

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>	
(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	F 000		
F 164 SS=D	<p>Annual Licensure and Certification survey.</p> <p>This was a Federal Oversight Support Survey.</p> <p>An extended survey was conducted.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164		4/9/09
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to provide privacy for two residents (R7 &amp; R12) in a sample of 30 and one resident (R41) outside of the sample while providing incontinent care.</p> <p>Findings includes:</p> <ol style="list-style-type: none"> <li>On 3/10/09 at approximately 10:18 AM, E5 (CNA) was observed to provide incontinent care to R41. R41 was observed to be incontinent of stool and urine. R41's pants were observed to be urine soaked down to the knees. E5 instructed R41 to stand beside his bed, which was located next to the window, pull down his pants and preceded to provide care. R41's entire buttocks was exposed. E5 failed to pull the privacy curtain and close the curtains to the window.</li> <li>On 1/11/09 at approximately 12:55 PM, E5 was observed to assist and remove R12 from his toilet in his room. R12 shares his room with three other roommates. E5 was observed to remove R11 from the toilet and change places with R12. The door to the toilet remained open. Each resident was positioned outside of the bathroom door and in clear view of each other. The door to the residents room remained opened.</li> <li>During an interview conducted 3/12/09, R7 stated she felt exposed when she takes a shower in the C-D women's shower room. R7 said she tries to use the second stall, so when someone opens the door it is harder for the people passing by to see her naked. R7 said she has mentioned this to several staff members and nothing has been done. Observation of the C-D shower room, it was noted that the shower stalls were located</li> </ol>	F 164			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 164  F 223 SS=J	Continued From page 2 by the door and when the door opens, the curtains were noted to open slightly from the air. 483.13(b), 483.13(b)(1)(i) ABUSE  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to: - prevent R33 from being sexually abused on 01/17/09 by R31 on 01/17/09, approximately 10 hours after re-admission from hospital evaluation for being sexually inappropriate with a another female resident. R31 physically pushed R33 up against her television, knocked her down onto a crate and grabbed ahold of her genitalia and would not release until R33 sprayed him in the face with aerosol antiperspirant. R31 had an identified offender status for violent aggressive behaviors (Murder conviction in 1990), which was not provided to facility from transferring sister facility on 01/07/09. Facility failed to assess and monitor R31 timely and appropriately to prevent this abuse. - prevent staff from being abrupt, rough, rude, demoralizing (by laughing at residents while gossiping about residents amongst each other in front of residents and being threatening to write them up which affects the residents "Level" and privilege ability and controlling to multiple residents resulting in residents feeling	F 164  F 223		3/24/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 223	<p>Continued From page 3</p> <p>demoralized and fear of voicing complaints due to fear of retaliation from staff.</p> <p>These failures resulted in an Immediate Jeopardy.</p> <p>The Immediate Jeopardy was identified on 3/12/09 at 9PM. The Immediate Jeopardy began on 01/16/09. Immediacy was removed 3/12/09. The facility remains out of compliance at a Level 2 due to the need to evaluate staff response to abusive situations and changes in the policy and procedure.</p> <p>This applies to 25 of 195 current residents and one discharged resident with aggressive behaviors (R31).</p> <p>Findings include:</p> <p>During facility abuse protocol and incident report review surveyor found the following investigations;</p> <p>1) On 01/17/09 at 9:45AM R31 entered R33's room and touched her in an sexually inappropriate place and pushed her onto the bed. R33 was heard screaming by staff. The report included a written statement by R33 that included that R31 entered her room, uninvited at 5:20AM, while she was only wearing a bra. R31 has done this 3 times now. R31 asked R33 if he could buy her television for \$1.00 and when R33 said no he left the room and sat outside R33's room, waiting for her. At 9:45AM R31 walked into R33's room and R33 told him to leave but R31 backed R33 against a television, R33 hit him and then R33 fell down onto a crate. R31 then grabbed R33's crotch and would not let go! R33 tried to reach the emergency call light but R31 would not let</p>	F 223			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 223	<p>Continued From page 4</p> <p>her. R33 was able to reach into her drawer and pull out a can of aerosol deodorant and spray it into R31's face. This gave R33 a chance to run to the door and yell for help. R33 wrote that she thought R31 was going to hurt her, he would not get off her and that she fears he will come back and kill her.</p> <p>The investigation included a written statement by E33 (CNA), stating that she observed R31 sitting outside R33's room 01/17/09 morning prior to the 9:45AM incident.</p> <p>R31 was a transfer admit from a sister facility on 01/17/09 with diagnosis to include Chronic Schizophrenia. 01/09/09 interim care plan included that R31 has hallucinations, delusion, history of substance abuse and receiving psychotropic medications.</p> <p>R31's 01/08/09 nurses notes include behavior of wandering into other resident rooms.</p> <p>R31's 01/16/09 psych evaluation indicates that he was paranois with loose association.</p> <p>R31's 01/16/09 8:30PM nurses note includes going into other residents rooms staff unable to re-direct him. A female resident alligated that R31 entered her room, un-zipped his pants in front of her.</p> <p>R31 sent to hospital for evaluation at 9:48PM but was sent right back and re-admitted at 10:50PM on 01/16/09. The next and last nurses note was the 01/17/09 incident of R31 sexually assaulting R33.</p> <p>R31's chart did not include an aggressive/harmful behavior risk assessment since admit and did not include any social service or psycho social notes with these behaviors and a plan to prevent aggressive or sexually inappropriate behaviors.</p>	F 223			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 223	<p>Continued From page 5</p> <p>During interview E1 (Administrator) told surveyors that R31's identified offender status was not included with his 01/07/09 admission transfer forms from a sister facility. R31 has a history of a Murder conviction in 1990.</p> <p>2) During the survey multiple residents approached surveyors and voiced complaints about nursing and dietary staff being rude, rough handling, disrespectful, abrupt, pushy, demanding, threatening, laughing at and gossiping about residents in front of other residents and staff. If a resident is incontinent during a meal the staff tell them they have to stay wet until after the meal. Residents voiced fear of retaliation if the voice a complaint to administration. 3 staff named were E6 and E15 (nurse aides) and E10 (nurse).</p> <p>Incident reports included incidents of nursing staff treating residents inappropriately. Examples include;</p> <ul style="list-style-type: none"> <li>- 02/04/09 R23 alligated that E6 was abrupt, pushy and argumentative with her and that E6 hit her in the hand. Facility investigation report concluded that E6 was inappropriately interacting with residents and received a write up.</li> <li>- 3/10/09 R7 alligated that E6 threaten to write up the resident if she did not leave the patio area. E6 said that she was locking it up but the facility policy is for residents to be able to go outside on patio and smoke with supervision until dark. R7 and E16 (nurse aides) written statements concur that E6 insisted the patio be closed and locked up before dark on 3/09/09. E6 was suspended for 2 days and eventually terminated 3/16/09 for inappropriate interactions and attitude toward</li> </ul>	F 223			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 223	<p>Continued From page 6</p> <p>residents. E16 also noted that E15 (nurse aide ) was involved with demanding residents get off patio and inside before the patio was supposed to be closed.</p> <p>- 3/10/09 R45 alligated that on 3/09/09 she heard someone call her a "fat a..", when she looked around to see who said it she saw E25 (nurse aide) laughing. R45 became upset and called E25 a "Bit..". E25 told R45 that she was going to write R45 up and R45 apologized. E25 refuse to accept the apology from R45. E25 was suspended 3/10/09 and terminated 3/16/09 for inappropriate response to resident behaviors.</p> <p>The facility took the following steps to remove the Immediacy:</p> <ul style="list-style-type: none"> <li>-increased monitoring at each nurses station</li> <li>-increased frequency of face checks from every 2 hours to hourly</li> <li>-inserviced all staff on the newly implemented monitoring program and on how to handle aggressive / harmful behaviors</li> <li>- All resident care plans were reviewed and up-dated to include approaches on how to deal with inappropriate behaviors</li> <li>- all residents with histories of inappropriate and or aggressive behaviors were re-assessed and care-planned</li> <li>- changed admission policy and procedures and new hire orientation programs.</li> <li>- Psych Director will immediately review any and all allegations of abuse in which the facility initiated an investigation and will be reviewed quarterly during facility QA committee meetings.</li> <li>- Aggressive / Harmful behavior risk assessments will be completed on all new and re-admits with-in 72 hours. 1:1 will be provided pending transfer to hospital on any resident exhibiting harmful behaviors to self or others.</li> </ul>	F 223			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 223	Continued From page 7	F 223			
F 224 SS=E	<p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review facility failed to prevent E29 (nurse aide), from roughly handling and speaking in a scolding and abrupt manner to two residents (R11 &amp; R12) on 03/12/09 while providing needed assistance with transfer and tilting; prevent staff from being abrupt, rough, rude, demoralizing (by laughing at residents while gossiping about residents amongst each other in front of residents and being threatening to write them up which affects the residents "Level" and privilege ability and controlling to multiple residents resulting in residents feeling demoralized and fear of voicing complaints due to fear of retaliation from staff.</p> <p>Findings include:</p> <p>1. During the survey, R11 and R12 were observed to be wheel chair bound and required staff assistance with transfers and toileting activities. On 3/12/09, E29 was observed roughly</p>	F 224		3/24/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 224	<p>Continued From page 8</p> <p>handling, frowning, using a sharp tone while directing R12 how to move while transferring him to a chair scale from bed and while toileting R11.</p> <p>Throughout the entire standard survey multiple residents approached surveyors individually and as groups to voice complaints about nursing and dietary staff being rude, rough handling, disrespectful, abrupt, pushy, demanding, threatening, laughing at and gossiping about residents in front of other residents and staff. If a resident is incontinent during a meal the staff tell them they have to stay wet until after the meal. Residents voiced fear of retaliation if they voiced a complaint to administration. Two staff named were E6 and E15.</p> <p>Incident reports included incidents of nursing staff treating residents inappropriately.</p> <ul style="list-style-type: none"> <li>- 02/04/09, R23 alligated that E6 was abrupt, pushy and argumentative with her and that E6 hit her in the hand. Facility investigation report concluded that E6 was inappropriately interacting with residents and received a write up.</li> <li>- 3/10/09, R7 alligated that E6 threatened to write up the resident if she did not leave the patio area. E6 said that she was locking it up but the facility policy is for residents to be able to go outside on the patio and smoke with supervision until dark. R7 and E16 (nurse aides) written statements concur that E6 insisted the patio be closed and locked up before dark on 3/09/09. E6 was suspended for two days and eventually terminated 3/16/09 for inappropriate interactions and attitude toward residents. E16 also noted that E15 was involved with demanding residents get off the patio and inside before the patio was to be closed.</li> </ul>	F 224			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 224	Continued From page 9  - 3/10/09, R45 alligated that on 3/09/09 she heard someone call her a "fat ass", when she looked around to see who said it she saw E25 (nurse aide) laughing. R45 became upset and called E25 a "Bit..". E25 told R45 that she was going to write R45 up and R45 apologized. E25 refused to accept the apology from R45. E25 was suspended 3/10/09 and terminated 3/16/09 for inappropriate response to resident behaviors.  Review of personal files and in-service records revealed that the facility failed to: - do reference checks on 12 of 17 certified nurse aides (CNA) - assure staff are trained in sensitivity to resident rights - how to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents.  During individual staff interviews E5, E8 (activity aide), E7 and E10 (nurses), surveyor was told that facility did not provide them with training on how to manage aggressive, violent and/ or catastrophic reactions of residents. Staff stated that they would call the counselors to intervene. 2. Interview on 3/4/09 at 5:40 p.m. with R14 in the dining room, stated, "I am 72 years old and sometimes I need help opening my milk carton. When I ask for help they are so rude, they open it and then slam it down on the table."	F 224			
F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS  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	F 225		3/24/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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	<p>Continued From page 10</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to investigate allegations of abuse to R27 and failed to</p>	F 225			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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	<p>Continued From page 11</p> <p>investigate an incident involving R32 being sexually inappropriate to an unknown female resident. These inappropriate behaviors resulted into fear and feelings of intimidation by the residents abused.</p> <p>Findings include:</p> <p>1. During an interview on 3/11/09 at 11:10 am, R27 stated that she is so bored in the facility that the thing she does most is sleep. R27 was alert and oriented. Minimum Data Set (MDS) dated 1/29/09, R27 is independent in all activities of daily living. When asked if she goes to any outside day programs, R27 stated she used to go to one but another resident (not from this facility) came up and punched her in the chest and she is scared to go back.</p> <p>Review of medical record shows that R27's PRSC (psycho/social rehab co-coordinator) made an entry on 11/3/08 stating that R27 expressed she does not want to go back to any day program due to incident in which she stated happened on 10/31/08 where where she was hit by another client. Later that day, another entry was found stating that R27's sister called facility and was concerned about the incident that happened at the day program. Staff assured her that R27 was just somewhat upset.</p> <p>E4 (psycho/social rehab director) was asked on 3/12/09 for the incident/investigation into the above incident and E4 stated he was not aware of the incident nor had there been an incident report/investigation. Facility obtained a statement regarding the incident from the day program during this survey on 3/12/09.</p>	F 225			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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  2. R31 was a transfer admit from a sister facility on 01/17/09 with diagnosis to include Chronic Schizophrenia. The 01/09/09 interim care plan included that R31 has hallucinations, delusion, history of substance abuse and receiving psychotropic medications. R31's 01/08/09 nurses notes includes behavior of wandering into other resident rooms. R31's 01/16/09 psych evaluation includes paranoia, hostile, loose association and hostile behaviors. R31's 01/16/09 8:30PM nurses note includes going into other residents rooms and staff unable to re-direct him. A female resident alligated that R31 entered her room, un-zipped his pants in front of her. R31 was sent to the hospital for evaluation at 9:48PM, but was sent right back and re-admitted at 10:50PM on 01/16/09. The next and last nurses note was the 01/17/09 incident of R31 sexually assaulting R33.	F 225			
F 226 SS=F	483.13(c) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record	F 226		3/24/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 13</p> <p>review facility failed to implement policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation and reporting of abuse, neglect and mistreatment of residents.</p> <p>Findings include:</p> <p>Screening:</p> <p>Review of personal files and in-service records revealed that facility failed to: Do reference checks on 12 of 17 certified nurse aides (CNA), (E5, E6, E10, E11, E12, E17, E18, E20, E21, E22, E23, E24) as described per facility policy.</p> <p>Staff training:</p> <p>During individual staff interviews E5 (CNA), E8 (activity aide), E7 and E10 (nurses), surveyor was told that facility did not provide them with training on how to manage aggressive, violent and / or catastrophic reactions of residents. E7, E8 and E10 have worked in facility over two years. E4 (CNA) told surveyors that if aggressive behaviors were exhibited she would call the counselors to intervene.</p> <p>E7 and E10 are charge nurses and both said that they were not provided any special training regarding how to recognize signs of burnout, frustration and stress that may lead to abuse.</p> <p>Prevention, Identification, Investigation and Protection:</p> <p>During the survey R11 and R12 were observed to</p>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 14</p> <p>be wheel chair bound and require staff assistance with transfers and toileting activities. On 3/12/09 surveyor observed E-29 (nurse aide), roughly handling, frowning, using a sharp tone while directing R12 how to move while transferring him to a chair scale from bed and while toileting R11.</p> <p>Throughout the entire standard survey multiple residents approached surveyors individually and as groups to voice complaints about nursing and dietary staff being rude, rough handling, disrespectful, abrupt, pushy, demanding, threatening, laughing at and gossiping about residents in front of other residents and staff. If a resident is incontinent during a meal the staff tell them they have to stay wet until after the meal. Residents voiced fear of retaliation if the voice a complaint to administration. Three staff named were E6 and E15 (nurse aides) and E10 (nurse).</p> <p>Residents stated that E27 and E28 (dietary servers), get angry if the residents ask for a substitute or voice a complaint about the food. E27 and E28 will throw their food trays down on their tray abruptly and yell at them.</p> <p>Incident reports included incidents of nursing staff treating residents inappropriately.</p> <p>Findings include:</p> <ul style="list-style-type: none"> <li>- 02/04/09 R23 alligated that E6 was abrupt, pushy and argumentative with her and that E6 hit her in the hand. Facility investigation report concluded that E6 was inappropriately interacting with residents and received a write up.</li> <li>- 3/10/09 R7 alligated that E6 threaten to write up</li> </ul>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 15</p> <p>the resident if she did not leave the patio area. E6 said that she was locking it up but the facility policy is for residents to be able to go outside on patio and smoke with supervision until dark. R7 and E16 (nurse aides) written statements concur that E6 insisted the patio be closed and locked up before dark on 3/09/09. E6 was suspended for 2 days and eventually terminated 3/16/09 for inappropriate interactions and attitude toward residents. E16 also noted that E15 (nurse aide) was involved with demanding residents get off patio and inside before the patio was supposed to be closed.</p> <p>- 3/10/09 R45 alligated that on 3/09/09 she heard someone call her a "fat ass", when she looked around to see who said it she saw E25 (nurse aide) laughing. R45 became upset and called E25 a "Bit.". E25 told R45 that she was going to write R45 up and R45 apologized. E25 refuse to accept the apology from R45. E25 was suspended 3/10/09 and terminated 3/16/09 for inappropriate response to resident behaviors.</p> <p>-On 01/17/09 at 9:45AM R31 entered R33's room and touched her in an sexually inappropriate place and pushed her onto the bed. R33 was heard screaming by staff. The report included a written statement by R33 that included that R31 entered her room, uninvited at 5:20AM, while she was only wearing a bra. R31 has done this 3 times now. R31 asked R33 if he could by her television for \$1.00 and when R33 said no he left the room and sat outside R33's room, waiting for her. At 9:45AM R31 walked into R33's room and R33 told him to leave but R31 backed R33 against a television, R33 hit him and then R33 fell down onto a crate. R31 then grabbed R33's crotch and would not let go! R33 tried to reach</p>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 16</p> <p>the emergency call light but R31 would not let her. R33 was able to reach into her drawer and pull out a can of aerosol deodorant and spray it into R31's face. This gave R33 a chance to run to the door and yell for help. R33 wrote that she thought R31 was going to hurt her, he would not get off her and that she fears he will come back and kill her.</p> <p>The investigation included a written statement by E33 (CNA), stating that she observed R31 sitting outside R33's room 01/17/09 morning prior to the 9:45AM incident.</p> <p>R31's record included that he was a transfer admit from a sister facility on 01/17/09 with diagnosis to include Chronic Schizophrenia. 01/09/09 interim care plan included that R31 has hallucinations, delusion, history of substance abuse and receiving psychotropic medications. R31's 01/08/09 nurses notes include behavior of wandering into other resident rooms. R31's 01/16/09 psych evaluation includes paranoia, hostile, loose association and hostile behaviors.</p> <p>R31's 01/16/09 8:30PM nurses note includes going into other residents rooms staff unable to re-direct him. A female resident alligated that R31 entered her room, un-zipped his pants in front of her.</p> <p>R31 sent to hospital for evaluation at 9:48PM but was sent right back and re-admitted at 10:50PM on 01/16/09. The next and last nurses note was the 01/17/09 incident of R31 sexually assaulting R33.</p> <p>R31's chart did not include an aggressive/harmful behavior risk assessment since admit and did not</p>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 17</p> <p>include any social service or psycho social notes with these behaviors and a plan to prevent aggressive or sexually inappropriate behaviors.</p> <p>R33's medical record failed to include any psycho-social counseling related to the above incident 01/17/09 through 02/09/09 discharge to the community.</p> <p>During interview E1 told surveyors that R31's identified offender status was not included with his 01/07/09 admission transfer forms from a sister facility. R31 has a history of a Murder conviction in 1990.</p> <p>- A review of the facility's incident reports dated February 10, 2009, to the Illinois Department of Public Health reports an allegation of sexual abuse to, R34, a 29 year old female by another resident( R32) a 53 year old male.</p> <p>The report documents that on 2/9/2009 (no time given), R34 was in her room sleeping . R32 came into R34's room lifted the covers and touched her under her bra and under her panties while she was sleeping.</p> <p>The investigation continues that R32 was bring milk to R34 daily. R34 said she did not ask for him to do this. R34 stated when she felt R32 touching her she woke up and called R32's name, and told R32 to leave her room. R34 said she told the staff immediately about the situation.</p> <p>The facility's conclusion of the investigation was: the facility was unable to substantiate the allegation. That R 32 was told and agrees he will not go to R34's room/wing.</p>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 18</p> <p>From record review, the 11/4/08 Identified Offender Risk Assessment documents R32 has a history of intentionally brushing up against others and touching females inappropriately and inappropriate sexual behaviors</p> <p>R32's plan of care dated 2/3/09 indicates problem #09 as physical touching, grabbing, sexual behavior in a public place. R32 is easily redirected regarding this behavior. no goals are identified.</p> <p>Problem # 25 notes R32 is at risk for sexually transmitted diseases due to being sexually active. The intervention written is for 1:1 counseling as needed for sexually inappropriate behavior. There is no indication of counseling interventions to address sexual behaviors.</p> <p>During the survey conducted 3/12/09, R34 was interviewed about the February 2009 incident. R34 stated she was afraid of R32 since the incident. R34 stated she told all the staff about the incident and they would tell her "don't worry about it, they would take care of it."</p> <p>R34 said it took the facility several days to get rid of R32.. R34 said" I was afraid he was going to come back at me. I did not feel safe while he was here." R34 said the facility did not conduct any counseling with her about the incident or have her examined for injury.</p> <p>R34 said, after R32 left she saw R34 at the outside day program which she attends. R34 said she stays away from R32, But R32 still has behaviors of bothering other women at the day program.</p> <p>Interview with( E4) the Psycho Social Rehab</p>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 19</p> <p>Director (PSRD) states, he was not aware that R32 was in attendance at the same day program as R34 and had not followed up with R34 about the allegations.</p> <p>- R34 stated also during the interview, that the incident in February 2009, was not the first time she was sexually attacked while in the facility .</p> <p>R34 stated another resident (R35) a 19 year old male came into her room some time after May 2008 and tried to get on top of her. R34 said and wrote that she that she use both of her hands to push him off of her. Stating R35 was a big man almost 300 pounds. R34 said she told the staff about this incident but noting was ever done about it. The staff told R34 " not to worry, they would take care of it"</p> <p>September 2008, they finally got rid of R35 for delusional and aggressive behaviors A review of R35's clinical records and plan of care the facility has identified that R35 to be in need of a sexual awareness group. Goals are: R35 will state one way to be sexually appropriate one x/week .</p> <p>A review of the groups progress notation,each month the staff notes: "There is nothing to note progress on due to R35's not attending any of the groups held within the last month. This goal will be continued in an attempt to encourage attendance and participation."</p> <p>Facility has no incident report for R34's above allegation of been assaulted in bed in 5/08.</p> <p>During a 3/12/09 individual interview with E4 (Psycho-Social Rehab Director), surveyor was</p>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	<p>Continued From page 20</p> <p>told that facility does not do aggressive behavior and identified offender status care plans and risk assessments until seven days after the minimum data set assessment is completed and R31's was not yet completed as of 01/17/09 when he had sexually abused R33.</p> <p>Reporting/Response:</p> <p>During interview with E1, E2 and E4, surveyor was notified that facility is only working on inappropriate smoking in facilities quality assurance committee.</p> <p>During 3/13/09 telephone interview of Z1 (Medical Director), he is not involved in QA's related to abuse or behavior problems in facility, he only deals with medical issues, not psychological issues or situations involving the police.</p> <p>Multiple resident interviews revealed fear of retaliation if they report inappropriate staff treatment therefore not always reported.</p> <p>E3 and E4 both told surveyor that incident reports and investigations are not completed on all incidents of aggression and sexual inappropriateness if considered a behavior episode. Behavior episodes are then documented in nurses notes. This was evidenced with R31's 01/16/09 sexual inappropriateness (entering a female residents room and exposing his genitalia to the resident).</p> <p>Facility protocols do not define what constitutes a behavior vs acts of aggression/harmful behaviors that require incident investigations. Therefore not all incidents are reported to state</p>	F 226			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 226	Continued From page 21 agency and local law enforcement agency.	F 226			
F 252 SS=E	<p>Review of R33's 01/17/09 and R34's 02/09/09 incident reports involving allegations of being sexually assaulted by male residents revealed no notification of local law enforcement agency. No psychological counseling or medical evaluation provided to either R33 or R34 after the above sexual assault incidents. Both R33 and R34 voiced fear of a re-occurrence and being harmed or "killed" by the offenders.</p> <p>483.15(h)(1) ENVIRONMENT</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide safe hand rails, windows and comfortable water temperatures in the showers and at hand washing sinks.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The handrail in the corridor near the laundry room has no support in the middle of the hand rail. The hand rail sags in the middle when residents lean on it.</li> <li>2. The window in room D4 does not prevent insects or hot and cold weather from entering the room. Duct tape was used to seal the window.</li> <li>3. The window in the dining room by the vending machines had a wet blanket folded on the</li> </ol>	F 252		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 22 window seal on March 10, 11 and 12, 2009. The blanket had a black mildew like substance on it.  4. On 3/10/09 the hot water temperatures in the men's AB shower and at the hand washing sinks in the A wing resident bathrooms ranged from 80 to 90 degrees F.  5. On 3/10/09, 3/11/09 and 3/12/09 the hot water temperatures at the shower head in the female shower room on AB wing were 90 degrees F. The hot water at the hand washing sink in the shower room was 110 degrees F., but the water in the shower stall was 90 degrees F.  6. On 3/11/09 the hot water temperatures in the lady's CD wing shower and the hand washing sinks on the C wing ranged from 92 to 95 degrees F.  7. During the group interview on 3/11/09 residents complained about cold showers.	F 252			
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272		4/15/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 272	<p>Continued From page 23</p> <p>Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to conduct an accurate and thorough assessment of three sampled residents in the area of urinary incontinence for R9, R25 &amp; R8.</p> <p>Findings include:</p> <p>1. Review of R9's Psychosocial History dated 12/23/08 indicates that R9 is 38 years old with diagnosis of Bipolar and Schizoaffective. Review of Incontinence Resident Assessment Protocol (RAP) dated 12/24/08 indicates that R9 is a new resident to the facility and triggered due to frequent episodes of incontinence. ... Will complete urinary incontinence assessment to complete investigation of incontinence and develop an appropriate toileting plan. Review of R9's urinary incontinence assessment is incomplete in the area of symptoms, serious</p>	F 272			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 272	<p>Continued From page 24</p> <p>conditions that cause or accompany incontinence, potential functional and cognitive causes that may affect toileting skills. Review of medical records shows that R9 does have multiple factors that may be contributing to her incontinence, but were not included in her incontinence assessment. Review of facility toileting flow sheet/urinary diary indicates R9 was incontinent mostly at night, not frequently as stated in the RAP.</p> <p>2. During the survey conducted 3/10/09, R25 approached surveyors to asked if something could be done to have a bathroom closer to the main dining room. R25 stated his room was so far from the area and he could not make it to the bathroom in time. R25 stated he would wet him self and he was embarrassed when he is wet.</p> <p>During interview with E3 (Restorative Nurse) who is in charge of the facility's incontinence program, she was asked how R25 was evaluated for incontinence. A toileting flow sheet/ urinary diary was presented for the dates 12/16/08 thru 12/22/08 as the assessment of continence for R25.</p> <p>This sheet identifies R25 as being as dry each day for a 24 hour period. The sheet did not identify when R25 does void. There are no recommendations or plan identified on the flow sheets. E3 states she was not aware that R25 was having difficulty.</p> <p>3. R8 is identified by the facility to be incontinent of bowel and bladder. From interview during the survey conducted 3/10/09, R8 said sometimes she wets her self. A review of the assessment dated 12/5/08 notes a urinary tract infection (UTI) 10/4/08. No reason is identified as to why R8 is</p>	F 272			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 272	Continued From page 25 still incontinent of bowel and bladder. A toileting flow sheet was presented for R8 by E3 dated 2/26/09 thru 3/4/09 and indicated R8 has voided in toilet at 10:00pm for three days 3/2/09 thru 3/4/09 and dry for the rest of the days. The sheet does not have a plan identified as to why R8 was incontinent or when she uses the toilet on her own.	F 272			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview the facility failed to: 1. Monitor patients condition after a fractured left elbow. 2. Educate residents on proper use of a sling to a fractured left elbow. 3. Follow facility's policy and procedure for the use of gloves while administering injections. 4. Follow facility's policy and procedures for administration of medication within policy time frames. This if for three of 30 sampled patients R19, R26 & R27 and two patients out side of sample, R43 and R52.  Findings includes:  1. R26 was observed during the survey conducted on 3/10/09, to have a cast on his left arm and in a sling that was not applied appropriately. Redness was noted to the back of his neck. R26's arm was noted to be in a dependent position and the left hand was noted	F 281		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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	<p>Continued From page 26</p> <p>to be swollen with the lowered fingers a darker in color. A review of the clinical record notes R26 had sustained a fracture of the left elbow 3/4/09 after falling on ice at the day program. Interview with facility staff and record review does not identify the condition of R26's arm. There is no notations about swelling or the color of R26's fingers or how the facility is educating R26 on the proper position of the sling.</p> <p>2. During observation of the evening medications pass on 3/11/09, E34 was observed to administer insulin injections to R27 and R52. During the injections, E34 was observed not using gloves. E34 was interviewed about the facility's policy on using gloves. E34 stated she was not sure. The Director of Nursing was interviewed about the policy it and stated the nurses should use gloves for administration of injections</p> <p>3. R43 was observed during the evening medication pass on 3/11/09 at 3:50 p.m. E10 was observed to administer an inhaler medication to R43. A review of the Physician Order Sheet (POS) indicated the medication was to be administered at 6:00 p.m. Interview with staff about the time of administration of medications, it was indicated that mediations could be given one hour before or after ordered times</p> <p>4. R19 approached surveyor during the survey conducted 3/10/09 to ask if any thing could be done to get him more food. R19 said he was hungry after he came back from work shop. R19 stated the food he gets at the work shop was not enough. Record review documents R19 is an insulin dependent diabetic with blood sugars ranging around 84 mg/dl. R19 stated he was to get double meat in the mornings, but it does not</p>	F 281			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 27	F 281			
F 315 SS=E	<p>happen all the time. R19 said he has been asking for more food and no one listens to him.</p> <p>483.25(d) URINARY INCONTINENCE</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Conduct an accurate and thorough assessment of factors that may predispose residents to having urinary incontinence.</li> <li>2. Identify whether the causes of incontinence were reversible or irreversible.</li> <li>3. Develop and implement a program based on individual resident assessment and</li> <li>4. Create a specific and individualized bladder plan of care for R8, R7, R9 &amp; R25.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the RAP dated 12/24/08 indicates that R9 is a new resident to facility and triggered due to frequent episodes of incontinence. ... Will complete urinary incontinence assessment to complete investigation of incontinence and develop an appropriate toileting plan. Review of R9's urinary incontinence assessment dated</li> </ol>	F 315		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 315	<p>Continued From page 28</p> <p>12/24/08 is incomplete in the area of symptoms, serious conditions that cause or accompany incontinence, potential functional and cognitive causes that may affect toileting skills. Review of medical record shows that R9 does have multiple factors that may be contributing to her incontinence, but were not included in her incontinence assessment nor were these factors assessed to determine if they are reversible or irreversible. Review of facility toileting flow sheet/urinary diary indicates R9 was incontinent mostly at night, not frequently as stated in the RAP. There is no indication as to how the facility was now going to implement a toileting program based on this flow sheet. The care plan for R9 in the area of incontinence is not individualized. It indicates to toilet at regular intervals, upon rising, before and after meals, at bedtime and prn.</p> <p>Interview with E3 stated on 3/11/09 at 2:40 PM stated that R9 had been identified with urge incontinence, but did not respond when asked if there are any factors which may be contributing to R9's incontinence which may be modified. Review of lab report dated 2/12/09 shows that R9 has elevated blood glucose (151) and A1C (7.5). These were not considered in evaluating possible causes of R9's incontinence.</p> <p>Interview with E19 (nurse's aide) on 3/11/09 at 4:00pm stated that R9 is incontinent at times and mostly the staff assist her with changing her clothes. E19 stated R9 can be incontinent two times a day and does wear regular underpants. E19 said R9 will go to the bathroom at times by herself, but when she has been crying, it's usually because she is wet.</p> <p>2. During the survey conducted 3/10/09, R25 approached surveyors to asked if something</p>	F 315			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 315	<p>Continued From page 29</p> <p>could be done to have a bathroom closer to the main dining room. R25 stated his room was so far from the area that he could not make it to the bathroom in time. R25 stated he would wet him self and he was embarrassed when he is wet.</p> <p>During an interview with E3 who is in charge of the facility's incontinence program, on how R25 was evaluated for incontinence, a toileting flow sheet/urinary diary was presented for the dates 12/16/08 thru 12/22/08 as the assessment of continence for R25. This sheet identifies R25 as being as dry each day for a 24 hour period. The sheet does not identify when R25 does void . There are no recommendations or plan identified on the flow sheets. E3 states she was not aware R25 was having difficulty.</p> <p>3. R8 was identified by the facility to be incontinent of bowel and bladder. From interview during the survey conducted 3/10/09, R8 said sometimes she wets her self. A review of the assessment dated 12/5/08 notes a UTI on 10/4/08. No reason is identified as to why R8 is still incontinent of bowel and bladder. A toileting flow sheet was presented for R8 by E3 dated 2/26/09 thru 3/4/09 and indicated R8 to have voided in toilet at 10:00 p.m. for three days 3/2/09 thru 3/4/09 and dry for the rest of the days. The sheet does not have a plan identified as to why R8 was incontinent or when she uses the toilet on her own.</p> <p>4. R7 is identified to have urge incontinence. During an interview conducted 3/12/09, R7 stated she stills dribble when she has to go to the bath room. The facility's continence assessment summary 1/7/09 indicates that R7 refuses to be awaken at night to be toileted. There is an</p>	F 315			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 315	Continued From page 30 incident dated 12/20/08 were R7 was found on the floor were she had slipped in urine. A 1/7/09 fall interventions indicates for R7 to call staff to clean liquids on the floor. There is no identified plan to work with R7's urgency during waking hours.	F 315			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  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 observation and interview the facility failed to assure residents have access to safe water temperatures in showers and at hand sinks and failed to transport three residents, two in the sample, R11 & R12 and one outside the sample, R41 who are confined to their wheel chairs in a safe manner.  Findings include:  On 3/10/09 the hot water temperatures at the hand washing sinks in CD wing lady's shower room and rooms C10, C5 and C7 were 120 degrees F. The maintenance man said he would turn the water temperature down. When the water temperatures were retaken, the hot water was 95 degrees F.  On 3/10/09, E5 was observed to transport R41 in his wheel chair from his room to the facility's main	F 323		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 31 dining room. R41 was observed with his feet dragging across the floor. E5 made no attempt to instruct R41 to raise his feet nor did E5 make any attempt to protect R41's feet from dragging across the floor.  On 3/11/09 E5 was observed pushing R12 from the dining room to his room. R12's feet were observed dragging across the floor with no intervention from E5. On 3/12/09 at approximately 10:10 AM, E29 was observed pushing R12 from the facility's dining room to his room with his feet dragging across the floor.  During an interview with E3, E3 stated that the facility staff should request residents to hold their feet up or use foot rests. On 3/10/09, the hot water temperatures at the hand washing sinks in CD wing lady's shower room and rooms C10, C5 and C7 were 120 degrees F.  The maintenance man said he would turn the water temperature down. When the water temperatures were retaken, the hot water was 95 degrees F.	F 323			
F 364 SS=D	483.35(d)(1)-(2) FOOD  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to hold the main course at the proper	F 364		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 364	Continued From page 32 temperature.  Findings include:  During the evening meal on 3/11/09 at 5:30pm, the cook had placed the 2nd large pan of goulash in the steam table. Surveyor took the temperature of the goulash with facility thermometer and it registered 120 degrees F immediately off the steam table. Hot foods are to be maintained at 140 degrees or above.  During the group meeting held on 3/11/09 at 2:00pm, several residents stated that the hot food is sometimes cold.	F 364			
F 366 SS=E	483.35(d)(4) FOOD  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to offer substitutes to residents who refused the food served.  Findings include:  During lunch and supper on 3/10 and 3/ 11/09, staff did not offer substitutes to residents who did not eat the food served.  During the group interview on 3/11/09 residents stated, "You have to ask for a substitute to the menu ahead of time." Residents indicated if you're sitting at the table and and don't like what's being served, it's to late to ask for a substitute.	F 366		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>	
(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 SS=F	<p><b>483.35(i) SANITARY CONDITIONS</b></p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a clean environment in the kitchen and properly store and label various food items in dry storage, refrigerators and freezers.</p> <p>Findings include:</p> <p>Observation of the dry storage area along with E26 (dietary manager) during initial tour at 10:20am on 3/10/09 found the following: Shelving with caked on debris and cob webs Open cereal bags with no dates Open package of cookies on shelf Dented cans mixed with non-dented Cans with dust and food particles Plastic tubs with with bags of stuffing and jello that were open and spilling contents onto lower shelves and floor Dirty mop in dirty water inside the doorway</p> <p>Inspection of freezer found the following: Bottom of freezer with spilled liquids and food particles Bag of french fries with expiration date of 6/29/08</p>	F 371		4/9/09

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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	<p>Continued From page 34 and 1/13/09 open packages of chicken nuggets without dates Unsealed bag of gray colored frozen patties with a smeared expiration date Large ham with expiration date of 2/18/09</p> <p>The refrigerator contained the following: Bagged lunches without dates Bags of lettuce without dates, tray of lettuce not fully covered Open boxes of produce without dates</p> <p>General observations made around around kitchen: Floors dirty with food and crumbs and greasy area in front of stove Various sizes of containers containing dried food products were dirty. Trays of wet cups/glasses turned upside down for resident use next meals E30 was observed during tour inserting entire arm into ice machine without pushing up sweater sleeve that was hanging down E31 was observed moving equipment, kitchen items and food without washing hands in between Three beverage containers with smears and particles on containers Uncovered pitcher of juice sitting out</p> <p>Along with E26, inspection of two four foot food serving carts were observed the following: Trays with single serving bowels of canned fruit were uncovered. E26 stated that these individual servings were to be served at this afternoon's meal. The rungs inside the cart that holds the trays were filthy and sticky. The bottom of the cart was dirty with food particles and puddles of liquid, some dried.</p>	F 371			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 35	F 371			
F 406 SS=G	<p>483.45(a) SPECIALIZED REHABILITATIVE SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to:</p> <ul style="list-style-type: none"> <li>- complete a thorough and timely assessment and develop a behavior care plan for aggressive /harmful behaviors, this is for one of 30 sampled residents (R31).</li> <li>- provide adequate supervision and monitoring of one of 30 sampled residents (R31) with a history of inappropriate sexually aggressive behaviors toward female residents. This failure resulted in incidents of sexual aggression toward one sampled female residents (R33).</li> <li>- provide psycho-social intervention and counseling to one sexually assaulted resident</li> </ul>	F 406		3/24/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 36 (R33).</p> <ul style="list-style-type: none"> <li>- prevent R33 from being sexually abused on 01/17/09 by R31 and failed to assess and monitor R31 timely and appropriately to prevent this abuse.</li> <li>-Assist R17 with active participation in the treatment plan for facility's Level System.</li> <li>-Reassess R27 following two attempts at day programming to determine what else may be effective</li> <li>-Make alternative attempts to engage Rs 13, 28, 3 and 17 in active participation with their programming needs.</li> <li>-Meet the needs of residents with a substance abuse history/diagnosis with more than 1/2 hr. meeting a week</li> <li>-Show how facility was assisting R13 in preparing for discharge to community.</li> <li>- R8 for activity of daily living programs</li> <li>- R36 monitoring for sexual behaviors</li> </ul> <p>Findings include:</p> <p>1) On 01/17/09 at 9:45AM, R31 entered R33's room and touched her in an sexually inappropriate place and pushed her onto the bed. R33 was heard screaming by staff. The report included a written statement by R33 that included that R31 entered her room, uninvited at 5:20AM, while she was only wearing a bra. R31 has done this 3 times now. R31 asked R33 if he could buy her television for \$1.00 and when R33 said no he left the room and sat outside R33's room, waiting for her. At 9:45AM, R31 walked into R33's room and R33 told him to leave but R31 backed R33 against a television, R33 hit him and then R33 fell down onto a crate. R31 then grabbed R33's crotch and would not let go! R33 tried to reach the emergency call light but R31 would not let</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 37</p> <p>her. R33 was able to reach into her drawer and pull out a can of aerosol deodorant and spray it into R31's face. This gave R33 a chance to run to the door and yell for help. R33 wrote that she thought R31 was going to hurt her, he would not get off her and that she fears he will come back and kill her. The investigation included a written statement by E33 (CNA), stating that she observed R31 sitting outside R33's room 01/17/09 morning prior to the 9:45AM incident.</p> <p>R31 was a transfer admit from a sister facility on 01/17/09 with diagnosis to include Chronic Schizophrenia. 01/09/09 interim care plan included that R31 has hallucinations, delusion, history of substance abuse and receiving psychotropic medications. R31's 01/08/09 nurses notes include behavior of wandering into other resident rooms. R31's 01/16/09 psych evaluation includes paranoia, hostile, loose association and hostile behaviors.</p> <p>R31's 01/16/09 8:30PM nurses note includes going into other residents' rooms, staff unable to re-direct him. A female resident alleged that R31 entered her room and un-zipped his pants in front of her.</p> <p>R31 was sent to the hospital for evaluation at 9:48PM but was sent right back and re-admitted at 10:50PM on 01/16/09. The next and last nurses note was the 01/17/09 incident of R31 sexually assaulting R33.</p> <p>R31's chart did not include an aggressive/harmful behavior risk assessment since admit, and did not include any social service or psycho social notes with these behaviors and a plan to prevent aggressive or sexually inappropriate behaviors.</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 38</p> <p>R33's medical record failed to include psycho-social counseling related to the above incident from 01/17/09 through 02/09/09 discharge to the community.</p> <p>During interview E1 told surveyors that R31's identified offender status was not included with his 01/07/09 admission transfer forms from a sister facility. R31 has a history of a Murder conviction in 1990.</p> <p>During 3/13/09 telephone interview of Z1 (Medical Director), he stated he is not involved in QA's related to abuse or behavior problems in facility, he only deals with medical issues, not psychological issues or situations involving the police.</p> <p>Multiple resident interviews revealed fear of retaliation if they report inappropriate staff treatment, therefore it is not always reported.</p> <p>E3 and E4 both told surveyor that incident reports and investigations are not completed on all incidents of aggression and sexual inappropriateness if considered a behavior episode. Behavior episodes are then documented in nurses notes. This was evidenced with R31's 01/16/09 sexual inappropriateness (entering a female residents room and exposing his genitalia to the resident).</p> <p>Facility protocols do not define what constitutes a behavior versus acts of aggression/harmful behaviors that require incident investigations.</p> <p>2) R8 was observed during survey conducted 3/10/09. R8 was identified to require supervision with cognitive skills, and has diagnoses of</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 39</p> <p>osteoporosis and Schizoaffective Disorder. During interview with R8, she asked whether anything could be done with her teeth. Stated that at times it is hard for her to eat because her teeth are so bad. Observation revealed the bottom row of R8's teeth were broken and blacken with foul odor. The patient has very poor oral care. Interview with E4 states R8 should be in an Activity of Daily Living Program</p> <p>A review of the program developed for R8 was: R8 will complete tasks of bathing, hair care, nail care and daily clothing changes with max of 2 staff verbal cues three x week during the 1:1 ADL program. Interview with E4, R8 has not been attending groups due to eye surgery. A review of a clinical record dated 1/7/08 from a digestive disease consult documents: Patient poor dentition and in need of dental extractions. The facility has not identified how it will assist patient in obtaining dental and oral care services.</p> <p>A review of the attendance and participation record for January and February 2008 indicate R8 attended one time for Express Yourself group to introduce herself to the group and state one positive trait she possess. R8 said she does not attend A review of the progress notations are vague and does not specifically detail how R8 is progressing in the groups as identifying traits, conducting ADL's and what household task R8 is working on.</p> <p>3) R36,during survey conducted 3/10/09,R36 stated to surveyors he was "servicing " the women at the facility. Interview with E35 the counselor as to what was being done to address R36's behaviors. E35 states, R36 is in a 1:1</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 40</p> <p>sexual awareness from 8/1/08 thru 3/5/09 in which R36 is met with to discuss the importance of not touching others without their permission. There are no clear guidelines to define how the facility is monitoring the behaviors of R36.</p> <p>4) Observation of R18 on 3/10/09 and 3/10/09 noted that R18 is a thin 81 year old resident who spends most of the time in her room. R18 was observed to ambulate with a walker and verbal cues. R18 was observed to only ambulate to the facility's main dining room only for meals. A review of the facility's accumulated diagnosis noted R18 to have Major depression, Bundle Branch Block, unspecified hearing loss, and Arthritis.</p> <p>A review of the facility's care plan for an identified problem of Major Depression noted that the goal for this problem is "R18 will greet counselor by name and then state why eating 3 meals daily is so important to her health ." On 3/11/09 at approximately 2:00 PM, E35(PRSA) was observed with R18 during her 1:session. R18 was seated in her chair that was located next to the wall toward the door to R18's room. E35 was observed seated on foot end of R18's bed, which placed him (E35) approximately 5 - 6 feet away from R18. It was observed that R18's television set was on with volume up for R18's comfort level. (Please note that one of R18's diagnosis is "hearing loss.) It was observed that E35 spoke very fast and it was observed that R18 had difficulty hearing him. E35 kept saying "why is it important for you to eat 3 meals per day?" R18 kept repeating "what is it time to eat?" R18 had an strained expression on her face. E35 made no effort to assure that R18 understood what he was saying. Finally, E35 stood up and informed R18 that he would come back at 2:30 PM to continue their session. During an interview with</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 41</p> <p>R18 after the session, R18 stated to surveyor"what was he talking about? Why was he here? I don't want him to come back.</p> <p>5) On 3/12/09 at approximately 11:10 AM, R22 was observed with self catheterization. R22 was observed to request and receive a catheter from the charge nurse on unit B. R22 was observed to return to her room and enter the bath. R22 removed the catheter from the container wearing no gloves. R22 was observed to fling the catheter around until the tip brushed up against the toilet seat, grab bar and tank set. R22 was observed to insert the catheter tubing directly into her cystectomy and began to drain the urine into the toilet. R22 removed the tubing and placed the catheter into a plastic bag that she kept on top of the cabin. R22 left the room and returned to the facility's main dining room without washing her hands. During an interview with R22, R22 stated that this is the way she has been doing this procedure since her admission. During an interview with the facility's charge nurse on unit B, the charge nurse stated that the resident refused to allow the nurses to help her. A review of the facility's nurses notes found no notations that the facility staff attempted to instruct and monitor R22's refusal.. During an interview with E3 (restorative nurse) on 3/12/09, E3 stated that she was not aware of R22s technique.</p> <p>6) R27 stated during interview on 3/11/09 that she is so bored the thing she does most is sleep. Review of medical record shows that R27's PSRC (psycho/social rehab co-coordinator) made an entry on 11/3/08 stating that R27 "expressed she does not want to go back to any day program due to incident in which she stated happened on 10/31/08 where where she was hit by another client". Psychosocial staff did not</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 42</p> <p>make attempt to assist R27 in in dealing with this incident and the resulting behavior of not returning to the day program. Record review shows R27 exhibits unrealistic fears. E4 (PSRD) stated on 3/12/09 that he thought R27 was currently attending an outside day program. Record review showed that R27's PSRC had documented 1/20/09 that R27 was attending another outside program but quit after 2 weeks. There is no documentation indicating the psycho/social staff attempted to find out why R27 quit this program. R27 complains of being bored. E4 was asked by surveyor what the facility's psychosocial department did in an attempt to understand why R27 quit going to day program and no response was given. There was no documentation in the record that the facility reassessed R27's needs, strengths and weaknesses now that R27 was no longer involved in programming.</p> <p>7) Review of Narrative Psychosocial History dated 1/9/09 states that R13 is a 23 year old admitted on 12/24/08 from a hospital. R13 took an overdose of Lithium (90 pills as identified elsewhere in record) in November 2008. R13 has other suicide attempts: cutting wrists and hanging self. R13 has a history of drinking cough syrup. Resident Assessment Protocol (RAP) dated 1/9/09 states that R13 will be placed in substance abuse group. R13 was not in any type of suicide groups.</p> <p>Interview with R13 on 3/12/09 at 2:00pm stated he does not go to the substance abuse meeting held one time a week for 30 min., saying all it consists of is a half hour movie. R13 said he does not attend any groups because he does not "see the point". He stated he is being discharged</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 406	<p>Continued From page 43</p> <p>to the community in April and does not get any thing from the groups the facility told him about-- -"simple, boring stuff". R13 stated the facility has not had anything to say about his discharge. E4 did not respond when asked what steps the facility had taken to involve R13 in any programming other than reminding him. Interview with E4 (PRSC) on 3/12/09 at 7:00pm stated the facility has not been assessed R13 for issues surrounding his discharge needs. E4 also stated there was no programming meeting the needs for residents in the area of independent community living skills.</p> <p>8) Review R3's psychiatric rehab progress note dated 2/11/09 states that R3 has been non-compliant with her care since admission. E4 stated R3 is on 1:1's. The only note from 1:1 is dated 2/11/09 and states they discussed foods to avoid and R3 enjoys fried food. E4 did not reply when asked how this assists R3 in her psych/social needs. There was no plan as to what the facility was attempting to do to get R3 more involved in her p/s rehab.</p> <p>9) Review of R17's psychosocial history dated 9/24/08 states R17 was admitted to facility in 2002 with current diagnosis of bipolar mixed with psychotic features. During interview R17 stated she is on Level 1 1/2. R17 stated she did not know she had been dropped from Level three until she went to go out for a cigarette. E4 stated that the facility meets with its residents who are on the level system every week to counsel them about their progress. E4 was unable to provide surveyor with documentation showing when why R17's level had been dropped.</p> <p>Facility has identified 30 residents as having</p>	F 406			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>	
(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 406	Continued From page 44 substance abuse problems, either a history of it or as part of their diagnosis. Review of program schedule shows that the psychosocial rehab department offers one substance abuse group for 1/2 hour, one x/week.  Interviews with R's 13, 37, 38, 28 stated that one substance abuse meeting for 1/2 hour/week is not enough.  Surveyor asked E4 on 3/11/09 at 3:30pm why facility does not provide more substance abuse groups such as AA. E4 stated that there is no one currently abusing substances. E4 also said that there had been someone from AA coming into the facility a couple years ago but he got upset at some of the residents and did not return.	F 406		
F 411 SS=D	483.55(a) DENTAL SERVICES - SNF  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to assist resident in	F 411		4/9/09

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 411	<p>Continued From page 45</p> <p>maintaining good oral care and assist in providing services to repair broken and blacken teeth for two of two residents identified with broken teeth and poor oral hygiene, R8 &amp; R14.</p> <p>Findings include:</p> <p>R8 was observed during survey conducted 3/10/09 identified to require supervision with cognitive skills. has diagnosis of osteoporosis and Schizoaffective Disorder. During interview with R8, patient asked was there any thing that could be done with her teeth. Stated that at times it is hard for her to eat because her teeth are so bad. Observation the bottom row of R8's teeth they were broken and blacken and malodorous. The patient has very poor oral care. Interview with E4 states R8 should be in an Activity of Daily Living Program</p> <p>A review of the program developed for R8 was: R8 will complete tasks of bathing, hair care and nail care and daily clothing changes with max of two staff verbal cues three x week during the 1:1 ADL program. Interview with E4, R8 has not been attending groups due to eye surgery. A review of a clinical record dated 1/7/08 from a digestive disease consult documents: Patient poor dentition and in need of dental extractions. The facility has not identified how it will assist patient in obtaining dental and oral care services. Review of Minimum Data Set dated 3/6/09 shows that R14 is 72 years old with diagnosis including bipolar and dementia. Cognitively, R14 is coded as a '2', moderately impaired and requiring supervisions in decision making.</p> <p>During interview with R14 on 3/11/09 at 2:30pm, R14 stated she would like to have some help with</p>	F 411			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 411	Continued From page 46 her teeth, they are broken and sometimes hurt. R14 stated she was told she has to wait for her circuit breaker to pay for the work. Observation of R14's teeth showed they were very discolored with multiple broken teeth. E2 was asked to provide surveyor documentation showing facility attention to this issue. A dental note written on 12/5/08 is not totally legible but reads in part, "Patient wants to defer until symptoms develop". Due to R14's cognitive level and the fact that R14 has a guardian, R14 should not be the responsible for decisions regarding her dental care.	F 411			
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of	F 431		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 431	<p>Continued From page 47</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to return or destroy discontinued medications to the pharmacy per facility's policy.</p> <p>Findings include:</p> <p>During the medication room observation on 3/12/09, the following medications were found in the medication room on the A/B units. These medications were found in the upper cabinets located over the counter with other items such as cups, clean bandages and other clean items.</p> <ol style="list-style-type: none"> <li>1. 5 Acetaminophen with Codeine #3 tablets were found with a discontinued date of 10/28/08 with R11's name.</li> <li>2. 9 tablets of Ativan 0.5, discontinued 12/2/08 for R51.</li> <li>3. 4 vials of Geodon 20Mg., discontinued 5/8/08 for R48.</li> <li>4. 20 tablets of Haldol 5mg., discontinued 2/20/09 for R46 (no longer at this facility).</li> <li>5. One bottle of Colace 50mg. for R48</li> <li>6. Benztropine MES 2mg. that was a "as needed every 12 hours" for R49.</li> <li>7. Chlorpromazine 100mg. discontinued 10/25/08 for R50</li> </ol>	F 431			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 431	Continued From page 48 8. Cogentin 2 mg. discontinued 4/22/08 for R49, and 3 individual enclosed Alprazolam 0.5mg. with no resident's name with an expiration dated of 4/10/08.  A review of the facility's Pharmore Drugs Discontinued orders noted "1. To D/C orders, fax the POS with the discontinued order to the pharmacy. When medications are discontinued or left in the facility when a patient is discharged, remove the medications from the cart immediately to avoid inadvertent administration. These medications should be marked as 'discontinued' and stored in a locked area until destroyed or picked up by pharmacy. Medications that do not qualify for return to the pharmacy must be destroyed per facility policy."  During an interview with E2, E2 stated that these medications should have been destroyed or sent back to pharmacy.	F 431			
F 441 SS=F	483.65(a) INFECTION CONTROL  The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.  This REQUIREMENT is not met as evidenced by:	F 441		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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	<p>Continued From page 49</p> <p>Based on observation record review and staff interview the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure the facility's infection control program have a system to monitor and investigate causes of infection and manner of spread.</li> <li>2. Ensure the infection control committee analyzes clusters, changes in prevalent organisms, or increases in the rate of infection in the facility</li> <li>3. Identify how the facility has trained R29 in handwashing and preventing the spread of infection.</li> </ol> <p>This is for one of one residents identified with infection in the facility, R29</p> <p>Findings include:</p> <p>R29 was identified by the facility to be in contact isolation for Methicillin Resistance Staphylococcus Aureus (MRSA) from a 2/18/09 lab report of the left nares. R29 was observed to be in the room with two other residents who were not identified to have any infections. During interview with Director of Nursing who is conducting the facility's infection Control Committee if the infection control had evaluated R29's case for room mates and how to prevent spread of infection. There was no evaluation available for R29.</p> <p>A policy was presented for MRSA for the facility to follow contact isolation. A review of the facility's infection control logs for October 2008 thru January 2009 the reports lists data collected and numbers of infections. However, there is no identification if the infections were acquired in the facility or in the community. There is no identifications of clusters or recommendations from the committee on how the facility will</p>	F 441			

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 50 prevent the spread of infections. No training of staff / residents are identified.	F 441			
F 444 SS=E	<p>R29 was observed to be in the common areas of the facility and during meal times to be at a table occupied with three other residents. A review of the plan of care for R29 and from interview does not indicate how the facility has trained the resident in hand washing or preventing the spread of infections</p> <p>483.65(b)(3) PREVENTING SPREAD OF INFECTION</p> <p>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility staff failed to wash their hands after performing direct contact care and during medication pass observation while administering an inhaler, eye drops, accucheck and insulin.</p> <p>Findings include:</p> <p>On 3/10/09 at approximately 10:18 AM, E5 (CNA) was observed to provide incontinent care to R41. (R41 was incontinent of stool and urine). E5 was observed to complete the entire procedure wearing the same gloves and never washed her hands. E5 was also observed to assist R12 on and off the toilet. E5 did not wear gloves and never washed her hands before assisting another resident.</p>	F 444		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 444	Continued From page 51 On 3/10/09 during the medication pass observation E10 (LPN) was observed to administer an inhaler to R43 and preform accucheck on R3, R55, R27 and R52. E10 did not wash her hands at any time in between resident contact. During an interview with E10, E10 stated that she was told that she did not have to wash her hands until after every 3 residents contact.  E34 (LPN) was observed to administer insulin to R27 and R52 and instill eye drops in R53's and R54's eyes. E34 was observed to complete these assignments and never wore gloves or washed her hands.  During interview with E2, E2 stated that the facility's staff should be following the facility's hand washing policy. A review of the facility's "Hand Hygiene" policy read " When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids,, and in case of a resident with a spore-forming organism (e.g., C-difficile), perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water. If hands are not visibly soiled, use an alcohol based hand rub for routinely decontaminating hands in all clinical situations other than those listed under 'handwashing' above.	F 444			
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced	F 456		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 456	Continued From page 52 by: Based on observation and interview the facility failed to ensure a weight scale was calibrated prior to obtaining a weight for two residents, R12 & R18, in the sample.  Findings include:  On 3/12/09, E29 was observed to obtain weights on R12 and R18. The chair weight was observed to be stored in a room near the nursing station on the A/B units. E29 was observed to abruptly bring the scales out and drag the scale down to R12's room. E29 was observed to transfer R12 from his bed to the chair scale and obtained a weight of 162lbs. (A record review of R12's last weight on 2/4/09 was recorded 168 lbs). E29 dragged the weight chair back down the hall to R18's room and repeated the same process. R18's weight was 103 lbs. (A record review of R18's last weight on 2/19/09 was recorded 105 lbs.) It was observed that when the chair was empty and the chair scale did not calibrate to zero. During an interview with E29, E29 stated that she is not responsible to calibrate the scales. During an interview with the administrative staff, the staff stated that the chair scale should be calibrated weekly by Maintenance.  A review of the facility's policy for their scales read "It is the policy of the facility to have the scales calibrated every Monday by Maintenance."	F 456			
F 501 SS=F	483.75(i) MEDICAL DIRECTOR  The facility must designate a physician to serve as medical director.  The medical director is responsible for	F 501		4/9/09	

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

PRINTED: 05/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14A151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOURBONNAIS TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 MOHAWK DRIVE BOURBONNAIS, IL 60914</b>		
(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 501	<p>Continued From page 53</p> <p>implementation of resident care policies; and the coordination of medical care in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review facilities medical director is not involved with identifying, analyzing, addressing/resolving clinical concerns related to allegations of abuse, aggressive/harmful behaviors in the facility.</p> <p>Findings include:</p> <p>During 3/13/09 telephone interview of Z1 (Medical Director), he is not involved in QA's related to abuse or behavior problems in facility, he only deals with medical issues, not psychological issues or situations involving the police.</p> <p>During interview with E1, E2 and E4, surveyor was notified that facility is only working on inappropriate smoking in facilities quality assurance committee.</p>	F 501			