STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E160	A. BUILDING _____ B. WING _____	C 12/13/2011

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

(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 Incident Report Investigation of 11/17/11/IL55429 - F225 and F279	F 000		
F 225 SS=D	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	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 survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to investigate allegation of verbal threat and allegation of attempted physical abuse involving 2 residents out of 8 residents (R3 and R5) reviewed for abuse. Findings include : Per hospital initial psychiatric evaluation of R3 on 10/29/11, R3 has Bipolar Disorder. R3's nurses note dated 11/25/11 indicated that at 2 PM, R3 threatened to kill R5 after R5 told staff R3 stole his DVD player. During 11/30/11 interview at 11:25 AM, R5 said that his DVD Player had been missing for 2 weeks, but that he saw R3 playing it in the facility's courtyard. R5 said that he took it from R3 but later, R3 wanted to fight R5 near the elevator, while staff was there. R5 said that R3 said " I'm gonna whoop your ass." Per E3 (agency nurse) during 11/30/11 interview at 11 AM, the Caucasian resident (referring to R3) got upset after he was accused by the African-American resident (referring to R5) of stealing R5's DVD Player. E3 continued that R3 indeed threatened to kill R5 during the	F 225		

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F 225	Continued From page 2 verbal altercation. Facility's abuse files showed no indication that this allegation of verbal threat and abuse was investigated by the facility to determine intent. Review of the facility's incident report dated 11/25/11 only showed an investigation of R5's allegation that R3 stole his DVD Player. There also was no indication that IDPH was notified of the initial and final abuse investigation involving R3 and R5 surrounding this incident. When E2 (Director of Nursing) was asked on 11/29/11 at 3:30 PM, E2 denied any verbal threats or fist fight during this incident on 11/25/11 between R3 and R5. Similarly, R3's nurses notes dated 11/7/11 indicated that at 4:00 PM, R3 reported that another resident attempted to hit him . There was no indication that this allegation was investigated, nor was there indication that IDPH was notified. According to E4 (nurse) during 11/30/11 interview, R3 informed her that a tall man tried to hit him (R3), and that R3 doesn't know who it was. E4 said that she probably informed E2 (Director of Nursing), but did not make an incident report. Review of facility's abuse files shows no incident report or any investigation involving this. Per E1 (administrator) on 11/30/11, the facility did not investigate this allegation because R3 could not even say if it was a white or black resident.	F 225		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 3 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to put in place a care plan addressing one resident's verbal threats towards other residents and failed to update his care plan on active drug use, for 1 resident out of 9 residents (R3) reviewed for care plan. Findings include : R3's nurses note dated 11/25/11 indicated that at 2 PM, R3 threatened to kill R5 after R5 told staff R3 stole his DVD player.	F 279		

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F 279	Continued From page 4	F 279		

During 11/30/11 interview at 11:25 AM, R5 said that his DVD Player had been missing for 2 weeks, but that he saw R3 playing it in the facility's courtyard. R5 said that he took it from R3 but later, R3 wanted to fight R5 near the elevator, while staff was there. R5 said that R3 said " I'm gonna whoop your ass."

Per E3 (agency nurse) during 11/30/11 interview at 11 AM, the Caucasian resident (referring to R3) got upset after he was accused by the African-American resident (referring to R5) of stealing R5's DVD Player. E3 continued that R3 indeed threatened to kill R5 during the verbal altercation.

Review of R3's nurses notes dated 11/15/11 indicated that at 9:50 PM, R3 was tested positive for THC, and that his guardian was notified.

E5 (nurse) verified during 11/30/11 interview at 3:13 PM, that she did a random drug test on R3 on 11/15/11, and that R3 tested positive for THC. E5 said that she can't remember if she notified R3's case worker.

Review of R3's care plan showed no indication of a care plan to address R3's verbal threat towards R5 on 11/25/11. There is also no care plan revision on R3's drug use care plan, even when he tested positive for THC on 11/15/11.

E6 (case worker) said on 11/30/11 at 1:13 PM, that R3 has no care plan addressing verbal threats or aggression towards other residents, because E6 was not aware of any verbal threats

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F 279	Continued From page 5 that R3 made against another resident. E6 also denied knowing that R3 was positive for drug test while at the facility. E6 said that if R3 became positive during a drug test, R3's care plan will be updated.	F 279		