he last participated in 8/17/11. R12 has not signed as had attended the TCOTP starting 8/27/11. Transportation tracking also did not show R12 ' s name. Review of psychologists sign in sheet also showed that R12 was not in their group even though social service annual summary dated 6/2/11 says R12 sees an psychiatrist/psychologist monthly.

During 9/29/11 interview at 11:38 AM, E8 was not aware that R12 had not attended after 8/17/11. No communication was given to E8 who was in charge of R12 ' s case so non- attendance could be addressed. In the meantime, R12 has not had any program to address his mental health after 8/17/11.

2) R30 was admitted to facility on 7/12/11 with diagnosis of Schizophrenia Paranoid Type. R30 ' s psychiatric notes dated 7/13/11 indicated impulsiveness, delusional, and with lability. Per nurse ' s notes dated 7/19/11 at 11 AM, R30 was caught smoking in the bathroom. Although R30 was given a PRN, and counseled, review of R30 ' s social service notes showed no indication this behavior was addressed.

During daily status on 9/29/11, E2 said he was in a smoking program and had attended a session on 7/18/11. When asked what did the facility do on 7/19/11 when R30 who was in a smoking program prior to this behavior was caught smoking in inappropriate places, E2 was not able to provide further information.

On 9/27/11 at approximately 1:30pm, E1 (Administrator) stated that there are 5 psychiatric

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 114 rehabilitation programs offered: Substance Abuse, Taking care of the People (TCOTP), Association Behavior Rehabilitation Services (ABRS) and 2 psychotherapy groups. There are 163 residents identified by the facility as having serious mental illness. Review of the facility ' s Serious Mental Illness (SMI) roster dated 9/14/11 shows R15, R16, R17, R21, R24, R85, R99 through R145 are not assigned to any psychiatric rehabilitation programs. 23 residents on the roster no longer reside in the facility. The TCOTP Day Program Tracking Form includes 1 discharged resident and 7 residents who are not on the SMI roster. The TCOTP In-House Group includes 3 discharged residents and 20 residents who are not on the SMI roster. The ABRS roster includes 1 discharged resident and 5 residents not on the SMI roster. The Alcohol and Drug Treatment Group includes 6 residents not on the SMI roster. Of the 59 residents identified as receiving psychotherapy, 32 are not listed on the SMI roster and 3 no longer reside in the facility. There was no Psychiatric Rehabilitative Services Director (PRSD) available for interview during the survey. (B) 300.4060b Section 300.4060b)1)2)3)4)5) Discharge Plans for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S b) Within one year prior to a planned discharge, preparation shall address: 1) Identification and linkage to proposed	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 115 community providers; 2) Self-directed initiation and compliance with mental health services while in the facility; 3) Use of community mental health services; 4) Assistance with locating and securing housing; and 5) Assistance with identification, application and securing financial resources. This requirement is not met as evidenced by: Based on record review and interview facility failed to provide discharge planning to one resident (R11) out of 25 residents reviewed for social services out a sample size of 30 residents. Findings Include: Interview with R11 on 9-29-11 at 12:00 PM, states he informed his social worker before she quit that he wanted to seek senior housing. R11 states that after his social worker quit he told E11 (Psychiatric Rehabilitation Services Coordinator) from the 7th floor that he wanted senior housing. R11 states he E11 told him that he placed him on the housing list but never did. Interview with E11 on 9-29-11 at 12:10 PM, states R11 acquired about housing for assistance with independent living. E11 states he was told by R11 but didn ' t do it but rather delegated it to E8 (Psychiatric Rehabilitation Services Coordinator). Interview with E# on 9-29-11 at 12:20 PM, states she does not know that R11. E8 doesn ' t recall being asked to assist R11 with placement for	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 116 housing. Record review of R11 ' s discharge potential assessment, review and plan dated 4-13-11 denotes discharge is uncertain. Record review of R11 ' s comprehensive care plan; anticipating discharge dated 4-16-11 denotes the resident favor discharge even though the resident requires extensive physical and/or mental heath service. Goal: resident will meet with social worker, nurse and significant other(s) to identify post-discharge needs by 7-16-11. Interview with E9 (Psychiatric Rehabilitation Services Coordinator) on 9-29-11 at 11:45 AM states she did not have the opportunity and time to accurately review R11s ' chart and other charts. E9 states this issue and others were brought to attention yesterday and now are being addressed and care plans are being updated. Record review of R11 ' s comprehensive care plan; anticipating discharge dated 9-28-11 Interventions: contact department of human services. Contact physician for home health nurse. Meet with resident on a regular basis to help with mental preparation for discharge. (B) 300.4030h) Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 117	F9999		

functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan.

This requirement is not met as evidenced by:

Based on record review and interview facility failed to review and revise care plan interventions to minimize the risk for falls for four residents (R15, R16, R18, R20) out of 13 reviewed for falls out of sample size of 30 and failed to review and revise the nutritional care plan for one resident (R11) out of 14 reviewed for weights/nutrition out of a sample size of 30.

Findings Include:

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 118 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. (B) 300.610a) 300.1210a) 300.1210b)5) 300.1210d)3)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 119 meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 120	F9999		

and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on observations, interview and record review, the facility failed to provide supervision for cognitively impaired individuals assessed as high risk for falls and failed to provide effective interventions to prevent the numerous falls, some falls resulting in fractures for R2 and sutures for R19 and R44, failed to provide supervision for cognitively impaired residents who have been in physical altercation with other cognitively impaired residents and resulted in injuries and failed to investigate and assess individuals for the root cause for falls in 6 of 13 residents (R2, R13, R15,R18, R19, R23) reviewed for falls in the sample of 30 residents and 8 residents (R34, R44, R38, R36, R33, R32, R39, R45) in the supplemental sample.

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 121 1) R2 is a wheel-chair bound, 67 year old male who has a diagnoses of alcohol abuse related dementia, hypertension and Cerebral Vascular Accident per the current 6/20/11 Minimum Data Set (MDS). R2 is disoriented by all 3 spheres (person, place and time) per the 5/9/11 and 9/14/11 care plan for memory and decision-making. On 9/27/11 at 10 a.m. in the 4th floor dining room, R2 was seated in wheel-chair. E16 (nurse aide) was standing along side him, re-applying his semi-cast and wrap to his right hand/wrist. E16 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. 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 doesn't 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 10:55 A.M., R2 is back in the dining room. The semi-splint is off and on the floor. E17 (activity aide) and E15, the P.R.S.C. (Psychiatric Rehabilitation Service Counselor) were circulating the room. Throughout the week, R2 was in his	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 122	F9999		

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.

Review of the incident reports for R2 document a fall on 6/8/11 at 6:15 A.M. in the 4th floor dining room, where R2 is found on the floor with an over-bed table broken next to him. It is not witnessed nor is it investigated. R2 was unable to say what happened.

Review of the nurses ' notes dated 6/8/11 document R2 found on dining room floor. R2 is confused however he interacts with staff. If R2 becomes more confused, he will be sent out to hospital.

The next fall is 6/11/11 at 12:15 P.M. when R2 is on the floor in the hall. The report documents that staff saw him walking down the hall prior to fall. The report does not indicate which staff person saw him walking and whether or not be should have been walking independently due to his unsteady gait. The report does not document if there were any injuries. It documents 911 was called.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 123	F9999		

Review of the nurses ' notes dated 6/11/11 document R2 was walking down hall to lunch and went to floor. R2 found on his right side with his right arm and hand under him. R2 complained of pain to head and arm. R2 complained of dizziness while standing and while on the floor. R2 ' s right side of face was red. 911 was called. R2 was admitted to the hospital with a diagnosis of Syncope. When he returned from the hospital, he had another diagnosis of encephalopathy.

The next documented fall is dated 6/14/11 at 6:30 p.m. where R2 was found on his floor. The report documents he was removed from floor and placed in wheel-chair. The report documents no injury but there is no investigation into the fall to determine how and why it happened. Nor is there any follow-up to ensure there is no injury.

The next documented fall is dated 6/21/11 at 11:40 A.M. where R2 is found on the dining room floor. R2 can not say what happened. R2, who is disoriented to all 3 spheres and confused, was reminded to stay in his chair. The interventions are to continue to monitor resident and to evaluate resident for laptop cushion. There was no investigation into the fall. The laptop cushion was not effective due to R2 removing it so the facility implemented the chair alarm but the time frames are unclear as to when the laptop was discontinued and the chair alarm implemented.

The report dated 8/31/11 at 2:40 p.m. document R2 stated another resident hit him and there was a new cut on the right cheek. R2 received first aid to cut. There was no investigation nor was the other resident identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 124	F9999		

The report dated 9/14/11 at 10:30 P.M. documents R2 on floor next to bed. When R2 was asked what happened, he stated he rolled onto the floor because it feels better. R2 ' s right arm cast is with in normal limits with some edema. It documented the cast is not related to this fall and R2 has soft cast to arm. None of the incident reports document fracture resulting from a fall.

Review of nurses ' note dated 8/10/11 at 6 A.M. document R2 on the floor sitting Indian-style. R2 claimed to not fall. There is no incident report seen or any investigation into it. The nurses ' note dated 8/11/11 documents R2 ' s right wrist swollen and R2 complaining of pain. X-rays were ordered. There was no investigation into this incident.

Review of the portable x-ray done on 8/11/11 documents no fracture.

Review of the nurses ' notes dated 9/4/11 documents R2 to be very lethargic and weak. R2 was pale in color and had swelling in the right eye orbital area and sent out to hospital. Nurses ' note dated 9/4/11 at 8 P.M. documents R2 was admitted under altered mental status. R2 returns back to the facility on 9/6/11 and an x-ray was done on 9/6/11 at the hospital. The hospital x-ray documents there is a fracture through the neck of the 5th metacarpal of the indeterminate age with close opposition of fracture fragments. There was no investigation into the fracture to determine when and how he fractured his 5th metacarpal.

On 9/29/11 at 11:15 A.M., in R2 ' s room, there is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 126	F9999		

to 10:35 A.M. during the initial tour of 4th floor with E13, E13 stated R19 wears the cervical collar due to his numerous falls.

Review of the incident reports for R19 document falls on 7/26/11, 8/14/11, 8/19/11 which were not witnessed and 2 of the incidents resulted in injuries. The incident report dated 8/14/11 at 2:50 P.M. documents R19 sitting on floor of another resident ' s room. R19 sustained a 2 inch cuts to forehead, above the right eye, the lip, left eye lid, left and right knees. R19 was sent out to hospital. There was no investigation. The incident dated 8/19/11 at 2:45 P.M. document R19 face down underneath a dresser in another resident ' s room. R19 sustained a cut to the shoulder and the left elbow. No investigation. The incident of 7/26/11 at 10:40 A.M. documents R19 sitting on the floor in the hallway next to a chair. No injuries were documented and no investigation done.

The incidents dated 7/18/11 at 4:20 A.M. document R19 fell from bed and " hit his upper left orbital area " sustaining a small 1 inch wound. R19 required 4 sutures to the forehead. The reports documents E32, a nurse aide, witnessed the incident but there is no statement from her nor was there an investigation. An incident dated 5/29/11 at 1:15 P.M. documents a housekeeper and a nurse aide see R19 ambulating in the dining room, stood still, lost balance and fell. R19 landed on his left side. R19 ' s left elbow is swollen. An order is obtained for an x-ray to entire left arm. The staff were not identified by name nor are there any statements. There were no x-ray results provided or seen. This incident was not investigated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 127 There is an incident for R19 dated 8/4/11 at 2 P.M. documents while making rounds R19 and another resident were swinging at each other in the hallway. R19 sustained a skin tear to the right wrist area. No injuries to other resident. The other resident was identified by room number but no name. Both separated and monitored. No investigation as to why it happened and why R19 and other resident were not in a structured activity. 3) R38 is a 57 year old, wheel-chair bound male who is confused and disoriented. R38 ' s diagnoses include schizoaffective disorder, dementia and convulsions per incident reports (6/11/11 and 7/5/11). On 9/27/11 between 9:50 A.M. to 10:30 A.M. during the initial tour with E13, R38 was seated in a wheel-chair in the 4th floor dining room. R38 was wearing a winter coat over street clothes and had long (1 inch) finger nails. Throughout the week, R38 was seen propelling himself throughout the unit, in and out of rooms and dining rooms. On 9/29/11 at 11:35 A.M. during the environmental tour with E20 (director of environmental tour), R38 was in the female common bathroom, which is located on the opposite side of the unit. R38 was in his wheel-chair in a toilet stall, facing toilet. When spoken to, R38 did not respond. E13, nurse, was summoned. In the meantime, R38 stood up from the wheel-chair using the grab bars in the toilet stall, failing to lock his wheel-chair, the chair rolled backwards. R38 removed his pants and incontinent brief and dropped them to the floor. It was then E13 entered the room and asked R38	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 128	F9999		

what he was doing in the female bathroom. No response from R38.

Review of the current quarterly (7/11/11) MDS documents R38 requires one person limited assistance for toilet use. R38 is continent of bowel and bladder.

Review of the incident report dated 5/24/11 at 2:10 P.M. document R38 lost his balance and fell in the 4th floor dining room, landing on his left side of his body and hitting his head on the floor. R38 could not say what happened. A nurse aide witnessed it but there is no name or statement from the person. An x-ray was done on left hand and it was negative. There was no investigation to determine the cause for R38 to loose his balance and fall.

Review of the incident dated 6/11/11 at 6 P.M. documents R38 is orient times two. R38 fell in the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 129	F9999		

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 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. document R38 was struck in the right side of the forehead by another peer because R38 had ran over the peer ' s feet with his wheel-chair. The peer is identified by room number but there is no other identifier for this resident. The aggressor ' s identity is unclear. The incident was witnessed by a nurse aide. This aide is not identified nor is there a statement from the aide. Both residents were re-directed.

On 9/30/11 at 9:55 A.M. during the daily meeting with administration staff, E2 and E3 stated they are unable to identify the residents involved in the physical altercations or any staff member who witnessed the falls. E2 stated to be employed for one month and E3 stated she thought the former Director of Nursing was doing the investigations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 130	F9999		

4) On 9/27/11 between the 9:50 A.M. to 10:30 A.M during the initial tour with E13 (MDS Coordinator/nurse), R44 was ambulating the unit and asking for money from E13. R44 was very confused. R44 ' s diagnoses include paranoid schizoaffective disorder, dementia and seizure disorder per the incident report (7/12/11).

On 9/29/11 at 11:23 A.M during the environmental tour with E20 (Director of Maintenance), R44 was standing inside his room at the doorway. In the hall outside of his room, on the floor, was a yellow-pooled liquid that looked like urine. E20 stated R44 has a habit of urinating on the floor and in the air conditioner units. The air conditioner unit in the room next to R44 ' s room, which is not occupied, smelled of urine. R44 had a fixed glare on his face and would not answer any questions. E20 summoned the housekeeper to mop up the spill.

Review of the current quarterly 8/11/11 MDS documents R44 requires one person limited assistance in toilet use and occasionally incontinent of bowel and bladder.

Review of R44 ' s incident reports dated 6/5/11 at 5:30 A.M., 7/12/11 at 12:30 A.M. and 7/18/11 at 2:30 P.M. documents all falls with the incident of 7/18/11 resulting in sutures to the left eye brow. The 6/5/11 incident was not witnessed and R44 was found sitting on the floor next to bed with a small amount of blood on the right cheek. R44 was unable to say what happened. There was no investigation to determine what caused the fall. The witnessed fall of 7/18/11 documents R44 as disoriented and he got up from his wheel-chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 131	F9999		

without locking the brakes and the wheel-chair rolled backwards. R44 lost his balance and fell forward hitting his head causing a cut above the left eye brow. It required 3 sutures. The intervention is to keep him out of any wheel-chair because he is ambulatory. R44 was unable to say what happened. There was an order for R44 to see a neurologist. The neurologist ' s report dated 8/12/11 documents R44 is a 56 year old male with history of Epilepsy. The chief complaint listed " Initial neurological exam. The patient has seizures disorder and dementia. " The report does not document any test done. Recommends levels (Valproic acid and Dilantin) and RTL (routine labs) in 2 months. There was no investigation and the witness is not identified.

The incident dated 7/12/11 documents the fall was witnessed by E34, a nurse aide. R44 had stumbled over his feet. The report does not document the factors such as condition of floor and R44 ' s foot wear. There is no statement from the unidentified nurse who assisted R44 off the floor.

5) R36 is a 60 year old, wheel-chair bound male. R36 was confused and not oriented to all 3 spheres. Staff would push R36 in and out of the dining room. At times, R36 would use his feet to propel the wheel-chair. R36 ' s diagnoses include dementia and schizoaffective disorder per the 4/14/11 incident report.

Review of R36 ' s annual 9/19/11 MDS documents R36 requires one person assistance with walking and uses a wheel-chair on the unit. The MDS documents he has impairment with his lower extremities and requires a wheel-chair for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 132	F9999		

mobility.

Review of R36 ' s incident reports dated 4/9/11 at 10:30 A.M., 4/29/11 at 2:40 p.m., 5/26/11 at 2:45 A.M. and 6/20/11 at 8:25 A.M. document witnessed falls. The incident dated 4/9/11 documents during a group meeting on the second floor, R36 stood up, was unsteady and fell hitting his right side of the face. R36 stated he remembers falling but denied headache or visual disturbances. The intervention is for activity staff to check with nurses prior to removing R36 from the floor. R36 has an unsteady gait and requires a wheel-chair when leaving floor. There was no investigation or statements to determine why R6 was not asked to remain seated when he got up from chair with unsteady gait.

The 4/29/11 incident documents R36 is sitting in a dining room chair, stood up, walked with unsteady gait across the room and fell. When R36 was asked if he was okay, he responded " no. " following the " no " response, the report documents R36 always responds " no " . E35, the nurse is the one who witnessed the fall and documents R36 ' s gait to be unsteady. The intervention was to counsel him on safety.

The incident of 5/26/11 documents E37, nurse aide saw R36 come out of his room, stumble down the hallway and fall. E37 informed the nurse, who is not identified, and she finds R36 on his backside on the hallway floor. No injuries. R36 stated he was going home, stumbled forward and used his hands to brace his fall. No investigation to determine why he is so unsteady.

The incident dated 6/20/11 documents R36 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 133	F9999		

carry his own breakfast tray, tripped over his own feet, falling to the floor and injuring both knees. The intervention were to check vitals and notify Physical therapy department. R36 stated he fell to the floor. There is no investigation as to why he continues to fall and why there are no interventions in place.

The incident dated 4/14/11 at 7:25 A.M, 8/28/11 at 11:45 A.M. and 9/16/11 at 6:15 A.M. are un-witnessed incidents, The 4/14/11 incident documents R36 face down on the floor in his room. R36 was unable to say what happened. The intervention is one on one monitoring. There was no investigation into the fall.

The incident 8/28/11 documents a nurse aide, not identified, finds R36 on the floor of his room. R36 stated he was walking and lost balance. The nurse aide stated during her rounds she found him on floor and informed the nurse. The nurse is not identified. The intervention is for R36 to use the hall rails if necessary and to ask for assistance if needed. There was no investigation to determine what caused him to fall.

The incident dated 9/16/11 documents a noise was heard and R36 found on floor in his room. No injuries. R36 responded he was trying to go home. The nurse aide, not identified, found R36 on the floor. The intervention is to place R36 in a wheel-chair but because he continued to get up from the chair he was placed at the nurses ' station. No investigation as to why he continues to fall.

6) On 9/28/11 at 11:58 A.M. in the 4th floor dining room, R32 was holding up his pants while he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 134	F9999		

walked because the pants were too big in the waist and the length of the pants were several inches too long. R32 ' s diagnoses include dementia secondary to the traumatic brain injury, subdural hematoma, bipolar disorder, seizure disorder and status post shunt and craniotomy per the 6/1/11 incident report.

Review of the annual 9/13/11 MDS documents him to be independent for walking but requires supervision and set-up for dressing.

The incident dated 6/1/11 at 2:30 P.M. documents R32 on his buttocks on the dining room floor. It was not witnessed. R32 was unable to say what happened. There was no investigation as why he fell.

The incident dated 8/27/1 at 9:50 A.M. documents R32 is pushed by a female peer and R32 turns around and hit her in the face. Both 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 and push him against the elevator doors. R32 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.

7) Throughout the week, R34 would ambulate in and out of her room to the nurses ' station and in/out of the dining room, carrying a bible and saying incoherent gibberish and return to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 135	F9999		

room where she would mostly stay, sitting on her bed. R34 would wear 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.

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.

The incident reports dated 4/29/11 at 2:30 A.M. documents a loud noise was heard by nurse and nurse aide, both not identified by name, who find R34 on the floor on her backside. R34 complained about soreness on her right shoulder but refused the Tylenol. X-ray was negative for a fracture and dislocation. R34 stated she had a dream that there were snakes in the bed so she ran to the window. There were no interventions put in place.

The incident dated 6/14/11 at 8:45 A.M. documents R34 is found on the floor of her room and has a cut on her forehead. Other resident re-directed and residents kept separate. There is no investigation into how the injury occurred and it does not identify the other resident. R34 sent out to hospital for evaluation and treatment but no follow-up to this information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 136	F9999		

The incident dated 7/22/11 at 2 A.M. documents a nurse aide, not identified by name, found R34 on the floor. The nurse aide helped R34 off the floor and onto the bed. R34 was unable to say what happened. There is no account from the nurse aide as to what she witnessed nor is there an investigation into why R34 fell. R34, who is cognitively impaired, was instructed to ask for assistance.

The incident dated 6/23/11 at 10:40 P.M. document R34 was punched in the right side of her head by another resident. The report documents a witness but no one is identified nor is there any statement. There was no investigation.

The incident dated 8/23/11 at 4:10 P.M. documents R34 being very upset and stated she was struck in the face by another female resident in the female Common Bathroom. No injuries seen. The other resident was not identified and there was no investigation into the incident. R34 was relocated to the dining room at this time.

The incidents dated 4/15/11 at 11 A.M and 6/24/11 at 4:30 P.M. document R34 physically assaulting (2.5 inch scratch on neck) the a hospice nurse for no reason except she walked by her when R34 was escalating at the nurses ' station. No investigation into what caused R34 to escalate. The incident dated 6/24/11 documents R34 scratched E38 (staff) when R34 was re-directed by E38. R34 was aggressive and uncooperative. R34 was sent out to hospital for psychiatric evaluation. No follow up to the incident nor was there an investigation into the cause of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 137 R34 ' s erratic behavior. 8) R33 is a 64 year old, ambulatory female who has a diagnosis that includes schizoaffective disorder. R33 was seen mostly in the bed due to radiation treatments. On 9/27/11 between 9:50 A.M. to 10:30 A.M. during initial tour with E13 (nurse), E13 stated R33 was receiving radiation treatment that morning and was out of facility. The incident dated 5/27/11 at 10:35 P.M. documents R33 as oriented and the incident report dated 6/10/11 at 2:30 P.M. document her as disoriented. These two incidents and incidents dated 6/28/11 at 12:30 P.M are all physical altercations between R33 and other residents. The 5/27/11 incident documents R33 complaining about her roommate hitting her in the back when she was taking a shower. Redness noted on her backside. The report documents that staff spoke to the aggressor and both are separated. No investigation documented. The incident dated 6/10/11 documents R33 and another resident were entangled in a physical altercation and pulled apart by staff. R33 stated the other resident scratched her hand so she threw a cup at her and will do it again. The intervention is to " see if R33 could have medication work-up on a psychiatric ward " per Z3, the psychiatrist. There was no documented follow through on this intervention. The incident dated 6/28/11 documents R33 being struck in the face by R38 and it was witnessed by staff. There are no staff identified and no investigation into what caused the altercation.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 138	F9999		

The incident dated 7/7/11 at 8 P.M. R33 is found on the floor. R33 is delusional and could not say what happened. The intervention was for R33 to " watch where she is going. " There was no investigation as to what caused the fall.

9) Throughout the week, R39 was in the 4th floor dining room ambulating in and out and Back and forth from his room.

Review of the incident report dated 9/13/11 at 9:30 A.M. documents R39 to be 58 years old with diagnoses to include dementia, bipolar disorder, schizoaffective disorder and seizure disorder. The 9/13/11 at 9:30 A.M incident documents 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.

10) 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. BUILDING _____ 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 139 11) The facility ' s policy labeled " Falls - Clinical Protocol " document that falls often have a medical causes; they are not just a " nursing issue. " Under Cause Identification, item 1. " Staff will attempt to define the possible causes within 24 hours of the fall. Item 2. If the cause of the fall is unclear, and it may be significant medical causes such as stroke or an adverse drug reaction or if the resident continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. Under item 3. The staff and physician will continue to collect and evaluate information until either the cause of falling is identified or it is determined that cause cannot be found or that finding the cause would not change the outcome or the management of the falls. Under Treatment/Management, under item 2., if the underlying cause cannot be identified or corrected, staff will try various relevant interventions based on assessment of the fall until the falls reduces or stop or until a reason is identified for its continuation. Under Monitoring and Follow-up, under item 4., if the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident ' s falling and will re-evaluate the continued relevance of current interventions. (B)	F9999		