STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146078	A. BUILDING _____ B. WING _____	01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSHING GARDENS HEALTHCARE CENTER	3900 SOUTH OAK PARK AVENUE STICKNEY, IL 60402

(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 225 SS=D	Annual Certification Survey 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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

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

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure with certainty that background checks were initiated within ten days of hire for four (E6-E9), (Certified Nursing Assistants) newly hired employees. Findings include: On 1/18/12 at 2:16pm, the personnel files for E6-E9 were reviewed with E2 (Assistant Administrator). The Uniform Conviction Information Act (Background check) for E6, E7, and E8 did not contain the date of submission. E2 stated that E2 can't explain when the background checks were submitted because there were no dates on the background check forms. There was no background check form located in the personnel file for E9. E2 searched through E9's chart and stated that E9 did not have a background check form. The facility's Abuse, Neglect and Exploitation policy documents: "Employee Screening-background, reference and credentials' check should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations."	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

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F 241	Continued From page 2 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on direct observations and interview the facility failed to provide privacy during assessment for 1 resident (R9), and to ensure the indwelling catheter bag out of view for 1 resident (R2) in a sample of 10 residents. Findings include: 1) On 1/18/2012 in the 2nd floor Dining Room at 9:56am R9 was being medically evaluated by Z2 (Hospice Nurse). Z2 was observed pulling down the front of R9's gown and the back of gown exposing skin, to listen with a stethoscope. In the dining room at the same table where R9 was being examined two residents sitting in their wheelchairs along with a family member. It was brought to E4 (Nurse) attention who instructed Z2 not to examine resident in Dining Room. 2) On 1/17/12 at 10:07am, R2 was sitting in the dining room in the reclining chair. R2's indwelling catheter bag was hooked to the front of R2's chair. The catheter bag contained visible urine and was not placed in a privacy bag. On 1/18/12 at 11:00, R2 was sitting in the reclining chair with the indwelling catheter bag exposed. The indwelling catheter bag contained urine and was hooked to the front of the chair in view of residents, staff and visitors.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 3 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess for, and treat pain in one resident (R4) from the sample of 10, and one resident (R11) in the supplemental sample. This resulted in one resident (R4) having avoidable pain from January 12th until January 17th 2012. Findings include: On 1/17/12 at 12:00 pm R4 was observed in a reclining wheelchair. R4 was holding his left thigh and had facial grimacing. When asked how he felt R4 stated, "My leg hurts. They never do anything about it. My ribs hurt to." When asked to describe his pain R4 makes a fist with his left hand and grimaces his face. The charge nurse E5 RN (registered nurse) was made aware by surveyor. E5 assessed R4 for pain. E5 brought R4 650mg of Tylenol. R4 stated "If I had a headache I would have asked for Tylenol. That drug does nothing for me." When asked if R4 had another drug ordered E5 stated "He has Norco ordered but it did not come in yet." Physician order dated 1/12/12 documents a physician order for Norco 7.5mg/325mg by mouth	F 309		

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F 309	Continued From page 4 every 6 hours as needed for pain. On 1/16/12 there is a new physician order to give a lower dose of Norco Stat (right away). E5 stated, "The drug was not available yesterday so I had to give the lower dose. At 2:30 pm E3(director of nursing)DON reported that R4's Norco had been delivered by the pharmacy. There is no documentation of pain assessment at regular intervals in R4's clinical record. There is also no documentation showing the effectiveness of previous pian medications in R4's clinical record. R4's careplan for pain is not accurate or updated. On 1/18/12 at 9:05 am R11 stated to E5, "My knees hurt. My legs too. The Tylenol #3 they gave me last night did not help at all. My legs hurt me all night long". R4 has scheduled Tylenol #3 at night and Regular strength Tylenol in the am. E5 RN stated "I assess for pain when I am passing my medications." E5 was asked if they use any assessment tools to assess for pain at regular intervals. E5 stated "No just on the nursing notes." There is no documentation in R11's record showing assessments for pain or effectiveness of pain medication.	F 309		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the	F 313		

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F 313	Continued From page 5 provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one resident (R6) was provided a hearing aide for one resident (R6) who wore hearing aides out of a sample of 10. Findings include: A review of the clinical record indicatres R6 is a 82 year old female with a diagnosis of long standing hearing loss per the last audiological assessment completed 12/21/09. A review of the audiological evaluation indicates R6 had wore hearing aides but the hearing aides were lost. The audiologist recommended R6 return to the original dispenser of the hearing aides to check the status of the hearing aide loss warranty. Interventions in R6's care plan, revised 11/14/11, do not address communication with R6 due to the hearing loss. A review of the record had completed "Monthly Summary" reports on 11/1/11, 10/1/11, 8/1/11, 7/4/11, and 5/29/11. These reports all state R6's hearing is adequate with a hearing aide. During observations 1/17/12 and 1/18/12 R6 did not have a hearing aide on. R6 was observed eating lunch on 1/17/12 at 12:05pm. E10, CNA was assisting R6 during the entire lunch meal. During the meal E10, CNA was observed communicating to R6 in a loud voice close to R6's ear.	F 313		

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F 313	Continued From page 6 During an interview on 1/18/12 at 1:20pm, E3 stated "R6 has had two sets of hearing aides since I have been here in the last 3 years. R6 refuses to wear them." When asked what was done to assist R6 to wear the hearing aides, E3 stated "short of placing them in her ears and having her take them out, nothing." E3 confirmed R6 did not have any hearing aides and the last time R6 had an audiological evaluation was 2009.	F 313		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on direct observations, interview,and record review the facility failed to assure that each resident (not self medicated) receives their medications in view of the nurse. This observation was made for 1 sampled (R1) resident in a total sample of 10. The facility also failed to secure potentially dangerous items from all resident's ambulating through the facility. The facility failed to thoroughly investigate falls for two residents (R4, and R6) out of the sample of ten. Findings include: 1. On 1/17/12 at 9:33a.m. in room 8 during initial	F 323		

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F 323	Continued From page 7 tour, Surveyor observed a paper cup with 8 pills on the over the bed table. Surveyor brought the container out to show charge nurse. Medical record indicates that R1 is not self medicated. R1 came out of room yelling at Surveyor that those were her pills. R9 stated she would take them when she wanted to. Surveyor brought this to the attention of E4 (Nurse) who stated that R9 takes the pills when she wants. E4 also stated that those pills were her a.m. medications and she had given R1 those pills 15 minutes prior. R1 has a diagnoses of Schizophrenia. 2. On 1/17/12 at 9:30am during initial tour a red metal cart with drawers is in the entry way to the dining room on the first floor. In the top drawer there are 3 razors and two bottles of shampoo being stored in the drawers. Other drawers contain plastic bags, towels, gloves and lotion. These drawers are easily accessible to all of the residents that can ambulate. The first floor dining room is also a entryway to the front of the building where many of the residents throughout the facility go out to smoke. R4 has had falls on 12/25/11, 12/26/11, 1/4/12, 1/5/12, and 1/10/12. There are no incident reports provided by the facility. E3 stated "They aren't really falls since he rolled off the bed." There also is no documentation for a change in interventions used to prevent further falls. The policy provided by the facility for falls dated 2008 (page 2 #3) documents that "the staff and the physician will to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk.	F 323		

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F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assess residents nutritional needs in a timely manner for 3 residents inside the sample (R1, R3 and R7) out of a total sample of 10 residents. Findings include: 1) R1 has a diagnosis of Schizophrenia and Uncontrolled Diabetes. Date of birth 12-6-50. R1 is on a No Concentrated Sweet diet with Double portions at lunch and dinner. On 1-15-12 the double portions were discontinued. The double portions were not evaluated in a timely manner especially since R1 continued to gain weight. July 2011-157lbs, September 2011- 169.2 lbs, December 2011-176.6lbs. and January 15, 2012 weight 182.0lbs. There has been a 25lbs. weight gain in 6 months. Height 60 inches with a height of 5'3. Usual weight 175.0lbs . Interview with Z1 stated that she only charts on weight gains at the	F 325		

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F 325	Continued From page 9 end of the month not when changes occur. Observations of R1 on 1-17-12 at 9:33 a.m in resident room, many food items such as cakes and sodas on bedside table. There is plan in the nutritional assessment for education on high weight and diabetes. 2) R3 has a diagnoses of Left Hip Rodding. Date of birth 1-22-67. R3 is on a Regular diet. Nutritional notes are done quarterly and not done when changes occur. There has been a consistent weight gain. There 6/2011-204.8lbs, 9/2011-206.8lbs. and 12/14/11-208.6lbs. Height 70 inches with a usual weight of 189lbs to 192lbs. The nutritional note from 12/5/11, reflects "excellent appetite, will discuss constant gradual weight gain." There has been no follow up since about this weight gain. 3) R7 has a diagnosis of Schizophrenia and History of Cancer Larynx. Diet: General with Double portions. Height 74 inches with an weight range of 165lbs to 175lbs. R7 weighed 175lbs in 7/11. 166.2lbs. in 11/11. Now in January 164lbs. Weight loss continues. The Nutritional note from 1/15/12 that R7 told Dietitian "I don't want to be fat". There was no intervention by Dietitian with Physician and or Nursing about weight loss and loss of appetite especially with diagnosis.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 10 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to attempt psychotropic medication dose reductions for one (R6) of two residents receiving psychotropic medications in a sample of 10. Findings include: R6 is an 82 year old female with a diagnosis of psychotic disorder and depression. Per Physician Orders for January 2012, R6 is receiving Buspar 10milligrams three times daily, Prozac 10 milligrams daily, Lorazepam 0.5 miligrams every 12 hours as needed, Depakote 500 milligrams daily, Seroguel 25 millgrams twice daily and Seroquel 50 milligrams at HS.	F 329		

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F 329	Continued From page 11 Per review of the record, R6 does not have an consent for the use of Depakote. Review of policy provided by the facility titled "Federal Guidelines for Proper Psychopharmacologic in the Long Term Care Setting" states psychotropic medications shall not be prescribed or administered without the informed consent of the resident, the residents guardian or other authorize representative. Per interview with E3 on 1/18/12 at 3:05pm, R6 has not had any medication reductions in the past year and there is not a current plan in place to reduce the medications.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer physician ordered pain medication one resident (R4) out of the sample of ten. Findings include: On 1/17/12 at 12:00 pm R4 was observed in a reclining wheelchair. R4 was holding his left thigh and had facial grimacing. When asked how he felt R4 stated, "My leg hurts, they never do anything about it, my ribs hurt." When asked to describe his pain R4 makes a fist with his left hand and grimaces his face. E5 assessed R4 for pain. E5 brought R4 650mg of Tylenol. R4 stated	F 333		

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F 333	Continued From page 12 "If I had a headache I would have asked for Tylenol. That drug does nothing for me." When asked if R4 had another drug ordered E5 stated "He has Norco ordered but it did not come in yet." Physician order dated 1/12/12 documents a physician order for Norco 7.5mg/325mg by mouth every 6 hours as needed for pain. On 1/16/12 there is a new physician order to give a lower dose of Norco Stat (right away). E5 stated, "The drug was not available yesterday so I had to give the lower dose". At 2:30 pm E3 reported that R4's Norco had been delivered by the pharmacy.	F 333		
F 406 SS=E	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide specialized rehabilitation services or programming for 3 (R1, R3, R7) of 5 residents reviewed for specialized rehabilitation programs in a sample of 10 residents, and for 2 (R12-R13) residents in the supplemental sample.	F 406		

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F 406	Continued From page 13 Findings include: 1) R1 has a diagnoses of Schizophrenia. Date of Birth 12/6/50. Observation all days of survey 1/17, 1/18 and 1/19/2012, to be in room and not engaged in any programming. In review of the medical record and interview with E3, R1 refuses to attend. There has been no interventions to assist resident with programming. Medical record has no record of programing. Interview with E1 on 1/19/12 at 10:45 a.m. in the Dietary Office, stated that he will be providing programming for residents at a later date for (R1, R3 and R7). 2) R3 has a diagnoses of Left Hip Pinning. Date of Birth 1/22/67, admit date 10/1/08. Observations all days of the survey, 1/17, 1/18 and 1/19/2012 to be in room and or watching television. R3 not engaged in any programming. Medical record has no record of programming. 3) R7 has a diagnoses of Schizophrenia. Date of birth 1/28/52. Observations all days of the survey, 1/17/ 1/18 and 1/19/2012 to be in room, sleeping. R7 not engaged in any programming. Medical record has no record of programming. 4) On 1/17/12 R12-R13 were not engaged in any specialized rehabilitation (rehab) programming during the hours of 9:30am- 3:00pm. On 1/18/12 at 2:16pm, there was no documentation related to specialized rehab (either within the facility or outside of the facility) located in the charts for R12-R13, whom were identified as having serious mental illnesses. E2 (Assistant Administrator) stated that R12 refuses everything. There was no documentation located in R12's chart related to R12 refusing specialized programming or interventions there of. E2 stated that E7 was	F 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146078	A. BUILDING _____ B. WING _____	01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 406	Continued From page 14 previously in a day program, but the program ended in Nov 2010. E2 goes on to state that there are no specialized rehab programs provided for E12 and E13 either within, or outside of the facility.	F 406		