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 _____	03/31/2011

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 Annual Licensure and Certification Survey Licensure Survey for SubPart S: SMI An extended survey was conducted.	F 000		
F 152	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain permission for annual flu and pneumonia vaccines from the guardian for 1 of 24 (R13) sampled residents. Findings include: R13 is a 69 year old male with diagnoses that include Bipolar, Hypertension, Dementia, and Hypothyroidism. During a review of R13's clinical record the facility documented that immunizations injections for influenza, and pneumococcal vaccinations had been offered to R13 on 10/18/10 and that R13 signed the consent form indicating that he was refusing the injections.	F 152		5/1/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E160	A. BUILDING _____ B. WING _____	03/31/2011

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 152	Continued From page 1 Z4 (guardian) stated in an interview on 3/17/11 at 2:30 PM, stated that he is R13's legal guardian. Z4 further stated that R13 does not always make sound decisions to protect R13's health. Z4 also stated that he has asked the facility in the past to please contact him with regards to health care decisions.	F 152		
F 154	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to inform and educate 2 of 24 sampled residents(R 8 and R20), who is receiving the medication Risperdal and Ativan, prior to administering. This failure has the potential to affect all residents that receive psychotropic medications. Findings Include: 1) R8 is a 47 year old resident admitted to the facility on 11-8-10 with medical diagnosis which includes Schizophrenia. On 3-14-11, an order was obtained for Risperdal to be given, 3 milligrams, twice daily. Risperdal is an	F 154		5/1/11

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 _____	03/31/2011

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 154	Continued From page 2 antipsychotic agent. Possible side effects includes confusion, agitation, blurred vision, and urinary retention. Review of the clinical record indicates that there was no informed consent related to the medication Risperdal. Review of the MAR (Medication Administration Record) indicates that R8 has received 5 dosages of the medication. Interview with E15 (Licensed Practical Nurse) on 3-18-11 at 2:30pm stated that prior to administration of any psychotropic medication, the resident is to be educated on the possible side effects and that if accepted, the resident would be asked to sign the consent form. This was not done. 2) Record review of physician's order sheet for R20 denotes on 12-30-10 to give Ativan 1 milligram intramuscular or by mouth every 4 hours as needed for anxiety. Record review of the controlled drug sheet for R20 denotes Ativan 1 tab was given by mouth every day as ordered by the doctor, 2-9-11 thru 2-19-11 every day. Record review of the informed consent for psychoactive medications for R20 are Cymbalta, Valium, Depakote, and Trazadone. E4 (assistant director of nursing) at 2:10 PM on 3-17-11, states when the doctor ordered Ativan a new informed consent for psychoactive medication for Ativan should have been created. E4 states the informed consent for psychoactive medication for Ativan was not in the chart were it is suppose to be. E4 states the consent is in medical records, but was not sure of this.	F 154		
F 167	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by	F 167		5/1/11

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 _____	03/31/2011

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 167	Continued From page 3 Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure that the posting of the facility's previous annual survey is complete. Findings include : During observation on 3/15/11 at 1:40 PM, the facility's previous annual survey posted on the 1st floor hallways was noted to be incomplete. The survey only included a F167 tag and partial pages for the F406 tag. Review of Casper Report 0003D indicated that on 2/18/10, the facility was cited F167, F250, F253, F323, F325, and F406. Per E1 (Administrator) during Daily Status Meeting on 3/15/11, it's always complete and the residents must have taken the rest of the survey pages.	F 167		
F 223	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	F 223		5/1/11

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 _____	03/31/2011

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 223	Continued From page 4 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 interview and record review, the facility failed : - to ensure 3 residents (R22, 25, and 26) in the sample of 24 are free from physical abuse and verbal abuse from staff, - to protect R22, and other residents residing on the 3rd floor, after abuse had taken place on 2/15/11 by allowing the abuser (E33 -nurse) to finish working the shift, - to report the abuse incident to Administration immediately when it happened on 2/15/11, -to have staff who had been properly trained in abuse protocols and reporting of abuse, - to report R22's abuse to the state agency, and investigate and report 45 other incidents of possible abuse. This resulted in R22 being hospitalized because of injury, and then refusing to go back to the facility because he feared for his safety. This failure resulted in an Immediate Jeopardy which was determined to start when on 2/15/11 at 9 PM, E33 (nurse) physically abused R22 which resulted to R22's mouth bleeding. E1 (Administrator), E2 (Director of Nurses) were notified of the Immediate Jeopardy on 3/17/11 at 1:35PM. Findings include :	F 223		

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 _____	03/31/2011

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 223	Continued From page 5	F 223		

1) R22 has diagnoses of Bipolar Disorder, Schizoaffective Disorder, and Asthma. R22 resided on the 3rd floor and this incident took place on the 3-11pm shift.

Nursing notes written by E33 (nurse) on 2/15/11 at 9:35pm state that R22 was delusional, grabbed E33's hair, and attacked E33 due to hearing voices.

R34 stated 3/17/11 at 1 PM, that he saw R22 yell at E33 who was at the nurses station. E33 then came out from behind the station and told R22 that he was going to "kick (R22's) ass." E33 got R22 in a headlock and starting hitting him. R22 was able to get away from E33 momentarily and then E33 started hitting R22 again after a short pause. R34 said that although R22 tried to fight, "(R22) cannot do anything against E33". R34 added that E32 (Certified Nursing Assistant - CNA) was there but was scared and was screaming for security.

E36's (Security Guard) signed statement dated 2/16/11 states that around 9:30 PM of 2/15/11, E36 ran from the 2nd floor to the 3rd floor because E32 was screaming for security and he heard a commotion on the 3rd floor. When he got to the 3rd floor, he saw E33 and R22 standing in front of each other, and R22 was bleeding from his mouth. Both R22 and E33 were cursing at each other as he was walking R22 to his room. Upon reaching the double doors (which were located near the nurse's station), E33 grabbed R22 by his shirt again and pulled R22 back towards the front to give R22 a PRN (as needed) medication. E36 told E33 that he was going to

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 _____	03/31/2011

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 223	Continued From page 6	F 223		

take R22 to his room first to change his clothes and to "cool him off". After this, E36 walked R22 back to the nurses station, where E33 gave R22 an injection.

E36 verified on 3/17/11at 12:10 PM, that his statement was true as it was written. E36 also stated that after the incident on 2/15/11, he made a report and put it under E1's (Administrator's) door. E1 later denied getting this report.

Despite of E36's seeing R22 bleeding from the lip while facing E33, E36 did not verbally report this allegation of abuse immediately to E1 (Administrator) or other administrative staff.

Review of E36's personnel file showed no evidence that E36 was given an orientation inservice on abuse policy and procedures, upon hire (12/15/10), nor had E36 attended an abuse inservice on 1/19/11.

E32 (CNA) stated on 3/18/11 at 10:51 AM, that E33 came out of the desk and "fought R22". E32, who was present during the actual physical fight between R22 and E33, did not call and report this abuse immediately to E1 (Administrator) or any of the administrative staff. E32 stated she didn't know she was suppose to report this fight until she attended an inservice on 2/18/11 about abuse after the incident had happened .
When her file was reviewed, E32 did not have any abuse training upon hire ; E32 also did not attended the inservice on abuse on 1/19/11

On 3/17/11 at 12:33 PM, Z3 (agency nurse) said that she worked on the 2nd floor on 2/15/11 and

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 _____	03/31/2011

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 223	Continued From page 7 came to the 3rd floor with a security staff. Z3 said she saw that "(R22) got (E33) by the hair, and that security got between the 2 of them". Z3 she saw R22 pulling E33's hair also but did not suspect abuse despite of actual physical contact between the two. Z3 added that she did not see R22's face as the security quickly took R22 away. Z3 said she did not suspect any abuse, and did not ask E33 if he had hit R22 because Z3 said she "had no reason to". Z3 also did not assess the resident or assist the resident in any way. Z3 also admitted during above interview that she did not have any abuse inservices prior to working in the facility as an agency nurse E39 (Security Guard) stated on 3/23/11 at 11 AM, that on 2/15/11, when he got to the 3rd floor after hearing E32 screaming on the radio, the altercation between R22 and E33 was already finished. E39 said that at that time, E33 was in the nurses station and R22 was at the area across the nurses station with E36 in the vicinity of R22. E39 stated that R22 was still cursing, and E33 said that R22 pulled out his hair. E39 got to the 3rd floor only after the physical altercation was already over but did not inquire about what had happened or get any information. E39 did state that a fight between a staff and a resident qualifies as a abuse allegation. During interview with E2 (Assist. Adm.) on 3/17/11 at 11:05 AM, E2 said that the facility started the investigation on 2/16/11 only after R18 asked E25 (Security) if E25 heard that E33 beat up and busted R22's lip the night before. E25 confirmed this on 3/17/11 at 12:05 PM and added that R18 asked him about the fight	F 223		

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 _____	03/31/2011

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 223	Continued From page 8 between R22 and E33 around noon time on 2/16/11. Per review of incident reports there were 12 residents (R's 4,13,17,18, 38, 39, 41 44, 46, 50, 58, and 65) as of 2/15/11, with documented aggressive behaviors under E33's care that night. E39 said during the 3/23/11 interview at 11 AM, that all residents in the facility have probably been verbally aggressive to staff at one point. The residents with documented and potential aggressive behaviors are being taken care of on the same floor by E33. The allegation was not reported immediately to administrative staff at the time it happened and the abuser (E33) was allowed to finish his shift on 2/15/11 placing the other 79 residents on the 3rd floor at risk for abuse. Review of personnel staff files showed that aside from E32 and E36, the following files of security staff showed the following: a) E19 - hired 3/15/11 - no evidence of abuse prevention training/ inservice upon hire b) E40 - hired 1/12/11 - no evidence of abuse prevention training/ inservice upon hire c) E41 - hired 7/24/07 - no evidence of abuse prevention training/ inservice upon hire d) E42 - hired 9/15/07 - no evidence of abuse prevention training/ inservice upon hire e) E43 - hired 5/4/10 - no evidence of abuse prevention training/ inservice upon hire f) E43 - hired 12/6/04 - no evidence of abuse prevention training/ inservice upon hire g) E44 - hired 12/2/09 - with abuse packet in	F 223		

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 _____	03/31/2011

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 223	Continued From page 9 file but abuse quiz was blank. Review of facility abuse inservice dated 1/19/11, showed that E's 19, 32, 36, 40, 41, 42, 43, 44, and 45 (security staff) did not attend this inservice. There was no indication that the agency nurses used by the facility were given a inservice on abuse to ensure that they know how to identify abuse, and to ensure that they know what they are supposed to do in case there is an allegation of abuse. During 3/23/11 interview with E46 (staffing coordinator) at 11:30 AM, E46 said that upon hire, although the new staff is given a packet that includes abuse prevention policy and procedure, there is really no one in the facility who sits downs with the new hires and discusses with them, the contents of the packet. The inservices on abuse were not started until 2/18/11 and ended with only 57 employees out of 133 attending. Those who did not get the inservice included E36, E39, and Z3. E46 said she "did not get all of the staff as some did not pick up their checks and did not attend the inservice". Review of the staff orientation packet given to new hires showed abuse policy and procedures including types of abuse, immediate reporting, separating abusers from the residents, immediate investigation, removing of the employee from further resident contact, etc. .	F 223		

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 _____	03/31/2011

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 223	Continued From page 10 E1 (Administrator) and E2 were made aware of the abuse incident between E33 and R22 on 2/16/11. The facility did not immediately inservice the staff on abuse to ensure that allegations are reported immediately, that allegations are investigated immediately, and that the victims of the alleged abuse are protected from perpetrator. 2) On 3/17/11 at 10:30 AM, E23 (smoking monitor) was observed standing in the hall of the main lobby of the facility near the elevator. E23 was observed yelling at R26 in a disrespectful tone. E23 yelled "pull your pants up and pull them up right now". R26 was observed wearing a belt on his pants. The pants were observed to be low around R26's mid buttocks area. E23 stated when interviewed at this time that he did not mean to yell at R26 and speak to the resident in a disrespectful manner. At 2:30 PM on 3/17/11 E23 was observed dispensing cigarettes to the residents on the smoking patio. R25 was observed to approach E23 and ask for a cigarette. E23 began to yell at R25 in a loud voice stating "didn't I tell you that you don't have any more cigarettes, now get out of line". E23 stated when interviewed after the incident and stated that he was aware of the abuse policy of the facility and that he was aware that residents are not to be yelled at or spoken to in an disrespectful tone. E23 also stated that he was also aware that this was verbal abuse.	F 223		

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 _____	03/31/2011

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 223	Continued From page 11 The above incident was reported to E23's direct supervisor, E22 (director of activities) at 2:45 PM. E22 stated that she would have a talk with E23. E22 further stated when interviewed at 3:20 PM, that she had spoken to E23 concerning his verbal abuse against R25 and R26. E22 failed to state that the above incidents were documented and reported to the facility's abuse coordinator per facility policy. E1 (administrator) stated when interviewed on 3/18/11 at 12:20 PM, that the above incident had been reported to her on 3/17/11 at 3:00 PM. E1 further stated that E23 had been sent home at 3:15 PM on 3/17/11. E1 stated that she had not documented the incidents or sent a copy of the initial report to the department of public health, nor had E1 begun an investigation into the verbal abuse incidents. . 3) Per review of the facility's abuse files the following incidents involving 12 sampled residents (R4, 5, 9, 10, 11, 13, 15, 17, 18, 19, 22) and 33 residents outside of the sample (30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 60, 61, 62, 63, 64, 65, 66 and 67) were noted to have not been investigated as abuse allegations. The facility as a result did not notify IDPH of the initial and final report of the investigation to determine if there really was abuse, nor had the facility investigated to determine if the physical altercations and allegations of abuse were willful and intentional or just part of the residents psychiatric diagnoses. Examples are as follows: a) R30 hit R15 on 12/31/10 because R15	F 223		

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 _____	03/31/2011

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 223	Continued From page 12 called R30 names. R15 sustained 2 lacerations above the eye. b) Per incident report dated 1/14/11, R13 accused R41 of hitting him. Per incident report, there was redness to R13's left jaw. c) R13's 12/26/10 incident report indicated R13 hit his roommate R42 with a shoe. Per report, R13 said he was mad because he did not get his date. d) Per incident report dated 1/10/11, R35 alleged that R15 put her hand on her (R35's neck. No abuse investigation was done nor was IDPH notified. e) R36 alleged that she was hit 3-4 times by a 3rd floor resident while she was in bed. There was no accompanying report that the facility investigated this to determine the identity of this resident to ensure that other residents are protected from this unknown perpetrator. No abuse investigation was done nor the IDPH was notified. f) R5 struck a staff member on 1/2/11 and punched a CNA (certified nurse aide) in the head on 12/12/10, per incident reports. No evidence in the abuse files that this was investigated, to ensure that staff as a result did not hit resident back. g) R22 stomped R31's foot and punched R31 on 1/2/11. No abuse investigation nor IDPH notification was done. h) R19 accused a resident of beating her face	F 223		

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 _____	03/31/2011

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 223	Continued From page 13	F 223		

and head and hit her on the right shoulder with a fan on 2/8/11. On 12/10/10, R19 alleged that she was punched by R67. For both these incidents, there were abuse investigations and IDPH notifications noted in the facility's abuse files.

i) On 2/14/11, R37 got up of her chair and hit another resident without provocation. There was no abuse investigation and IDPH notification noted for this incident. There also was no indication in the incident report of who this other resident is.

j) On 2/18/11, R44 attacked and wrestled R38. R44 said he wrestled R38 because R38 of spitting on his face and R38 denied the allegation. There was no abuse investigation noted nor was there IDPH notification.

k) On 12/8/10, R44 alleged that he was hit by another resident after saying " Kirk Douglas" . The other resident was just identified with initials but incident report does not indicated who this other resident is. No abuse investigation no IDPH notification was found.

On 12/11/10, R66 swung at R44 after R66 alleged that R44 threatened R66 and was at R66's face. Although R44 denied he threatened R66, a staff saw R44 threatened R66 and walked right to R66's face. No evidence of abuse investigation was found nor IDPH notification.

l) R40 hit R46 on 2/26/11. R40 said she hit R46 because R46 won't share her food. R40 also threatened and cursed staff. No abuse investigation was found and no IDPH notification was done.

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 _____	03/31/2011

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 223	Continued From page 14	F 223		

m) On 12/2/10, R47 kicked R48 on her left leg because R48 wouldn't give R47 her coleslaw. No abuse investigation or IDPH notification was made.

n) R37 punched R49 on the left jaw without provocation while standing at the medication line on 2/14/11. There was no abuse investigation noted nor was there IDPH notification.

o) On 2/14/11, R43 was hit by another resident while she was standing in front of the nurses station. The identity of the other resident wasn't shown in this incident report. There was no abuse investigation noted nor was there IDPH notification.

p) On 2/28/11, R9 alleged that R11 hit her on her shoulder and thus she hit him back. There was no abuse investigation noted nor was there IDPH notification.

q) R50 alleged that on 3/1/11, R17 pushed him for no reason. This resulted in a fight. There was no abuse investigation noted nor was there IDPH notification.

s) R52 slapped R51 in the arm on 3/4/11 while they were in the bathroom. R51 said she tried to remove R52's purse from the sink so R51 could wash her hands, but was slapped by R52. There was no abuse investigation noted nor was there IDPH notification.

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 _____	03/31/2011

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 223	Continued From page 15	F 223		

t) On 3/8/11, while in the cigarette line, R53 became verbally aggressive and punched a staff on the right jaw after staff told her to put a coat on. No abuse investigation was done to determine is staff retaliated back. There was no abuse investigation noted nor was there IDPH notification.

u) On 3/11/11, R4 alleged that R18 punched R4 on the chest and arm. Another resident confirmed this. R18 said he was just playing. There was no abuse investigation noted nor was there IDPH notification.

v) R54 wanted to sign AMA on 3/19/11, grabbed a pole from the tent and hit the security. There was no abuse investigation noted nor was there IDPH notification.

w) R56 slapped R55 on the face on 3/11/11 unprovoked. There was no abuse investigation noted nor was there IDPH notification.

x) On 11/27/10, R58 pushed R57 after R57 would not move out of R58's way. This resulted to mutual pushing. There was no abuse investigation noted nor was there IDPH notification.

y) On 11/24/10, R41 put his hands around R4 to choke him or push him away. R41 was

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 _____	03/31/2011

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 223	Continued From page 16 agitated, delusional, and hard to redirect. R41 said it is because R4 touched R41's hair. There was no abuse investigation noted nor was there IDPH notification. z) On 11/24/10, R60 hit R63 without provocation. R60 said he doesn't not like R63 that is why. There was no abuse investigation noted nor was there IDPH notification. aa) R61 scratched a resident on the right neck on 11/23/10. R61 stated she was being bothered by this other resident , calling R61 a Hub. The other resident was only identified with an initial KK and there was no indication in the report who this is. There was no abuse investigation noted nor was there IDPH notification. bb) On 11/20/10, R62 threw a chair at R63 and spat at her face. R62 said that R63 hit him first. R63 said she was just sitting in line when R62 spat at her and threw a chair at her. There was no abuse investigation noted nor was there IDPH notification. cc) R10 arrived from a hospital with scrapes and scabs on both knees on 12/27/10. R10 alleged that hospital security threw him on the ground. Although facility called the hospital and got in touch with the unit coordinator who said the hospital is going to investigate the allegation, there was no facility investigation, follow up and reporting sent to IDPH. dd) On 12/26/10 at 1:45 PM, while R64 was sitting in the dining room, R65 run towards her	F 223		

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 _____	03/31/2011

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 223	Continued From page 17 with a butter knife and a fork and threatened her. R64 scratched R65 on his face in self defense. R65 said R64 keeps on bugging him, so he had to do something so she leaves R65 alone. There was no abuse investigation noted nor was there IDPH notification. While the Immediacy was removed on 3/23/11, the facility remains out of compliance at severity level 2, because the facility has yet to inservice the new hires on all shifts, has yet to assess if new interventions and policies are effective on the possible affected residents, and the facility's evaluation of the new plan of care has yet to be conducted. The facility took the following steps to correct the Immediate Jeopardy: 1) E33 was terminated after the allegation of abuse was substantiated by the facility investigation which started 2/16/11. E33's last working day was on 2/15/11, when he finished his 3-11 shift after the abuse incident. 2) All scheduled staff were immediately inserviced on abuse prevention policy by the Social service Consultant, E1 and E3, focusing on immediate reporting of abuse allegations and protection of residents. This started on 3/17/11 at 3:00 PM This will be monitored by E1 or her designee for compliance. 3) No staff member will be scheduled to work until they had been inserviced on abuse. 4) All agency nurses will be inserviced by their agency on the facility's abuse policy and	F 223		

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 _____	03/31/2011

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 223	Continued From page 18 procedure prior to being scheduled to work at the facility. They will not be allowed to work at the facility, until written proof of abuse inservice attended is given to the facility. This was completed on 3/23/11. 5) New hires will not be allowed to work until abuse inservice that includes policy on reporting and resident protection is completed by the new staff. This will be monitored by the Administrator/ designee and will be a part of the facility's weekly QA process. 6) Continuing abuse inservice will be given monthly by the Social Service Consultant, including timely reporting of abuse allegation and resident protection. This inservice will include the security department. This will be monitored monthly by the Administrator/designee to ensure 100% compliance of all employees, as part of the QA process. 7) Nurse consultant will come to the facility twice a month to monitor if facility and administration is compliant with the monthly inservicing of staff by Social Service Consultant, with the inservicing on abuse of the agency staff prior to working, and with the weekly QA process to ensure new hires had been given abuse inservice prior to start.	F 223		
F 225	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	F 225		5/1/11

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 _____	03/31/2011

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 225	Continued From page 19 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 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 3 residents (R22, 25, and 26) in the sample of 24 are free from physical abuse and verbal abuse from staff,	F 225		

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 _____	03/31/2011

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 225	Continued From page 20 - to protect R22, and other residents residing on the 3rd floor, after abuse had taken place on 2/15/11 by allowing the abuser (E33 -nurse) to finish working the shift, - to report the abuse incident to Administration immediately when it happened on 2/15/11, -to have staff who had been properly trained in abuse protocols and reporting of abuse, - to report the abuse to the state agency and investigate 45 other incidents of possible abuse. This resulted in R22 being hospitalized because of injury,and then refusing to go back to the facility because he feared for his safety. This failure resulted in an Immediate Jeopardy which was determined to start when on 2/15/11 at 9 PM, E33 (nurse) physically abused R22 which resulted to R22's mouth bleeding. E1 (Administrator), E2 (Director of Nurses) were notified of the Immediate Jeopardy on 3/17/11 at 1:35PM. Findings include : 1) R22 has diagnoses of Bipolar Disorder, Schizoaffective Disorder, and Asthma. R22 was initially admitted to the facility on 8/12/10. R22 resided on the 3rd floor. The incident took place on the 3-11pm shift. Nursing notes written by E33 (nurse) on 2/15/11 at 9:35pm state that R22 was delusional and grabbed E33's hair and attacked E33 due to hearing voices. R34 stated 3/17/11 at 1 PM, that he saw R22 yell at E33 who was at the nurses station. E33 then	F 225		

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 _____	03/31/2011

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 225	Continued From page 21 came out from behind the station and told R22 that he was going to "kick (R22's) ass". E33 got R22 in a headlock and starting hitting him. R22 was able to get away from E33 momentarily and then E33 started hitting R22 again after a short pause. R34 said that although R22 tried to fight, "(R22) cannot do anything against E33". R34 added that E32 (Certified Nursing Assistant - CNA) was there but was scared and was screaming for security. E36's (Security Guard) signed statement dated 2/16/11 states that around 9:30 PM of 2/15/11, E36 ran from the 2nd floor to the 3rd floor because E32 was screaming for security and he heard a commotion on the 3rd floor. When he got to the 3rd floor, he saw E33 and R22 standing in front of each other, and R22 was bleeding from his mouth. Both R22 and E33 were cursing at each other as he was walking R22 to his room. Upon reaching the double doors (which were located near the nurse's station), E33 grabbed R22 by his shirt again and pulled R22 back towards the front to give R22 a PRN (as needed) medication. E36 told E33 that he was going to take R22 to his room first to change his clothes and to cool him off. After this, E36 walked R22 back to the front, where E33 gave R22 an injection. E36 verified on 3/17/11at 12:10 PM, that his statement was true as it was written. E36 also stated that after the incident on 2/15/11, he made a report and put it under E1's (Administrator's) door. Despite of E36's seeing R22 bleeding from the lip while facing E33, E36 did not verbally report this	F 225		

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 _____	03/31/2011

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 225	Continued From page 22 allegation of abuse immediately to E1 (Administrator) or other administrative staff. Review of E36's personnel file showed no evidence that E36 was given an orientation inservice on abuse policy and procedures, upon hire (12/15/10), nor had E36 attended an abuse inservice on 1/19/11. E32 (CNA) stated on 3/18/11 at 10:51 AM, that E33 came out of the desk and "fought R22". E32, who was present during the actual physical fight between R22 and E33, did not call and report this abuse immediately to E1 (Administrator) or any of the administrative staff. E32 stated she didn't know she was suppose to report this fight until she attended an inservice on 2/18/11 about abuse after the incident had happened . When her file was reviewed, E32 did not have any abuse training upon hire ; E32 also did not attended the inservice on abuse on 1/19/11 On 3/17/11 at 12:33 PM, Z3 (agency nurse) said that she worked on the 2nd floor on 2/15/11 and came to the 3rd floor with a security staff. Z3 said she saw that "(R22) got (E33) by the hair, and that security got between the 2 of them". Z3 she saw R22 pulling E33's hair also but did not suspect abuse despite of actual physical contact between the two. Z3 added that she did not see R22's face as the security quickly took R22 away. Z3 said she did not suspect any abuse, and did not ask E33 if he had hit R22 because Z3 said she "had no reason to". Z3 also did not assess the resident or assist the resident in any way. Z3 also admitted during above interview that she did not have any abuse inservices prior to	F 225		

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 _____	03/31/2011

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 225	Continued From page 23 working in the facility as an agency nurse E39 (Security Guard) stated on 3/23/11 at 11 AM, that on 2/15/11, when he got to the 3rd floor after hearing E32 screaming on the radio, the altercation between R22 and E33 was already finished. E39 said that at that time, E33 was in the nurses station and R22 was at the area across the nurses station with E36 in the vicinity of R22. E39 stated that R22 was still cursing, and E33 said that R22 pulled out his hair. E39 got to the 3rd floor only after the physical altercation was already over but did not inquire about what had happened or get any information. E39 did state that a fight between a staff and a resident qualifies as a abuse allegation. During interview with E2 (Assist. Adm.) on 3/17/11 at 11:05 AM, E2 said that the facility started the investigation on 2/16/11 only after R18 asked E25 (Security) if E25 heard that E33 beat up and busted R22's lip the night before. E25 confirmed this on 3/17/11 at 12:05 PM and added that R18 asked him about the fight between R22 and E33 around noon time on 2/16/11. Per review of incident reports there were 12 residents (R's 4,13,17,18, 38, 39, 41 44, 46, 50, 58, and 65) as of 2/15/11, with documented aggressive behaviors under E33's care that night. E39 said during the 3/23/11 interview at 11 AM, that all residents in the facility have probably been verbally aggressive to staff at one point. The residents with documented and potential aggressive behaviors are being taken care of on	F 225		

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 _____	03/31/2011

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 225	Continued From page 24 the same floor by E33. The allegation was not reported immediately to administrative staff at the time it happened and the abuser (E33) was allowed to finish his shift on 2/15/11 placing the other 79 residents on the 3rd floor at risk for abuse. Review of personnel staff files showed that aside from E32 and E36, the following files of security staff showed the following: a) E19 - hired 3/15/11 - no evidence of abuse prevention training/ inservice upon hire b) E40 - hired 1/12/11 - no evidence of abuse prevention training/ inservice upon hire c) E41 - hired 7/24/07 - no evidence of abuse prevention training/ inservice upon hire d) E42 - hired 9/15/07 - no evidence of abuse prevention training/ inservice upon hire e) E43 - hired 5/4/10 - no evidence of abuse prevention training/ inservice upon hire f) E43 - hired 12/6/04 - no evidence of abuse prevention training/ inservice upon hire g) E44 - hired 12/2/09 - with abuse packet in file but abuse quiz was blank. Review of facility abuse inservice dated 1/19/11, showed that E's 19, 32, 36, 40, 41, 42, 43, 44, and 45 (security staff) did not attend this inservice. There was no indication that the agency nurses used by the facility were given a inservice on abuse to ensure that they know how to identify abuse, and to ensure that they know what they are supposed to do in case there is an allegation of abuse.	F 225		

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 _____	03/31/2011

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 225	Continued From page 25 During 3/23/11 interview with E46 (staffing coordinator) at 11:30 AM, E46 said that upon hire, although the new staff is given a packet that includes abuse prevention policy and procedure, there is really no one in the facility who sits downs with the new hires and discusses with them, the contents of the packet. The inservices on abuse were not started until 2/18/11 and ended with only 57 employees out of 133 attending. Those who did not get the inservice included E36, E39, and Z3. E46 said she "did not get all of the staff as some did not pick up their checks and did not attend the inservice". Review of the staff orientation packet given to new hires showed abuse policy and procedures including types of abuse, immediate reporting, separating abusers from the residents, immediate investigation, removing of the employee from further resident contact, etc. . E1 (Administrator) and E2 were made aware of the abuse incident between E33 and R22 on 2/16/11. The facility did not immediately inservice the staff on abuse to ensure that allegations are reported immediately, that allegations are investigated immediately, and that the victims of the alleged abuse are protected from perpetrator. 2) On 3/17/11 at 10:30 AM, E23 (smoking monitor) was observed standing in the hall of the main lobby of the facility near the elevator. E23 was observed yelling at R26 in a disrespectful	F 225		

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 _____	03/31/2011

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 225	Continued From page 26 tone. E23 yelled "pull your pants up and pull them up right now". R26 was observed wearing a belt on his pants. The pants were observed to be low around R26's mid buttocks area. E23 stated when interviewed at this time that he did not mean to yell at R26 and speak to the resident in a disrespectful manner. At 2:30 PM on 3/17/11 E23 was observed dispensing cigarettes to the residents on the smoking patio. R25 was observed to approach E23 and ask for a cigarette. E23 began to yell at R25 in a loud voice stating "didn't I tell you that you don't have any more cigarettes, now get out of line". E23 stated when interviewed after the incident and stated that he was aware of the abuse policy of the facility and that he was aware that residents are not to be yelled at or spoken to in an disrespectful tone. E23 also stated that he was also aware that this was verbal abuse. The above incident was reported to E23's direct supervisor, E22 (director of activities) at 2:45 PM. E22 stated that she would have a talk with E23. E22 further stated when interviewed at 3:20 PM, that she had spoken to E23 concerning his verbal abuse against R25 and R26. E22 failed to state that the above incidents were documented and reported to the facility's abuse coordinator per facility policy. E1 (administrator) stated when interviewed on 3/18/11 at 12:20 PM, that the above incident had	F 225		

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 _____	03/31/2011

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 225	Continued From page 27	F 225		

been reported to her on 3/17/11 at 3:00 PM. E1 further stated that E23 had been sent home at 3:15 PM on 3/17/11. E1 stated that she had not documented the incidents or sent a copy of the initial report to the department of public health, nor had E1 begun an investigation into the verbal abuse incidents. .

3) Per review of the facility's abuse files the following incidents involving 12 sampled residents (R4, 5, 9, 10, 11, 13, 15, 17, 18, 19, 22) and 33 residents outside of the sample (30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 60, 61, 62, 63, 64, 65, 66 and 67) were noted to have not been investigated as abuse allegations.
The facility as a result did not notify IDPH of the initial and final report of the investigation to determine if there really was abuse, nor had the facility investigated to determine if the physical altercations and allegations of abuse were willful and intentional or just part of the residents psychiatric diagnoses. Examples are as follows:

a) R30 hit R15 on 12/31/10 because R15 called R30 names. R15 sustained 2 lacerations above the eye.

b) Per incident report dated 1/14/11, R13 accused R41 of hitting him. Per incident report, there was redness to R13's left jaw.

c) R13's 12/26/10 incident report indicated R13 hit his roommate R42 with a shoe. Per report, R13 said he was mad because he did not get his date.

d) Per incident report dated 1/10/11, R35

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 _____	03/31/2011

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 225	Continued From page 28	F 225		

alleged that R15 put her hand on her (R35's neck. No abuse investigation was done nor was IDPH notified.

e) R36 alleged that she was hit 3-4 times by a 3rd floor resident while she was in bed. There was no accompanying report that the facility investigated this to determine the identity of this resident to ensure that other residents are protected from this unknown perpetrator. No abuse investigation was done nor the IDPH was notified.

f) R5 struck a staff member on 1/2/11 and punched a CNA (certified nurse aide) in the head on 12/12/10, per incident reports. No evidence in the abuse files that this was investigated, to ensure that staff as a result did not hit resident back.

g) R22 stomped R31's foot and punched R31 on 1/2/11. No abuse investigation nor IDPH notification was done.

h) R19 accused a resident of beating her face and head and hit her on the right shoulder with a fan on 2/8/11. On 12/10/10, R19 alleged that she was punched by R67. For both these incidents, there were abuse investigations and IDPH notifications noted in the facility's abuse files.

i) On 2/14/11, R37 got up of her chair and hit another resident without provocation. There was no abuse investigation and IDPH notification noted for this incident. There also was no indication in the incident report of who this other resident is.

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 _____	03/31/2011

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 225	Continued From page 29	F 225		

j) On 2/18/11, R44 attacked and wrestled R38. R44 said he wrestled R38 because R38 of spitting on his face and R38 denied the allegation. There was no abuse investigation noted nor was there IDPH notification.

k) On 12/8/10, R44 alleged that he was hit by another resident after saying " Kirk Douglas" . The other resident was just identified with initials but incident report does not indicated who this other resident is. No abuse investigation no IDPH notification was found.

On 12/11/10, R66 swung at R44 after R66 alleged that R44 threatened R66 and was at R66's face. Although R44 denied he threatened R66, a staff saw R44 threatened R66 and walked right to R66's face. No evidence of abuse investigation was found nor IDPH notification.

l) R40 hit R46 on 2/26/11. R40 said she hit R46 because R46 won't share her food. R40 also threatened and cursed staff. No abuse investigation was found and no IDPH notification was done.

m) On 12/2/10, R47 kicked R48 on her left leg because R48 wouldn't give R47 her coleslaw. No abuse investigation or IDPH notification was made.

n) R37 punched R49 on the left jaw without provocation while standing at the medication line on 2/14/11. There was no abuse investigation noted nor was there IDPH notification.

o) On 2/14/11, R43 was hit by another resident

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 _____	03/31/2011

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 225	Continued From page 30 while she was standing in front of the nurses station. The identity of the other resident wasn't shown in this incident report. There was no abuse investigation noted nor was there IDPH notification. p) On 2/28/11, R9 alleged that R11 hit her on her shoulder and thus she hit him back. There was no abuse investigation noted nor was there IDPH notification. q) R50 alleged that on 3/1/11, R17 pushed him for no reason. This resulted in a fight. There was no abuse investigation noted nor was there IDPH notification. s) R52 slapped R51 in the arm on 3/4/11 while they were in the bathroom. R51 said she tried to remove R52's purse from the sink so R51 could wash her hands, but was slapped by R52. There was no abuse investigation noted nor was there IDPH notification. t) On 3/8/11, while in the cigarette line, R53 became verbally aggressive and punched a staff on the right jaw after staff told her to put a coat on. No abuse investigation was done to determine is staff retaliated back. There was no abuse investigation noted nor was there IDPH notification. u) On 3/11/11, R4 alleged that R18 punched R4 on the chest and arm. Another resident	F 225		

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 _____	03/31/2011

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 225	Continued From page 31	F 225		

confirmed this. R18 said he was just playing. There was no abuse investigation noted nor was there IDPH notification.

v) R54 wanted to sign AMA on 3/19/11, grabbed a pole from the tent and hit the security. There was no abuse investigation noted nor was there IDPH notification.

w) R56 slapped R55 on the face on 3/11/11 unprovoked. There was no abuse investigation noted nor was there IDPH notification.

x) On 11/27/10, R58 pushed R57 after R57 would not move out of R58's way. This resulted to mutual pushing. There was no abuse investigation noted nor was there IDPH notification.

y) On 11/24/10, R41 put his hands around R4 to choke him or push him away. R41 was agitated, delusional, and hard to redirect. R41 said it is because R4 touched R41's hair. There was no abuse investigation noted nor was there IDPH notification.

z) On 11/24/10, R60 hit R63 without provocation. R60 said he doesn't not like R63 that is why. There was no abuse investigation noted nor was there IDPH notification.

aa) R61 scratched a resident on the right neck

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 _____	03/31/2011

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 225	Continued From page 32 on 11/23/10. R61 stated she was being bothered by this other resident , calling R61 a Hub. The other resident was only identified with an initial KK and there was no indication in the report who this is. There was no abuse investigation noted nor was there IDPH notification. bb) On 11/20/10, R62 threw a chair at R63 and spat at her face. R62 said that R63 hit him first. R63 said she was just sitting in line when R62 spat at her and threw a chair at her. There was no abuse investigation noted nor was there IDPH notification. cc) R10 arrived from a hospital with scrapes and scabs on both knees on 12/27/10. R10 alleged that hospital security threw him on the ground. Although facility called the hospital and got in touch with the unit coordinator who said the hospital is going to investigate the allegation, there was no facility investigation, follow up and reporting sent to IDPH. dd) On 12/26/10 at 1:45 PM, while R64 was sitting in the dining room, R65 run towards her with a butter knife and a fork and threatened her. R64 scratched R65 on his face in self defense. R65 said R64 keeps on bugging him, so he had to do something so she leaves R65 alone. There was no abuse investigation noted nor was there IDPH notification. While the Immediacy was removed on 3/23/11, the facility remains out of compliance at severity level 2, because the facility has yet to inservice the new hires on all shifts, has yet to assess if new interventions and policies are effective on the possible affected residents, and the facility's	F 225		

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 _____	03/31/2011

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 225	Continued From page 33 evaluation of the new plan of care has yet to be conducted. The facility took the following steps to correct the Immediate Jeopardy: 1) E33 was terminated after the allegation of abuse was substantiated by the facility investigation which started 2/16/11. E33's last working day was on 2/15/11, when he finished his 3-11 shift after the abuse incident. 2) All scheduled staff were immediately inserviced on abuse prevention policy by the Social service Consultant, E1 and E3, focusing on immediate reporting of abuse allegations and protection of residents. This started on 3/17/11 at 3:00 PM This will be monitored by E1 or her designee for compliance. 3) No staff member will be scheduled to work until they had been inserviced on abuse. 4) All agency nurses will be inserviced by their agency on the facility's abuse policy and procedure prior to being scheduled to work at the facility. They will not be allowed to work at the facility, until written proof of abuse inservice attended is given to the facility. This was completed on 3/23/11. 5) New hires will not be allowed to work until abuse inservice that includes policy on reporting and resident protection is completed by the new staff. This will be monitored by the Administrator/ designee and will be a part of the facility's weekly QA process.	F 225		

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 _____	03/31/2011

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 225	Continued From page 34 6) Continuing abuse inservice will be given monthly by the Social Service Consultant, including timely reporting of abuse allegation and resident protection. This inservice will include the security department. This will be monitored monthly by the Administrator/designee to ensure 100% compliance of all employees, as part of the QA process. 7) Nurse consultant will come to the facility twice a month to monitor if facility and administration is compliant with the monthly inservicing of staff by Social Service Consultant, with the inservicing on abuse of the agency staff prior to working, and with the weekly QA process to ensure new hires had been given abuse inservice prior to start.	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 interview and record review, the facility failed to follow their policy on abuse prevention by failing to: - protect R22, and other residents residing on the 3rd floor, after abuse had taken place on 2/15/11 by allowing the abuser (E33 -nurse) to finish working the shift, - to report the abuse incident to Administration immediately when it happened on 2/15/11, -to have staff who had been properly trained in abuse protocols and reporting of abuse,	F 226		5/1/11

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 _____	03/31/2011

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 226	Continued From page 35 - to report the abuse to the state agency and investigate and report 45 other incidents of possible abuse. This failure resulted in an Immediate Jeopardy which was determined to start when on 2/15/11 at 9 PM, E33 (nurse) physically abused R22 which resulted to R22's mouth bleeding. No protection of the resident was done, the abuser (E33) was allowed to finish his work shift, and no reporting of the abuse was done to Administration on 2/15/11. E1 (Administrator), E2 (Director of Nurses) were notified of the Immediate Jeopardy on 3/17/11 at 1:35PM. Findings include: Per facility's policy and procedure on abuse, " Any incident concerning a resident that appears to be abuse or neglect will be reported immediately to the administrator or designee for further investigation. Resident alleging abuse must be protected from harm. The accused perpetrator must be immediately separated from the alleged victim. Employees will be immediately suspended and all consultants and vendors will be asked to leave the building." On 2/15/11 at 9 PM, after R22 yelled at E33 (nurse), E33 got out of the 3rd floor nurses station, and put R22 in a headlock, and started hitting R22. Per R34 who witnessed this abuse, R22 managed to get out of the headlock, but E33 started hitting R22 again. E36 (Security Guard) separated R22 from E33	F 226		

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 _____	03/31/2011

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 226	Continued From page 36	F 226		

when he got to the 3rd floor, but E36 was not able to ensure that R22 was protected and out of reach from E33, as E33 grabbed R22 again while being led by E36 to his room. E36 did not protect the resident from E33.

Z3, E36, and E32 were there and allowed E33 to even give R22 a PRN (as needed) medication injection near the 3rd floor nurses station after the altercation. None of this staff intervened to stop the abuse or assist the resident. No reporting of the abuse was done by any of the staff to administration on 2/15/11.

E39 (Security Guard) stated on 3/23/11 at 11 AM, that on 2/15/11, when he got to the 3rd floor, after hearing E32 screaming on the radio, the altercation between R22 and E33 was already finished.
E39 went to the 3rd floor but did not inquire about what had happened or get any other information. He also did not report the incident to administrative staff.

During interview with E2 on 3/17/11 at 11:05 AM, E2 said that the facility started the investigation only on 2/16/11, after R18 asked E25 (security) if E25 heard that E33 beat up and busted R22's lip the night before. E25 confirmed this on 3/17/11 at 12:05 PM and added that R18, asked him about the fight between R22 and E33 around noon time on 2/16/11.

Review of personnel staff files showed that aside from E32 and E36, the following files of security staff showed the following:

a) E19 - hired 3/15/11 - no evidence of abuse

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 _____	03/31/2011

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 226	Continued From page 37 prevention training/ inservice upon hire b) E40 - hired 1/12/11 - no evidence of abuse prevention training/ inservice upon hire c) E41 - hired 7/24/07 - no evidence of abuse prevention training/ inservice upon hire d) E42 - hired 9/15/07 - no evidence of abuse prevention training/ inservice upon hire e) E43 - hired 5/4/10 - no evidence of abuse prevention training/ inservice upon hire f) E43 - hired 12/6/04 - no evidence of abuse prevention training/ inservice upon hire g) E44 - hired 12/2/09 - with abuse packet in file but abuse quiz was blank. Moreover, review of facility abuse inservice dated 1/19/11, showed that E' s 19, 32, 36, 40, 41, 42, 43, 44, and 45 did not attend this inservice During 3/23/11 interview with E46 (staffing coordinator) at 11:30 AM, E46 said that upon hire, although the new staff is given a packet that includes abuse prevention policy and procedure, there is really no one in the facility who sits downs with the new hires and discusses with them the contents of the packet. Review of the staff orientation packet given to new hires showed abuse policy and procedures including types of abuse, immediate reporting, separating abusers from the residents, immediate investigation, removing of the employee from further resident contact, etc. After E1 and E2 were made aware of the 2/15/11 abuse incident between E33 and R22, the facility did not immediately inservice the staff on abuse. The abuse inservice done by E46 (staffing	F 226		

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 _____	03/31/2011

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 226	Continued From page 38 coordinator) was started on 2/18/11 and ended with only 57 staff inserviced out of the 133 employees in the entire facility. Added to this, there was no indication that the agency nurses used by the facility were given inservice on abuse to ensure that they know how to identify abuse, and to ensure that they know what they are supposed to do in case there is an allegation of abuse. Included in those who did not get inserviced on 2/18/11 were E36, Z3, and E39. E46 said she did not get all the staff, as some did not pick up their checks and did not attend the inservice. The lack of staff training on abuse before and after the incident on 2/15/11, puts all the residents, especially the 3rd floor residents at risk, of not having future abuse allegations reported immediately. This also puts them at risk of being susceptible to the abuse, as the perpetrator (whether a resident or staff) was not immediately removed from direct resident care. Per review of the facility's abuse files the following incidents involving 12 sampled residents (R4, 5, 9, 10, 11, 13, 15, 17, 18, 19, 22) and 33 residents outside of the sample (30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 60, 61, 62, 63, 64, 65, 66 and 67) were noted to have not been investigated as abuse allegations. The facility as a result did not notify IDPH of the initial and final report of the investigation to determine if there really was abuse, nor had the	F 226		

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 _____	03/31/2011

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 226	Continued From page 39	F 226		

facility investigated to determine if the physical altercations and allegations of abuse were willful and intentional or just part of the residents psychiatric diagnoses. Examples are as follows:

a) R30 hit R15 on 12/31/10 because R15 called R30 names. R15 sustained 2 lacerations above the eye.

b) Per incident report dated 1/14/11, R13 accused R41 of hitting him. Per incident report, there was redness to R13's left jaw.

c) R13's 12/26/10 incident report indicated R13 hit his roommate R42 with a shoe. Per report, R13 said he was mad because he did not get his date.

d) Per incident report dated 1/10/11, R35 alleged that R15 put her hand on her (R35's neck. No abuse investigation was done nor was IDPH notified.

e) R36 alleged that she was hit 3-4 times by a 3rd floor resident while she was in bed. There was no accompanying report that the facility investigated this to determine the identity of this resident to ensure that other residents are protected from this unknown perpetrator. No abuse investigation was done nor the IDPH was notified.

f) R5 struck a staff member on 1/2/11 and punched a CNA (certified nurse aide) in the head on 12/12/10, per incident reports. No evidence in the abuse files that this was investigated, to ensure that staff as a result did not hit resident back.

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 _____	03/31/2011

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 226	Continued From page 40	F 226		

g) R22 stomped R31's foot and punched R31 on 1/2/11. No abuse investigation nor IDPH notification was done.

h) R19 accused a resident of beating her face and head and hit her on the right shoulder with a fan on 2/8/11. On 12/10/10, R19 alleged that she was punched by R67. For both these incidents, there were abuse investigations and IDPH notifications noted in the facility's abuse files.

i) On 2/14/11, R37 got up of her chair and hit another resident without provocation. There was no abuse investigation and IDPH notification noted for this incident. There also was no indication in the incident report of who this other resident is.

j) On 2/18/11, R44 attacked and wrestled R38. R44 said he wrestled R38 because R38 of spitting on his face and R38 denied the allegation. There was no abuse investigation noted nor was there IDPH notification.

k) On 12/8/10, R44 alleged that he was hit by another resident after saying " Kirk Douglas" . The other resident was just identified with initials but incident report does not indicated who this other resident is. No abuse investigation no IDPH notification was found.

On 12/11/10, R66 swung at R44 after R66 alleged that R44 threatened R66 and was at R66's face. Although R44 denied he threatened R66, a staff saw R44 threatened R66 and walked right to R66's face. No evidence of abuse investigation was found nor IDPH notification.

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 _____	03/31/2011

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 226	Continued From page 41	F 226		

l) R40 hit R46 on 2/26/11. R40 said she hit R46 because R46 won't share her food. R40 also threatened and cursed staff. No abuse investigation was found and no IDPH notification was done.

m) On 12/2/10, R47 kicked R48 on her left leg because R48 wouldn't give R47 her coleslaw. No abuse investigation or IDPH notification was made.

n) R37 punched R49 on the left jaw without provocation while standing at the medication line on 2/14/11. There was no abuse investigation noted nor was there IDPH notification.

o) On 2/14/11, R43 was hit by another resident while she was standing in front of the nurses station. The identity of the other resident wasn't shown in this incident report. There was no abuse investigation noted nor was there IDPH notification.

p) On 2/28/11, R9 alleged that R11 hit her on her shoulder and thus she hit him back. There was no abuse investigation noted nor was there IDPH notification.

q) R50 alleged that on 3/1/11, R17 pushed him for no reason. This resulted in a fight. There was no abuse investigation noted nor was there IDPH notification.

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 _____	03/31/2011

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 226	Continued From page 42 s) R52 slapped R51 in the arm on 3/4/11 while they were in the bathroom. R51 said she tried to remove R52's purse from the sink so R51 could wash her hands, but was slapped by R52. There was no abuse investigation noted nor was there IDPH notification. t) On 3/8/11, while in the cigarette line, R53 became verbally aggressive and punched a staff on the right jaw after staff told her to put a coat on. No abuse investigation was done to determine is staff retaliated back. There was no abuse investigation noted nor was there IDPH notification. u) On 3/11/11, R4 alleged that R18 punched R4 on the chest and arm. Another resident confirmed this. R18 said he was just playing. There was no abuse investigation noted nor was there IDPH notification. v) R54 wanted to sign AMA on 3/19/11, grabbed a pole from the tent and hit the security. There was no abuse investigation noted nor was there IDPH notification. w) R56 slapped R55 on the face on 3/11/11 unprovoked. There was no abuse investigation noted nor was there IDPH notification. x) On 11/27/10, R58 pushed R57 after R57 would not move out of R58's way. This resulted to mutual pushing. There was no abuse	F 226		

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 _____	03/31/2011

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 226	Continued From page 43 investigation noted nor was there IDPH notification. y) On 11/24/10, R41 put his hands around R4 to choke him or push him away. R41 was agitated, delusional, and hard to redirect. R41 said it is because R4 touched R41's hair. There was no abuse investigation noted nor was there IDPH notification. z) On 11/24/10, R60 hit R63 without provocation. R60 said he doesn't not like R63 that is why. There was no abuse investigation noted nor was there IDPH notification. aa) R61 scratched a resident on the right neck on 11/23/10. R61 stated she was being bothered by this other resident , calling R61 a Hub. The other resident was only identified with an initial KK and there was no indication in the report who this is. There was no abuse investigation noted nor was there IDPH notification. bb) On 11/20/10, R62 threw a chair at R63 and spat at her face. R62 said that R63 hit him first. R63 said she was just sitting in line when R62 spat at her and threw a chair at her. There was no abuse investigation noted nor was there IDPH notification. cc) R10 arrived from a hospital with scrapes and scabs on both knees on 12/27/10. R10 alleged that hospital security threw him on the ground. Although facility called the hospital and got in touch with the unit coordinator who said the	F 226		

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 _____	03/31/2011

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 226	Continued From page 44	F 226		

hospital is going to investigate the allegation, there was no facility investigation, follow up and reporting sent to IDPH.

dd) On 12/26/10 at 1:45 PM, while R64 was sitting in the dining room, R65 run towards her with a butter knife and a fork and threatened her. R64 scratched R65 on his face in self defense. R65 said R64 keeps on bugging him, so he had to do something so she leaves R65 alone. There was no abuse investigation noted nor was there IDPH notification.

Per CMS form 672, all 146 residents in the facility have documented psychiatric diagnosis and all 146 have behavioral symptoms.

Per E1, during Daily Status Meeting on 3/17/11, the facility does not investigate just any resident altercations but they do investigate injuries of unknown origin. When asked to review a specific investigation for R15, none was produced.

While the Immediacy was removed on 3/23/11, the facility remains out of compliance at severity level 2, because the facility has yet to inservice the new hires on all shifts, has yet to assess if new interventions and policies are effective on the possible affected residents, and the facility's evaluation of the new plan of care has yet to be conducted.

The facility took the following steps to correct the Immediate Jeopardy:

1) E33 was terminated after the allegation of abuse was substantiated by the facility investigation which started 2/16/11. E33's last

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 _____	03/31/2011

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 226	Continued From page 45 working day was on 2/15/11, when he finished his 3-11 shift after the abuse incident. 2) All scheduled staff were immediately inserviced on abuse prevention policy by the Social service Consultant, E1 and E3, focusing on immediate reporting of abuse allegations and protection of residents. This started on 3/17/11 at 3:00 PM This will be monitored by E1 or her designee for compliance. 3) No staff member will be scheduled to work until they had been inserviced on abuse. 4) All agency nurses will be inserviced by their agency on the facility's abuse policy and procedure prior to being scheduled to work at the facility. They will not be allowed to work at the facility, until written proof of abuse inservice attended is given to the facility. This was completed on 3/23/11. 5) New hires will not be allowed to work until abuse inservice that includes policy on reporting and resident protection is completed by the new staff. This will be monitored by the Administrator/ designee and will be a part of the facility's weekly QA process. 6) Continuing abuse inservice will be given monthly by the Social Service Consultant, including timely reporting of abuse allegation and resident protection. This inservice will include the security department. This will be monitored monthly by the Administrator/designee to ensure 100% compliance of all employees, as part of the QA process.	F 226		

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 _____	03/31/2011

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 226	Continued From page 46 7) Nurse consultant will come to the facility twice a month to monitor if facility and administration is compliant with the monthly inservicing of staff by Social Service Consultant, with the inservicing on abuse of the agency staff prior to working, and with the weekly QA process to ensure new hires had been given abuse inservice prior to start.	F 226		
F 241	: 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		5/1/11

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 _____	03/31/2011

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 241	Continued From page 47 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the dignity of 3 sampled (R7, R10 and R13) and 1 outside of the sample(R 27). This failure has the potential to affect all 146 residents in the facility. Findings Include: 1) During observation of the dining room on 3 of 4 days of the survey (March 15 th, 16 th, and 17 th), observed R 27 entering the dining room with the same shirt on. Also noted that the resident(Female) is without a bra. The resident's breasts are visibly outlined under her shirt. Review of R 27 careplan indicates that R 27" prefers not to wear a bra and sometimes refuse to change clothing." Interventions noted includes " make sure resident wears appropriate blouses/shirts that do not show she isn't wearing a bra." This was not done. On 3-17-11 at 4:45pm, during the Daily Status Meeting, the facility was informed of the observations. 2) During initial tour on 3-15-11 at 10:08 AM observed R10 in his room with black stained blue jeans on.Observed in R10's room three empty dresser drawers next to his bed. Record review of physicians order sheet denotes R10 re-admitted 2-9-11. Interviewed R10 on 3-15-11 at 10:10 AM, states his clothes have not been returned since he has	F 241		

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 _____	03/31/2011

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 241	Continued From page 48	F 241		

been back in the facility. R10 states he believes his clothes are still in storage.

Observed E8 (certified nurse) pushing a grey large garbage bin with three large clear plastic bags; each bag full of clothes into R10's room.

Interviewed E8 (certified nurse) on 3-15-11 at 10:27 AM, states she was told by her supervisor this morning to go get R10's clothes. E8 states she just got the clothes from storage.

Interviewed E7 (certified nurse supervisor) on 3-15-11 at 10:29 AM, states she did not know why his clothes were just brought up from storage today.

Interviewed E9 (laundry aide) on 3-17-11 at 11:30 AM, states when a resident goes out the hospital, clothes are stored in the laundry department. E9 states the certified nurse have to inform the laundry department when a resident comes back from the hospital, then someone from the laundry department bring the clothes to the resident.

Record review of R10's patient's clothes and personal belonging list from 4-13-10 denotes R10 had 14 T-shirts, 10 Trousers, 6 jackets, 10 socks, and 7 underwear.

3) During an initial tour of the facility on 3/15/11 that began at 8:45 AM, R13 was observed walking down the corridor, wearing gym shoes that appeared to be a size too large for him. It was observed that with each step, R13's feet was slipping in and out of the shoes. In addition, upon entering R13's room (302), two signs had been posted above the bed that read: "no sexual

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 _____	03/31/2011

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 241	Continued From page 49 comments, no touching female staff, no request for sexual favors from staff, be respectful, keep hands to self, respect others space". A review of R13's clinical record dated 3/1/11, R13 is a 69 year old male with diagnoses that include Bipolar, Dementia, and Hypertension. Nursing care plan dated 2/2011 documents that R13 is sexually inappropriate in requesting sexual favors from staff. When interviewed on 3/15/11 at 10:00 AM, R13 stated that he was embarrassed by the signs. E14 (psych rehab service coordinator) stated when interviewed on 3/16/11 at 11:45 AM, that it was R13 's idea to post the signs for behavior over the bed. 3) R7 was admitted to the facility on 2/19/2011 with a diagnosis of schizoaffective disorder. On 3/15/2011 at 11:44 a.m., R7 was observed in the room in bed clothed in a blue sweatshirt and khaki pants. R7 was asked by the surveyor what was planned for the day. R7 stated he was tired and was just going to relax in bed. On 3/16/2011 at 1:32 p.m., R7 was observed in bed clothed in a blue sweatshirt and khaki pants. On 3/17/2011 at 10:35 a.m., R7 was observed in his room in bed clothed in a blue sweatshirt and khaki pants. On 3/18/2011 at 2:42 p.m., interview E3 regarding how the facility ensures that independent residents are performing ADLs, E3 stated " the resident daily ADL care sheet is supposed to trigger the CNA (certified nurse ' s assistant) to ask the resident " .	F 241		
F 250	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		5/1/11

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 _____	03/31/2011

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 250	Continued From page 50 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that social services were provided to assess and develop necessary interventions for 8 sampled residents (R2, R4, R6, R7, R9, R10, R13, R15, and R16) in the sample of 24 to address their psychiatric diagnoses and other issues.. Finding include: 1) E6 interviewed (psychiatric rehabilitation services coordinator) on 3-15-11 at 3:35 PM, states R10 has not been going to group, but talked to him 1:1 about going groups. E6 states she does not have any documentation from 1:1 sessions. E6 states she did document on 2-9-11 in the P.R.S.C. progress notes when R10 was re-admitted. E6 states that R10 has not attended scheduled 1:1 session, but has to seek him out for 1:1. E6 states that R10's lack of involvement in group and 1:1 sessions is a problem that will be addressed in the next care plan and quarterly meeting. Record review of the psychiatric rehabilitation services coordinator progress notes on 2-9-11; R10 re-admitted and to resume normal routine.	F 250		

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 _____	03/31/2011

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 250	Continued From page 51 Interviewed E5 (psychiatric rehabilitation services director) on 3-16-11 10:20 AM states she is suppose to be informed by the psychiatric rehabilitation services coordinator that R10 was not attending 1:1 sessions and that she was not aware. Record review of the facilities policy and procedure for the role of the psychiatric rehabilitation services coordinator is the outcome of each meeting will be recorded on the Specialized Services One to One Response sheet and kept in the resident's chart. Relevant information will be shared with involved professional staff. Interventions will be documented in the resident care plan. . Record review of R10's care plan denotes on 9-10-10 and 12-10-10 resident (R10) does not attend 1:1 sessions; goal not met. 2) R4 and R6 are diagnosed as Bipolar and Schizophrenic respectively and qualify as Subpart S. R4 nurses notes on 8/21/10, 9/20/10, 10/22/10, 1/1/11 and 1/2/11 document behavioral issues which include physical altercations and inappropriate touching. R6 nurses notes on 11/19/10, 12/2/10, 12/5/10, 12/9/10 documented episodes of aggression and sexual inappropriate behavior On 3/15 through 3/17/11 R4 and R6 did not attend any psychosocial groups. Facility forwarded copies of 1 month psychosocial	F 250		

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 _____	03/31/2011

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 250	Continued From page 52	F 250		

group attendance sheets. R4 and R6 names did not appear on any sign in sheet.

Facility roster for psychosocial groups does not list either R4 or R6 as belonging to any groups.

On 3/15/11 at 12:15 pm R4 stated, " went to group 5 - 6 months ago. Not right now in groups. I don ' t go. "

On 3/16/11 at 1:00 pm E15 (Psychosocial Rehabilitation Counselor) stated with regards to R4, " Not attending group. Try to engage in one to one ' s. He doesn ' t talk when meets with you. The interdisciplinary team has not met to discuss his non-compliance with groups and how to address since I ' ve been here. "

R4 last documented quarterly Psychiatric Rehabilitation Services Coordinator Summary is dated 10/13/10. That quarterly documents Social Skills and Coping Skills as Psychiatric Rehabilitation priorities.

On 3/15/11 at 11:45 pm R6 stated, " Don ' t want participate in groups. "

On 3/16/11 at 10:30 am E14, PRSC (psychosocial rehabilitation counselor for R6) stated, " I do one on one ' s with (R6) He ' s not attending groups. He qualifies for Subpart S. " Do one to one ' s instead of groups. " Care plan review for R6 does not include interventions to assist in gaining R6 compliance with attendance at psychosocial groups. Facility has no plan in place to get R6 to attend groups.

3) R13 is a 69 year old male with diagnoses that

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 _____	03/31/2011

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 250	Continued From page 53	F 250		

include Bipolar, Dementia, and Hypertension. Nursing care plan dated 2/2011 documents that R13 is sexually inappropriate in requesting sexual favors from staff. A review of R13's social service notes failed to document that an Advance Directive had been discussed with R13's guardian.

E1 (administrator) stated when interviewed on 3/18/11 at 2:30 PM, that none of the facility's residents had advanced directives.

4) According to the clinical record current minimum data set and physician orders R2 is a resident in the facility identified with a mental illness of schizophrenia. On 3/15/11 during the initial tour at 10:05am R2 was observed to alert and oriented with some confusion. R2 was able to identify staff by name. According to R2's clinical record current care plan no care was noted developed for R2's mental illness. R2's current care plan did include his delusional thoughts and his denial of his mental illness, with interventions to include 1:1 session to discuss R2's likes and dislikes.

On 3/15/11 during the initial tour at 10:00am R2 said that he don't participate in any group therapies, R2 was able to verbalize E21 as his case worker.

On 3/16/11 at 1:30pm in the conference room E21 (social service aide), said that R2 was a resident on her current case load. E21 said that R2 was alert and oriented with delusional thoughts, and that R2 doesn't believe he needs to at the facility and that R2 don't believe that he is a human being. E21 said that she is aware that R2

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 _____	03/31/2011

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 250	Continued From page 54	F 250		

has the diagnosis of schizophrenia, E21 said that R2 is currently not enrolled in any psycho-social group therapy. E21 said that R2 isn't enrolled in any psycho-social group therapy because R2 don't believe he needs therapy. E21 said that she has been working in the current position for 4.5 years. E21 said that she stops by and provides 1:1 sessions daily with R2. E21 said the sessions may last about 5 to 10 minutes a session. E21 said that this all of the interaction that R2 receives daily, and that R2 stays in his room most of the time, except for meals. E21 said that there was no current plan in place to address R2, isolative behaviors.

According to R2's clinical record specialized service one to one progress note, R2 last received 1:1 services on 1/24/11. The 1:1 session and progress note gives a description of R2's behaviors, but no therapeutic intervention documented.

On 3/16/11 at 1:30pm in the conference room E21 was unable to verbalize why R2's last 1:1 session given was 1/24/11, E21 was unable to provide survey team with updated 1:1 session notes during the survey period.

5) According to the clinical record physician orders sheet R9 is identified to have the diagnosis of Bipolar disorder. According to R9's care plan R9 was admitted to the facility with a diagnosis of Biplor disorder, with an intervention to include coping skills group. According to R9's plan of care R9 has been assessed with a problem of refusing medication at times. R9's plan of care intervention includes resident to attend medication management group, and

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 _____	03/31/2011

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 250	Continued From page 55	F 250		

symptom management group. R9 is identified on the current plan of care as refusing to attend rehabilitation groups, the problem also includes that R9 is aware of her mental illness. The plan of care interventions for refusing to attend group includes encourage to attend coping skills group 2 times a week.

On 3/16/11 at 2:00pm in the conference room E31 (social service case worker), said that she has been employed at the facility for 11 years. E31 said that R9 has a diagnosis of Bipolar disorder, E31 said that the facility is addressing her mental illness by sending R31 to psycho-social group therapy (coping skills, social skills, symptom management), 1:1 session daily, and the psychiatrist in to see R9 monthly. E31 said that she reminds R9 to attend the approppriate group sessions, but does not follow up with R9 to ensure she attends. E31 said that she don't go to the group sessions to see it R9 attends the groups. E31 also said that she provides R9 with daily 1:1 sessions but don't document the sessions. E31 was unable to verbalize to survey team how R9's treatment plan is measured. E31 was unable to verbalize the next step taken for residents who refuse psycho-social programming. E31 said the facility has behavior contracts, but R9 is not currently on a behavior contract.

A review of the last 3 months of psycho-social group programming attendance records R9 attended 1 group session dated 3/15/11.

On 3/15/11 at 10:30am with E26 (nurse supervisor), R9 said that she don't attend the psycho-social groups, but does like art activities.

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 _____	03/31/2011

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 250	Continued From page 56 On 3/16/11 E25 (group leader), said that social service case worker give names of the residents who will attend his groups. E25 said that he don't follow up or remind residents to attend the group session. E25 said that it is the residents and/or the case responsibility to ensure the resident attend the group. E25 said that if a resident is consistently not attending the group session he will delete them from the group. 6) According to R15's clinical record R15 has a diagnosis of Bipolar disorder. According to R15's current plan of care updated January, 2011 R15 is identified with the problem of being suspicious of peers motives with intervention to include 1:1's to assist R15 in getting along with people, and to attend social skills group sessions 2 times a week. R15 is also identified as being anxious and agitated along with being delusional, and can become physically / verbally abusive, with interventions to include participating in coping skills, social skills and anger management groups 2 times a week. R15 is also identified to demonstrate behavior symptoms concerning inappropriate boundaries in the form of attempting to develop inappropriate relationships with male peers, with interventions to i include attending behavior management group, social skills, and coping skills group 2 times a week. On 3/18/11 at 12:00pm before the lunch meal R15 said that she don't attend any psycho-social group therapy. R15 said that she don't like going to group. R15 identified E14 as her case worker. R15 said that she don't meet , with E14, and that E14 does not encourage her to attend the groups. R15 said that E14 rarely talks with her.	F 250		

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 _____	03/31/2011

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 250	Continued From page 57 On 3/15/11 and 3/17/11 at 2:00pm survey attended the anger management psycho-social group and noted that R15 was present at either session. On 3/17/11 E25 (group leader), said that R15 don't attend the group even though her name is on the roster. On 3/18/11 at E14 (social service case worker), said that R15 is currently on his caseload, identified R15 as having behavior of accusatory, physically / verbally aggressive at times E14 said that R15 has been assessed and enrolled in psycho-social group therapy to include, coping skills, anger management, social skills, and behavior management skill group. E14 said that he was aware that R15 don't attend the psycho-social group, but said that R15 becomes excitable at times in groups and may not do well. E14 was asked what was the next plan of care for R15 when excitable, and E14 said that he provide 1:1 therapy with R15. E14 said that the 1:1 therapy he provides is not documented, it is informal. E14 was asked how does he measure the outcomes of the therapy, E14 said it is measured in the psycho-social group R15 attends. E14 said that he was aware of the facility's one on one session progress notes. E14 was asked if the facility has behavior contracts E14 responded yes. E14 was asked what was the consequences for not attending psycho-social group therapy, and E14 said none. E14 denied that R15 was on any type of behavior contracts for not following facility's protocol. E14 said that if R15 don't attend the schedule psycho-social group he encourages her to attend.	F 250		

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 _____	03/31/2011

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 250	Continued From page 58 7) According to R16's clinical record R16 has a diagnosis of Bipolar disorder, and Depression. According to R16's current care plan R16 is identified with moderate intense anger issues, related to paranoid delusions, R16 is identified in with poor listening skills which leads to R16 to become verbally aggressive, with interventions to include attending coping skills biweekly or 1:1 session for anxious behavior. R16 is also assessed to have poor impulse control as it is related to anger, with interventions to include anger management 2 times a week, R16 is also encouraged to role play socially appropriate behavior in a group setting. R16 is also assessed to make inappropriate remarks toward female staff and residents, with intervention by social service case worker 1:1 sessions to role play and discuss socially/sexually appropriate behaviors. On 3/18/11 at 12:45pm R16 said that he don't attend any psycho-social groups, nor does he meet with his case worker weekly. R16 identified his social service case worker as E14. R16 said that he normally speaks to E14 in passing. According to the facility listing and roster of psycho-social group R16 is enrolled in social skills. A review of the last three months of psycho-social group attendance sheets R16 has not attended any groups. On 3/18/11 at 1:15pm E14 (social service case worker), said that R16 attends the psycho-social groups to include (social skills, anger management, coping skills). E14 was unable to verbalize why R16 was not on the roster for anger management, and coping skills psycho-social group. E14 said that he was unaware that R16	F 250		

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 _____	03/31/2011

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 250	Continued From page 59 hasn't been going to social skill psycho-social group. E14 said that he don't attend the psycho-social groups, and don't follow up to see who if R16 attended the psycho-social group that day. E14 said that when R16 has a behavior he will provide an informal 1:1 session , E14 said that the informal sessions are not documented. According to R16's clinical record last documented 1:1 session was noted 2/28/11. The reviewed 1:1 sessions provided descriptions of R16's behaviors, but failed to provide therapeutic interventions. 8)R7 was admitted to the facility on 2/19/2011 with a diagnosis of schizoaffective disorder. The assessment summary for mentally ill residents completed by the facility on 2/25/2011, rehabilitation recommendations are as follows: Skills group, Medication management and Intensive rehabilitation day program. The psychiatric rehabilitation skills assessment completed by the facility on 2/25/2011 recommends the following skill areas to be addressed: Medication compliance, reality orientation, community living, and social skills. Additional recommendations are as follows: Intensive rehabilitation program, coping skills, social skills, medication management, building rapport and motivate to participate in skills group. On 3/15/2011 at 11:44 a.m., R7 was observed in the room in bed clothed in a blue sweatshirt and khaki pants. R7 was asked by the surveyor what was planned for the day. R7 stated he was tired and was just going to relax in bed. On 3/16/2011 at 1:32 p.m., R7 was observed in bed clothed in a blue sweatshirt and khaki pants. On 3/17/2011 at 10:35 a.m., R7 was observed in his room in bed	F 250		

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 _____	03/31/2011

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 250	Continued From page 60 clothed in a blue sweatshirt and khaki pants. On 3/15/2011 at 2:37 p.m., interviewed E6, regarding R7 ' s programs E6, PRSC (Psychiatric Rehabilitation Services Coordinator), stated that R7 " refuses to participate in any programs because he thinks he is a psychiatrist " E6 stated that she placed R7 in a one on one program with a focus on motivation and building rapport. Record review on 3/15/2011 revealed no documentation of any One on One session. On 3/17/2011 at 2:42 p.m., interviewed E6 regarding one on one documentation with R7 and she stated " I don ' t have any documentation of my one on one sessions, I was going start that this week ." Surveyor: REID, ELISHA Based on observation, interview and record review the facility failed to ensure that 4 of 24	F 250		

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 _____	03/31/2011

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 250	Continued From page 61 sampled residents R2,R9, R15, R16 attend scheduled therapeutic psycho-social therapy/ group. All 4 residents are identified with diagnosis of mental illness. Findings include: According to the clinical record current minimum data set and physician orders R2 is a resident in the facility identified with a mental illness of schizophrenia. On 3/15/11 during the initial tour at 10:05am R2 was observed to alert and oriented with some confusion. R2 was able to identify staff by name. According to R2's clinical record current care plan no care was noted developed for R2's mental illness. R2's current care plan did include his delusional thoughts and his denial of his mental illness, with interventions to include 1:1 session to discuss R2's likes and dislikes. On 3/15/11 during the initial tour at 10:00am R2 said that he don't participate in any group therapies, R2 was able to verbalize E21 as his case worker. On 3/16/11 at 1:30pm in the conference room E21 (social service aide), said that R2 was a resident on her current case load. E21 said that R2 was alert and oriented with delusional thoughts, and that R2 doesn't believe he needs to at the facility and that R2 don't believe that he is a human being. E21 said that she is aware that R2 has the diagnosis of schizophrenia, E21 said that R2 is currently not enrolled in any psycho-social group therapy. E21 said that R2 isn't enrolled in any psycho-social group therapy because R2 don't believe he needs therapy. E21 said that she	F 250		

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 _____	03/31/2011

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 250	Continued From page 62 has been working in the current position for 4.5 years. E21 said that she stops by and provides 1:1 sessions daily with R2. E21 said the sessions may last about 5 to 10 minutes a session. E21 said that this all of the interaction that R2 receives daily, and that R2 stays in his room most of the time, except for meals. E21 said that there was no current plan in place to address R2, isolative behaviors. According to R2's clinical record specialized service one to one progress note, R2 last received 1:1 services on 1/24/11. The 1:1 session and progress note gives a description of R2's behaviors, but no therapeutic intervention documented. On 3/16/11 at 1:30pm in the conference room E21 was unable to verbalize why R2's last 1:1 session given was 1/24/11, E21 was unable to provide survey team with updated 1:1 session notes during the survey period. According to the clinical record physician orders sheet R9 is identified to have the diagnosis of Bipolar disorder. According to R9's care plan R9 was admitted to the facility with a diagnosis of Biplor disorder, with an intervention to include coping skills group. According to R9's plan of care R9 has been assessed with a problem of refusing medication at times. R9's plan of care intervention includes resident to attend medication management group, and symptom management group. R9 is identified on the current plan of care as refusing to attend rehabilitation groups, the problem also includes that R9 is aware of her mental illness. The plan of care interventions for refusing to attend group	F 250		

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 _____	03/31/2011

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 250	Continued From page 63 includes encourage to attend coping skills group 2 times a week. On 3/16/11 at 2:00pm in the conference room E31 (social service case worker), said that she has been employed at the facility for 11 years. E31 said that R9 has a diagnosis of Bipolar disorder, E31 said that the facility is addressing her mental illness by sending R31 to psycho-social group therapy (coping skills, social skills, symptom management), 1:1 session daily, and the psychiatrist in to see R9 monthly. E31 said that she reminds R9 to attend the appropppriate group sessions, but does not follow up with R9 to ensure she attends. E31 said that she don't go to the group sessions to see it R9 attends the groups. E31 also said that she provides R9 with daily 1:1 sessions but don't document the sessions. E31 was unable to verbalize to survey team how R9's treatment plan is measured. E31 was unable to verbalize the next step taken for residents who refuse psycho-social programming. E31 said the facility has behavior contracts, but R9 is not currently on a behavior contract. A review of the last 3 months of psycho-social group programming attendance records R9 attended 1 group session dated 3/15/11. On 3/15/11 at 10:30am with E26 (nurse supervisor), R9 said that she don't attend the psycho-social groups, but does like art activities. On 3/16/11 E25 (group leader), said that social service case worker give names of the residents who will attend his groups. E25 said that he don't follow up or remind residents to attend the group	F 250		

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 _____	03/31/2011

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 250	Continued From page 64 session. E25 said that it is the residents and/or the case responsibility to ensure the resident attend the group. E25 said that if a resident is consistently not attending the group session he will delete them from the group. According to R15's clinical record R15 has a diagnosis of Bipolar disorder. According to R15's current plan of care updated January, 2011 R15 is identified with the problem of being suspicious of peers motives with intervention to include 1:1's to assist R15 in getting along with people, and to attend social skills group sessions 2 times a week. R15 is also identified as being anxious and agitated along with being delusional, and can become physically / verbally abusive, with interventions to include participating in coping skills, social skills and anger management groups 2 times a week. R15 is also identified to demonstrate behavior symptoms concerning inappropriate boundaries in the form of attempting to develop inappropriate relationships with male peers, with interventions to i include attending behavior management group, social skills, and coping skills group 2 times a week. On 3/18/11 at 12:00pm before the lunch meal R15 said that she don't attend any psycho-social group therapy. R15 said that she don't like going to group. R15 identified E14 as her case worker. R15 said that she don't meet , with E14, and that E14 does not encourage her to attend the groups. R15 said that E14 rarely talks with her. On 3/15/11 and 3/17/11 at 2:00pm survey attended the anger management psycho-social group and noted that R15 was present at either	F 250		

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 _____	03/31/2011

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 250	Continued From page 65	F 250		

session. On 3/17/11 E25 (group leader), said that R15 don't attend the group even though her name is on the roster.

On 3/18/11 at E14 (social service case worker), said that R15 is currently on his caseload, identified R15 as having behavior of accusatory, physically / verbally aggressive at times E14 said that R15 has been assessed and enrolled in psycho-social group therapy to include, coping skills, anger management, social skills, and behavior management skill group. E14 said that he was aware that R15 don't attend the psycho-social group, but said that R15 becomes excitable at times in groups and may not do well. E14 was asked what was the next plan of care for R15 when excitable, and E14 said that he provide 1:1 therapy with R15. E14 said that the 1:1 therapy he provides is not documented, it is informal. E14 was asked how does he measure the outcomes of the therapy, E14 said it is measured in the psycho-social group R15 attends. E14 said that he was aware of the facility's one on one session progress notes. E14 was asked if the facility has behavior contracts E14 responded yes. E14 was asked what was the consequences for not attending psycho-social group therapy, and E14 said none. E14 denied that R15 was on any type of behavior contracts for not following facility's protocol. E14 said that if R15 don't attend the schedule psycho-social group he encourages her to attend.

According to R16's clinical record R16 has a diagnosis of Bipolar disorder, and Depression. According to R16's current care plan R16 is identified with moderate intense anger issues, related to paranoid delusions, R16 is identified in

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 _____	03/31/2011

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 250	Continued From page 66 with poor listening skills which leads to R16 to become verbally aggressive, with interventions to include attending coping skills biweekly or 1:1 session for anxious behavior. R16 is also assessed to have poor impulse control as it is related to anger, with interventions to include anger management 2 times a week, R16 is also encouraged to role play socially appropriate behavior in a group setting. R16 is also assessed to make inappropriate remarks toward female staff and residents, with intervention by social service case worker 1:1 sessions to role play and discuss socially/sexually appropriate behaviors. On 3/18/11 at 12:45pm R16 said that he don't attend any psycho-social groups, nor does he meet with his case worker weekly. R16 identified his social service case worker as E14. R16 said that he normally speaks to E14 in passing. According to the facility listing and roster of psycho-social group R16 is enrolled in social skills. A review of the last three months of psycho-social group attendance sheets R16 has not attended any groups. On 3/18/11 at 1:15pm E14 (social service case worker), said that R16 attends the psycho-social groups to include (social skills, anger management, coping skills). E14 was unable to verbalize why R16 was not on the roster for anger management, and coping skills psycho-social group. E14 said that he was unaware that R16 hasn't been going to social skill psycho-social group. E14 said that he don't attend the psycho-social groups, and don't follow up to see who if R16 attended the psycho-social group that day. E14 said that when R16 has a behavior he	F 250		

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 _____	03/31/2011

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 250	Continued From page 67 will provide an informal 1:1 session , E14 said that the informal sessions are not documented. According to R16's clinical record last documented 1:1 session was noted 2/28/11. The reviewed 1:1 sessions provided descriptions of R16's behaviors, but failed to provide therapeutic interventions.	F 250		
F 253	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, and comfortable interior, and failed to maintain a clean and sanitary environment. Findings Include: 1. On 3-15-11, and 3-16-11, room 340 bathroom, noted lighted mirror was missing 1 vertical light. 2. 1st floor Men's bathroom, noted on 3-15-11 and 3-16-11, the sink does not have available paper towels for proper hand hygiene. Random observation of 10 residents entering the bathroom indicated that all 10 immediately left the bathroom without attempting handwashing. On 3-16-11 at 4:30pm, during the Daily Status Meeting, the facility was informed of the observation.	F 253		5/1/11

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 _____	03/31/2011

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 253	Continued From page 68 3))During the initial tour of the facility on 3/15/11 at 8:45 AM, it was observed that the toilet in the men's bathroom on unit 3 was backed up and was near overflowing with fecal material. An unidentified nurse aide stated when interviewed at that time that the toilet did not appear to be backed up earlier that morning but she would call maintenance to repair the toilet. 4) 3/17/11, the following observations were made during the environmental tour of the facility with E37 (Maintenance Director) and E38 (Housekeeping Supervisor) that started at 11:20am: -An accumulation of garbage and debris in the outside stairwells and surrounding grounds of the building. -An odor of decaying garbage and debris was observed in the outside generator area. -The outside smoking area was littered with Styrofoam cups flying in the wind. -Sump pump located in the laundry room had an odor because it did not have a proper cover. The laundry room is used to store resident personal belongings that are in the hospital. -Blinds in the first floor dining room, are in poor condition. -Snack shop refrigerator is used to refrigerate soda pop for the residents. An accumulation of dirt and debris was observed in the bottom of the refrigerator. Also, there was no thermometer in	F 253		

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 _____	03/31/2011

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 253	Continued From page 69 the unit. -The laminate counter top in the snack was in poor condition. Large section was missing.	F 253		
F 272	483.20(b)(1) 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 resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; 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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		5/1/11

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 _____	03/31/2011

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 272	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to include psychiatric evaluation in the Comprehensive Assessment for 1 (R17) of 24 Sub-part S sampled residents. Findings include: R17 facesheet documents admission date of 2/8/11. R17 has Bipolar Affective Disorder. On 3/17/11 E14 (Psychosocial Rehabilitation Counselor for R17) stated, " He (R17) is Subpart S. I don ' t see psychiatrist evaluation. " Facility was advised of lack of psychiatrist evaluation during daily status meeting on 3/18/11.	F 272		
F 276	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure completion of Psychiatric	F 276		5/1/11

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 _____	03/31/2011

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 276	Continued From page 71 Rehabilitation Services Coordinator Quarterly Progress Note Summary for 1 (R4) out of 24 sampled residents in Subpart S. Findings include: Facility Quarterly psychosocial rehabilitation Summary includes goals and evaluation of progress toward goals. R4 last quarterly summary was dated 10/13/2010. On 3/16/11 at 1:00 pm E15 (psychosocial rehabilitation counselor) for R4 stated, " I ' m here since January 14. I don ' t see Quarterly has been updated. " Facility was advised of lack of Quarterly update during daily status on 3/17/11. Based on interview and record review, the facility failed to ensure completion of Psychiatric Rehabilitation Services Coordinator Quarterly Progress Note Summary for 1 (R5) out of 24 sampled residents in Subpart S. Findings include: Facility Quarterly psychosocial rehabilitation Summary includes goals and evaluation of progress toward goals. R5 last quarterly summary was dated 10/13/2010. On 3/16/11 at 1:00 pm E15 (psychosocial rehabilitation counselor) for R5 stated, " I ' m here since January 14. I don ' t see Quarterly has been updated. "	F 276		

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 _____	03/31/2011

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 276	Continued From page 72 Facility was advised of lack of Quarterly update during daily status on 3/17/11.	F 276		
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure accuracy of the Minimum Data	F 278		5/1/11

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 _____	03/31/2011

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 278	Continued From page 73 Set (MDS) assessment for one sampled resident R7; The MDS assessment included a signature certifying accuracy for sampled resident (R7) of the 24 sampled residents. Findings include: R7 was admitted to the facility on 2/19/2011 with a diagnosis of schizoaffective disorder. The assessment summary for mentally ill residents completed by the facility on 2/25/2011, rehabilitation recommendations are as follows: Skills group, Medication management and Intensive rehabilitation day program. 3/16/2011 record review of the MDS assessment with an observation end date of 3/3/2011, shows section S9000 IL Skills training, coded as "1" Yes Skills training was provided in accordance with the Illinois DPH Section 300.4050 a) 1) A-D and 300.4050 a) 3) and Illinois DPA section 147, Table A. Interviewed E6, PRSC (Psychiatric Rehabilitation Services Coordinator), who is responsible for coding R7's MDS section S with the observation end dates of 3/11/2011, regarding R7 ' s skills program, E6 stated R7 is in a " one on one program " . E6 was asked if the one on one program met the criteria for a skills training as outlined in the MDS reference manual for section S. E6 stated "I would have to look at the definition " . On 3/17/2010 at 2:42 p.m., interviewed E6, regarding whether the One on One program meets the criteria for skills training. E6 stated that the IOP (Intensive Outpatient Program) meets the criteria for skills training and that R7, was enrolled but never attended.	F 278		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		5/1/11

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 _____	03/31/2011

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 279	Continued From page 74 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 initiate care plans for smoking, psych meds, and behavioral issue involving 3 sampled resident (R5, R7 and R 21) of 24 sampled residents and 1 outside the sample (R28). Findings Include: 1) Review of the PRSC(Psyche Rehab Social Coordinator) note dated 10-7-10 indicates that " resident is noted for smoking in his room and	F 279		

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 _____	03/31/2011

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 279	Continued From page 75 having a cigarette lighter." Immediate intervention, " resident was counseled by PRSC on smoking restrictions." Further record review indicates that no plan of care regarding the incident was initiated. There is no further documented evidence of continued monitoring of R 21 regarding inappropriate smoking. R 21 medical diagnosis includes Bipolar Disorder, and Chronic Mental Illness, and Schizoid Paranoid Type. Interview with E 1(Administrator) on 3-18-11 at 3:30pm, when asked, why wasn't a careplan immediately initiated on 10-7-10? E 1 stated that because R 21 was smoking Marijuana, not a nicotine cigarette, and that it was only a one time thing that did not require a careplan. 2) R1 is a 28 year old male who was admitted to the facility on 3/4/11 with diagnoses that include Schizo Affective Disorder. R1 has a previous history of elopement from another facility, auditory hallucinations coupled with paranoid delusions, physical aggression toward peers and staff, attempted suicide, and arson (attempted to set self on fire-served 3 years in prison). Nursing documents that on 3/7/11, R1 was in a physical altercation with another resident and sustained a cut lip. R1 and other resident was observed wresting on the floor. On 3/9/11 R1 was in a physical altercation with a peer on the elevator. He appeared highly agitated. On 3/14/11 R1 begin swinging fist at a peer and hit the peer in the shoulder. Nursing documents that on 3/15/11 R1 continued with unprovoked violence with peers, with homicidal ideation. R1	F 279		

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 _____	03/31/2011

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 279	Continued From page 76 was sent to the hospital for a psychological evaluation. A review of R1's record failed to document that no initial plan of care was in place to assist with R1's behaviors. E15 PRSA (psych rehab service coordinator) stated when interviewed on 3/17/11 at 11:30 AM, that an initial care plan had not been initiated but R1 had been placed in group for coping skills. E21 further stated that she was unsure if R1 was attending the groups. 3)R7 was admitted to the facility on 2/19/2011 with a diagnosis of schizoaffective disorder. R7 ' s medications include Lithium carbonate 300mg twice a day, Zyprexa 20mg at hour of sleep, Invega susten 156mg monthly. On 3/16/2011, record review revealed no evidence of a care plan for psychotropic medications. On 3/18/2011 at 2:48 p.m., interviewed E13 , regarding the care plan for psychotropic not being found in the medical record. E13 , stated that care plan for psychotropic medication " was in the computer " . 4)R5 was admitted to the facility in March of 2005 with a diagnosis of Anorexia. 2/15/11, R5 was transferred to the hospital because he was vomiting clear or yellow liquids. The resident returned to the facility with a diagnosis of Fecal Impaction. In a nutritional note dated, 3/4/11, the facility ' s dietitian says R5 suffered a weight loss of 6.2 pounds, because his diet order for double portions and ensure supplement had, somehow, been dropped from his diet. R5 was on a high fiber general diet when he suffered the fecal impaction, according to the note. She	F 279		

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 _____	03/31/2011

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 279	Continued From page 77 recommends that the double portions be, again, added to the diet order and the high fiber diet " continue " . The dietitian notes the constipation problem as a secondary problem, but no recommendations made specifically to prevent fecal impaction. Only the weight loss is addressed. R5 ' s care plans were reviewed. The resident had a care plan for maintaining his weight dated 3/11/2011 with a goal date of 6/2011. Nothing was added concerning preventing fecal impaction. The facility presented a previous care plan from 2010. The older dietary care plan, again, addresses his weight problem, only. The facility staff stated the resident has a care plan for anemia.	F 279		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		5/1/11

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 _____	03/31/2011

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 280	Continued From page 78 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to review and revise a care plan by an interdisciplinary appropriate for the care of 7 sampled residents (R4, R6, R7, R10, R15, R16 and R18) in a sample of 24 residents. Findings include: 1) Record review of R10's care plan denotes on 9-10-10 and 12-10-10 resident (R10) does not attend 1:1 sessions; goal not met. Record review of psychiatric rehabilitation services coordinator progress notes on 12-22-10 recommendation to change goal and to engage R10 in conversation 3 times weekly. Record review of the facilities policy and procedure for the role of the psychiatric rehabilitation services coordinator is the outcome of each meeting will be recorded on the Specialized Services One to One Response sheet and kept in the resident's chart. Relevant information will be shared with involved professional staff. Interventions will be documented in the resident care plan. E6 interviewed (psychiatric rehabilitation services coordinator) on 3-15-11 at 3:35 PM, states R10 has not been going to group, but talked to him 1:1 about going groups. E6 states she does not have any documentation from 1:1 sessions except on 2-9-11 in the P.R.S.C. progress notes. E6 states that R10 has not attended scheduled 1:1 session,	F 280		

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 _____	03/31/2011

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 280	Continued From page 79	F 280		

but has to seek him out. E6 states that R10's lack of involvement in group and 1:1 sessions is a problem that will be addressed in the next care plan and quarterly meeting.

Record review of the psychiatric rehabilitation services coordinator progress notes on 2-9-11; R10 re-admitted and to resume normal routine.

Interviewed E5 (psychiatric rehabilitation services director) on 3-16-11 10:20 AM states she is suppose to be informed by the psychiatric rehabilitation services coordinator that R10 was not attending 1:1 sessions and that she was not aware.

2) Sign in sheets for all psychosocial groups for last month was requested of facility during daily status. On 3/18/11 during daily status facility verified all attendance sheets had been forwarded to surveyors for review.

R4 and R6 have not attended any psychosocial programs in last month. Review of psychosocial program attendance sheets for last month shows no signatures for either R4 or R6.

Both R4 and R6 are classified as Subpart S.

On 3/15/11 at 12:15 R4 stated, " Not right now in groups. I don ' t know who my counselor is. "

R4 care plan for behavior problems documents approach to lack of insight to include, " resident will attend symptoms management 2 times weekly. " On 3/16/11 E15 (Psychosocial rehabilitation counselor for R4) stated, " He ' s

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 _____	03/31/2011

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 280	Continued From page 80	F 280		

(R4) not attending groups. Try to engage and do 1 on 1 sessions. The interdisciplinary team has not met to discuss his noncompliance and approaches for non-compliance since I have been here. "

On 3/15/11 at 12:10 pm R6 stated, " don ' t talk about nothing. I don ' t want to participate in groups. "

R6 care plan for behavior problems has approach dated 2/11 which includes " enrolled in I.O.P. (outpatient program) "

On 3/16/11 at 10:30 am E14 (psychosocial rehabilitation counselor) for R6 stated, " I do 1 on 1 sessions with him (R6). "

R6 care plan has not been revised by interdisciplinary team to include approaches to promote attendance by R6 in psychosocial programming.

3)R18 is a 22 year old male that was admitted to the facility on 9/15/11 with diagnoses that include Schizophrenia, depressed type, and Asthma. The care plan originally dated 10/2010, and 1/2011 documents that R18 has a preoccupation with sexual delusions and will often falsely accuse others of approaching him for sex. R18 was given intructions that he was not to go into other residents rooms nor was R18 allowed on the 2nd floor. On 10/6/10 R18 was observed in another residents room stating that the other resident wanted R18 to have sex with him. 10/14/10, R18 attempted to leave the facility by jumping over the back fence. 10/24/10 R18 followed and attempted kiss one of the staff nurse aides. On 11/8/10

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 _____	03/31/2011

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 280	Continued From page 81	F 280		

nursing documents that R18 became paranoid and threatened to do harm to others, he was sent to the hospital for an evaluation. Nursing documents that on 12/31/11 R18 was found on the 2nd floor. When staff attempted to redirect R18 he became aggitated and refused to listen. R18 was sent out to the hospital.

There was no updating of R18's care plan post incidents or upon his return from the hospital.

E15 PRSC (psych rehab service coordinator) stated when interviewed on 3/17/11 at 11:10 AM, that R18 had been assigned to groups but that R18 was not attending. E15 also stated that he was aware that the plan of care for R18 had not been updated since R18 had been hospitalizated. E15 further stated that he was unsure if R1 was attending the groups.

4) According to R15's social service notes dated 1/10/11 hospitalization note indicate that R15 was discharged to the hospital from the facility for psychiatric evaluation. The note indicates per nurses note R15 came to the nurses station stating that she didn't want to live anymore. "I can't take it anymore". The note indicates that R15 made other suicidal statements, though did not identify any reason for these statements. According to another social service note dated 1/10/11 4:30pm indicates that R15 told social service case worker she was depressed at the moment and did not want to live anymore and that dead now is better than being here.

According to the clinical record dated 1/10/11 petition for involuntary/judicial admission R15 was involuntarily discharged for reason to engage in

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 _____	03/31/2011

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 280	Continued From page 82 conduct placing such person or another in physical harm or in reasonable explanation of being physically harmed. The petition indicates that R15 complained of being depressed and wanting to die, the note indicates that R15 complained of being suicidal. According to R15's current care plan dated January, 2011 no plan of care was noted with interventions related to R15's recent hospitalizations for verbalizing suicidal ideations. On 3/18/11 at 1:30pm in the social service group room, E14 (social service case worker), said that he was aware of R15's hospitalization for psychiatric evaluation for verbalizing suicidal ideations. E14 said that when R15 returned to the facility on 1/17/11 he spoke with her, and that she didn't verbalize any suicidal thoughts when she returned to the facility, and that it was an isolated episode he didn't think the behavior required a care plan with interventions. E14 said that he thought the 1:1 meeting upon return to the facility was sufficient. On 3/18/11 at 1:55pm in the office of social service E5 (social service director), said that the social service department reviewed and updated care plans quarterly, and when new behaviors are observed or required treatment. E 5 said that she would expect E14 to initiate a plan of care for R15's suicidal ideation, with interventions to assess R15 daily. 5) According to the R16's social service note dated 2/25/11 indicates that R16 was on smoking restriction for safety precautions due to failure to	F 280		

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 _____	03/31/2011

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 280	Continued From page 83 comply with facility's smoking policy. The note indicates that R16 requires supervision while smoking. A review of R16's current care plan there was no plan of care indicated to address R16's behavior of unsafe smoking noted. On 3/18/11 at 1:30pm E14 said that he was aware that R16 had a history of unsafe smoking. E14 said that he was aware of the note dated 2/25/11, but was un-aware of who wrote the note. E14 said that he met with R16 1:1 regarding his behavior of unsafe smoking. E14 said that R16 denied smoking unsafely, however E14 said that he review the smoking policy with R16. E14 said that he didn't initiate or develop a plan of care with intervention to ensure R16 complies within the facility's smoking policy. E14 was unable to verbalize why he didn't develop a plan of care for R16's behavior of unsafe smoking. A review of R16's current 1:1 intervention and progress dated 2/28/11 note failed to note R16's behavior of unsafe smoking. On 3/18/11 1:55pm in the social service office E5 said that residents are identified as an unsafe smoker, are placed on smoking restrictions, E5 said that social service should have developed a plan of care with interventions to monitor and supervise R16 and avoid the behavior of unsafe smoking. 6) R7 was admitted to the facility on 2/19/2011 with a diagnosis of schizoaffective disorder. On 3/15/2011 record review of R7 ' s care plan for behavior problems has an intervention as follows:	F 280		

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 _____	03/31/2011

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 280	Continued From page 84 PRSC will seek out resident for one on one session 3x weekly. On 3/17/2011 at 2:42 p.m., interviewed E6 regarding one on one documentation with R7 and she stated " I don ' t have any documentation of one on one sessions. I was going start one on one sessions that this week " . Based on interview and record review the facility failed to revise and implement the plan of care for 2 of 24 sampled residents R15/R16 with new intervention after R15 was hospitalized for suicidal ideation, and R16 was assess to be a unsafe smoker. Findings include: According to R15's social service notes dated 1/10/11 hospitalization note indicate that R15 was discharged to the hospital from the facility for psychiatric evaluation. The note indicates per nurses note R15 came to the nurses station stating that she didn't want to live anymore. "I can't take it anymore". The note indicates that R15 made other suicidal statements, though did not identify any reason for these statements. According to another social service note dated 1/10/11 4:30pm indicates that R15 told social	F 280		

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 _____	03/31/2011

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 280	Continued From page 85 service case worker she was depressed at the moment and did not want to live anymore and that dead now is better than being here. According to the clinical record dated 1/10/11 petition for involuntary/judicial admission R15 was involuntarily discharged for reason to engage in conduct placing such person or another in physical harm or in reasonable explanation of being physically harmed. The petition indicates that R15 complained of being depressed and wanting to die, the note indicates that R15 complained of being suicidal. According to R15's current care plan dated January, 2011 no plan of care was noted with interventions related to R15's recent hospitalizations for verbalizing suicidal ideations. On 3/18/11 at 1:30pm in the social service group room, E14 (social service case worker), said that he was aware of R15's hospitalization for psychiatric evaluation for verbalizing suicidal ideations. E14 said that when R15 returned to the facility on 1/17/11 he spoke with her, and that she didn't verbalize any suicidal thoughts when she returned to the facility, and that it was an isolated episode he didn't think the behavior required a care plan with interventions. E14 said that he thought the 1:1 meeting upon return to the facility was sufficient. On 3/18/11 at 1:55pm in the office of social service E5 (social service director), said that the social service department reviewed and updated care plans quarterly, and when new behaviors are observed or required treatment. E 5 said that she would expect E14 to initiate a plan of care for	F 280		

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 _____	03/31/2011

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 280	Continued From page 86 R15's suicidal ideation, with interventions to assess R15 daily. According to the R16's social service note dated 2/25/11 indicates that R16 was on smoking restriction for safety precautions due to failure to comply with facility's smoking policy. The note indicates that R16 requires supervision while smoking. A review of R16's current care plan there was no plan of care indicated to address R16's behavior of unsafe smoking noted. On 3/18/11 at 1:30pm E14 said that he was aware that R16 had a history of unsafe smoking. E14 said that he was aware of the note dated 2/25/11, but was un-aware of who wrote the note. E14 said that he met with R16 1:1 regarding his behavior of unsafe smoking. E14 said that R16 denied smoking unsafely, however E14 said that he review the smoking policy with R16. E14 said that he didn't initiate or develop a plan of care with intervention to ensure R16 complies within the facility's smoking policy. E14 was unable to verbalize why he didn't develop a plan of care for R16's behavior of unsafe smoking. A review of R16's current 1:1 intervention and progress dated 2/28/11 note failed to note R16's behavior of unsafe smoking. On 3/18/11 1:55pm in the social service office E5 said that residents are identified as an unsafe smoker, are placed on smoking restrictions, E5 said that social service should have developed a plan of care with interventions to monitor and	F 280		

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 _____	03/31/2011

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 280	Continued From page 87 supervise R16 and avoid the behavior of unsafe smoking.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to follow their policy regarding informed consent of psychotropic medications involving 1 of 24 sampled residents(R 8). Findings Include: R 8 is a 47 year old resident admitted to the facility on 11-8-10 with medical diagnosis which includes Schizophrenia. On 3-14-11, an order was obtained for Risperdal to be given, 3 milligrams, twice daily. Risperdal is an antipsychotic agent. Possible side effects includes confusion, agitation, blurred vision, and urinary retention. Review of the clinical record indicates that there was no informed consent related to the medication Risperdal. Review of the MAR(Medication Administration Record) indicates that R 8 has received 5 dosages of the medication. interview with E 15(Licensed Practical Nurse) on 3-18-11 at 2:30pm stated that prior to administration of any psychotropic medication, the resident is to be educated on the possible side effects and that if accepted, the resident would be asked to sign the consent form. This was not done.	F 281		5/1/11
F 285	483.20(m), 483.20(e) PASRR REQUIREMENTS	F 285		5/1/11

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 _____	03/31/2011

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 285	Continued From page 88 FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental	F 285		

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 _____	03/31/2011

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 285	Continued From page 89 illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain a Preadmission Screening and Resident Review (PASRR) for 3 sampled residents (R6, R9, and R17) with Serious Mental Illness, out of 24 residents in the sample . Findings include: 1)According to R9's current physician order sheet R9 has a diagnosis of bipolar disorder. According to R9's clinical record dated 3/14/2006 interagency certification of screening results indicates that R9 is appropriate for nursing facility services. The facility also provided survey team with R9's obra-1 initial screen dated 3/2/2006 indicating R9 was identified with mental illness verified by the DSM-IV classification which substantially impairs (cognitive, emotional and /or behavioral functioning. The screen also indicates R9 has a history of psychiatric hospitalizations. The screen indicates if R9 is identified with any areas in section II / III complete section IV and refer to the appropriate agent. R9 was marked yes on two area of section III as indicated above. A review of R9's pre admission screen there was no section IV available during the survey observation time. Along with missing section IV of the screen there was no determination and	F 285		

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 _____	03/31/2011

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 285	Continued From page 90 outcome summary available, nor was the nursing facility level of care determination available during the survey. On 3/17/11 at 9:45am during the morning meeting E1 (administrator), said that she provided the survey team with all of the information she had for R9's pre-admission screening. 2)R6 and R17 were admitted to the facility on 7/24/08 and 2/8/11 respectively. Physician order sheets document R6 is diagnosed as Schizophrenic and R17 as Bipolar disorder. On 3/17/11 during daily status, PASRR of R6 and R17 was requested. Facility presented document titled " interagency certification of screening results for long term care, for R6 and R17. This document is not a PASRR screening. PASRR screening is required prior to admission and outlines specialized rehabilitative services required by the resident. Based on record review and interview the facility failed ensure that the pre-admission screen and resident review was complete, for 1 of 24 sampled residents R9. R9 is identified with a mental illness diagnosis. Findings include. According to R9's current physician order sheet R9 has a diagnosis of bipolar disorder.	F 285		

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 _____	03/31/2011

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 285	Continued From page 91 According to R9's clinical record dated 3/14/2006 interagency certification of screening results indicates that R9 is appropriate for nursing facility services. The facility also provided survey team with R9's obra-1 initial screen dated 3/2/2006 indicating R9 was identified with mental illness verified by the DSM-IV classification which substantially impairs (cognitive, emotional and /or behavioral functioning. The screen also indicates R9 has a history of psychiatric hospitalizations. The screen indicates if R9 is identified with any areas in section II / III complete section IV and refer to the appropriate agent. R9 was marked yes on two area of section III as indicated above. A review of R9's pre admission screen there was no section IV available during the survey observation time. Along with missing section IV of the screen there was no determination and outcome summary available, nor was the nursing facility level of care determination available during the survey. On 3/17/11 at 9:45am during the morning meeting E1 (administrator), said that she provided the survey team with all of the information she had for R9's pre-admission screening.	F 285		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		5/1/11

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 _____	03/31/2011

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 312	Continued From page 92 by: Per observation and record review, the facility failed to assist 1 sampled resident (R13), and 1 (R28) outside the sample of 24. Findings include : 1) During observations made on 3/15/11 and 3/16/11, R13 was observed wearing gym shoes that were at least a size too large for his feet. R13's was observed with his feet slipping in and out of the shoes with each step. In addition, R13 was observed 3/15/11 and 3/16/11 to have a large amount of facial hair (3/15/11 and 3/16/11). When interviewed on 3/16/11 at 3:45 PM, R13 stated that he did not shave himself. R13 further stated that he is shaved by a staff member but they have not given him a shave in the last couple of days. E3 (director of nursing) stated when interviewed on 3/16/11 at 4:00 PM, that R13 is shaved by the staff. 2) On 3/15/11 and 3/16/11 R28 was observed to be wearing the same clothing. The oversized, yellow tee shirt was observed to be stained with black and brown stains. R28's pants were also stained. R28 was observed to be holding his pants up with his hand. When interviewed at that time R28 stated that his pants were falling down because he did not have a belt for his pants.	F 312		

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 _____	03/31/2011

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 312	Continued From page 93 E3 stated when interviewed on 3/16/11 at 4:00 PM, that R28 had been given a belt but that R28 would not wear the belt.	F 312		
F 323	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: I Based on interview and record review, the facility failed to provide adequate supervision for 1 resident (R6) who is an identified sexual offender and failed to supervise i newly admitted resident (R23) to ensure he does escape the facility, in the sample of 24. Findings include: 1) R6 is a Registered Sex offender with history of " criminal sexual assault " per Illinois Sex Offender Information. R6 has care plan for exhibiting, " physical and sexual aggression towards some female residents. He displays aggression by grabbing them inappropriately or physically touching them. 3 incidents dated 12/9/10, 12/23/10 and 12/30/10 of sexually inappropriate behavior are documented on this care plan. As approach/intervention for sexual aggression, "	F 323		5/1/11

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 _____	03/31/2011

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 323	Continued From page 94	F 323		

(R6) is not allowed on the second floor. " On 3/18/11 at 2:00 pm, E5 (Psychosocial rehabilitation Director) was shown copy of (R6) behavior care plan for sexual aggression and stated, " (R6) is not allowed on 2nd floor. That care plan restricting his access to second floor has been in place since November, 2010. "

On 3/18/11 at 8:15 am E16 (L.P.N on duty during incident of 12/9/10) stated, " He (R6) went down to 2nd floor. She (R30) said he was touching her while asleep. We brought him upstairs for 1:1. "

R6 was on second floor when he is " not allowed on the second floor, " per care plan for behaviors. "

On 3/18/11 E31 (Licensed Practical Nurse) pointing to R16 picture at front desk stated, " (R16) is only resident restricted from being on 2nd floor. "

2) R23 was admitted to the facility on 1/6/11 with diagnoses of Schizophrenia, Schizoaffective Disorder, and Substance Abuse.

Per nurses notes dated 1/10/11 at 12:31 PM, E3 (Director of Nursing) reported that R23 eloped from facility and 911 was called. Per 911 dispatcher, a call was made 10 minutes prior to E3's and a police car is already out.

Per R23's 1/8/11 Progress Notes, R23 was hospitalized for active hallucinations and for becoming hostile and aggressive towards staff. The notes added that R23 at the time was unreliable source of information and has loose associations of thoughts and struggles with focus. It also indicated that R23 was last seen as he

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 _____	03/31/2011

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 323	Continued From page 95 pushed through a staff member while eloping from facility. It says that 2 security guards, maintenance and social service staff pursued resident via car and foot but was not found. Per 3/18/11 interview with E49 (case worker) at 3:15 PM, R23 was at the facility for 2 days then he eloped. E49 added that he is not suppose to go out for 14 days upon admission. On 1/11/11, per nurses notes, E3 indicated that R23 was at his mother's house. II Based on observation, and interview, the facility failed to ensure that the room of 1 of 24 sampled residents(R 3), was free of accident hazards and failed to initiate interventions associated with inappropriate smoking involving 1 of 24 sampled residents(R21). Findings Include: 1) During the initial tour on 3-15-11, entered the room of R 3. Noted that between the bedroom and the adjoining bathroom is a 2 inch floor drop when entering the bathroom. This non level area of the floor between the bedroom and the bathroom could potentiate a tripping hazard. On 3-16-11 at 4:30pm, during the daily status meeting, the facility was informed of the concern. No facility response received. 2) Review of the PRSC(Psyche Rehab Social Coordinator) note dated 10-7-10 indicates that " resident(R21) is noted for smoking in his room and having a cigarette lighter." Immediate intervention, " resident was counseled by PRSC	F 323		

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 _____	03/31/2011

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 323	Continued From page 96 on smoking restrictions." Further record review indicates that no plan of care regarding the incident was initiated. There is no further documented evidence of continued monitoring of R 21 regarding inappropriate smoking. R 21 medical diagnosis includes Bipolar Disorder, and Chronic Mental Illness, and Schizoid Paranoid Type. Interview with E 1(Administrator) on 3-18-11 at 3:30pm, when asked, why wasn't a careplan immediately initiated on 10-7-10? E 1 stated that because R 21 was smoking Marijuana, not a nicotine cigarette, and that it was only a one time thing that did not require a careplan. III Based on observation and interview the facility failed to ensure the soiled utility closet with chemicals on the second floor was locked and secured. The failure has the potential to effect 74 residents residing on the second floor. Findings include: During the initial tour on the second floor with E26 (nurse supervisor), the survey team opened the laundry/soiled utility closet. E26 said that the closet should be locked at all times, to keep residents form having access to potentially hazardous chemicals. On 3/15/11 during the initial tour at 10:00am with E26 (nurse supervisor), the 3 open bottles of bleach was observed open in the utility closet. There was 2 bottle of glass cleaner, and (1) bottle of acid bath cleaner.	F 323		

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 _____	03/31/2011

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 323	Continued From page 97 Based on observation and interview the facility failed to ensure the soiled utility closet with chemicals on the second floor was locked and secured. The failure has the potential to effect 74 residents residing on the second floor. Findings include: During the initial tour on the second floor with E26 (nurse supervisor), the survey team opened the laundry/soiled utility closet. E26 said that the closet should be locked at all times, to keep residents form having access to potentially hazardous chemicals. On 3/15/11 during the initial tour at 10:00am with E26 (nurse supervisor), the 3 open bottles of bleach was observed open in the utility closet. There was 2 bottle of glass cleaner, and (1) bottle of acid bath cleaner.	F 323		
F 329	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 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	F 329		5/1/11

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 _____	03/31/2011

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 329	Continued From page 98 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 have adequate indication for 1 medication involving 1 of 24 sampled residents(R 21). Findings Include: Review of R 21's record indicates that he receives Ambien 5 milligrams every hours sleep when necessary. Review of the POS(Physician Orders Sheet) indicates that the initial order date is May of 2010. Ambien is classified as a Hypnotic. According to the Drug Information Handbook for Nursing , 10 th edition, 2009, " Ambien is used for short term treatment of insomnia." Review of the POS, MAR(Medication Administration Record), Careplans, MDS(Mini-Data-Set), Physician Progress Notes, and Psychiatrist Progress Notes , does not indicate Insomnia as a medical diagnosis. Also, there is no documented evidence of any previous	F 329		

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 _____	03/31/2011

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 329	Continued From page 99 attempts to reduce or discontinue this medication. On 3-16-11 during the daily status meeting, the facility was informed of the concern. Interview with R 21 on 3-17-11 at 10:00 am stated that he does not have any problems sleeping either during the day or night.	F 329		
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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, record review, and interview, the facility failed to provide 3 ounces of meat for 1 lunch meal menu, and failed to follow the recipe for 1 lunch meal menu. This failure has the potential to affect all 146 residents in the facility. Findings Include: Review of the facility nutritional spread sheet indicates that the 3-15-11 lunch menu includes chopped steak & gravy. The recipe indicates that each chopped steak portion should be at 3 ounces. On 3-15-11 at 12:25pm, instructed E 10(Dietary Supervisor), to weigh 1 fully cooked chopped steak. The chopped steak weighed 2.75 ounces. Instructed E 10 to weigh 2 additional chopped steaks. The 2 additional chopped steaks weighed were 2.75 ounces. E 10 stated at 12:30pm that each portion should weigh	F 364		5/1/11

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 _____	03/31/2011

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 364	Continued From page 100 at 3 ounces or higher. Review of the facility nutritional spread sheet indicates that the 3-16-11 lunch menu includes polish sausage, rice pilaf, and zucchini squash. The recipe indicates that at 200 servings, 18.3/4 pounds of rice and 4.2/3 gallons of water will be needed to make the meal. On 3-16-11 at 9:30 am, observed E 11(Cook) prepare the lunch meal. Noted that an unknown volumn of rice and an unknown volumn of water were inside of a 4 inch steam table pan. The following questions were asked: What is your serving size? E 11 stated 200. At 200 servings, how much rice is needed? E 10 stated 10 pounds. How much water is needed at 200 servings? E 10 stated that she did not know. E 10 also stated that the water that was added to the 4 inch steam table pan was not measured, but was added directly from the water faucet. When asked did you follow the recipe? E 11 stated that she was preparing the meal from memory.	F 364		
F 366	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE 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 record review, and interview, the facility failed have an established substitute plan available for breakfast. This failure has the potential to affect all 146 residents in the facility. Findings Include:	F 366		5/1/11

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 _____	03/31/2011

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 366	Continued From page 101 Review of the facility substitute policy on 3-16-11 at 10:30 am indicates that food substitutes are available for lunch and dinner only. Interview with E 10(Food Service Supervisor) on 3-16-11 at 11:00 am stated that at this present time, there is no substitute plan available for breakfast meals.	F 366		
F 372	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain the outside dumpster area in a clean sanitary manner. An odor, garbage and debris were observed in the surrounding dumpster area. Findings Include: 1. 3/17/11, the following observation was made during the environmental tour of the facility with E37 (Maintenance Director) and E38 (Housekeeping Supervisor) which started at 11:20am. The outside garbage dumpsters are located right off the resident ' s outside smoking area. An odor coming from the dumpsters was observed as you walked toward them. There was a large accumulation of garbage and debris on the ground surrounding the dumpsters. Three cardboard dumpsters were overflowing with garbage. A gray bin stored in the area, had standing water and an odor.	F 372		5/1/11

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 _____	03/31/2011

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 406	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 rehab services involving 7 sampled residents of 24 sampled residents(R 1, R3, R8, R10, R11, R14, R18, and R 21) with history of mental illness and classified as identified offenders. Findings Include: 1) R3 is a 60 year old resident admitted to the facility on 2-4-09 with medical diagnosis which includes Bipolar Affective Disorder, Poly Substance Abuse, and Hepatitis. R 3 is also classified as a Convicted Sex Offender. Observed resident spending most of the time in his bed followed by walking thruout the facility. Record review indicates that R 3 behaviors includes "poor medication compliance, and at times, inappropriate sexual behavior related to poor impulse control, anxiety, and denial of having an mental illness." Review of the facilities schedule of specialized rehab programs does not	F 406		5/1/11

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 _____	03/31/2011

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 406	Continued From page 103	F 406		

indicate that R 3 is participating . Interview with E 12(PRSC/Psyche Rehab Social Coordinator) on 3-16-11 at 11:30 am stated that R 3 does not attend any programs, but receives one to one counseling sessions.

2) R8 is a 47 year old male admitted to the facility on 11-8-10 with medical diagnosis which includes Schizophrenia, Poly Substance Abuse, Depression, and Suicidal Ideation. R 8 is also classified as an Identified Offender. Observed resident mostly lying in bed without any interaction with peers. Review of record indicates that R 3 behaviors includes " poor medication compliance, abusive with substances, and self harm ideations." Review of the facilities schedule of specialized rehab programs does not indicate that R 8 is participating. Interview with R 8 on 3-16-11 at 10:30 am stated that he does not participate in any group programs.

3) R21 is a 44 year old male admitted to the facility on 1-18-10 with medical diagnosis which includes Schizoid-Paranoid Type, Bipolar Disorder, Chronic Mental Illness. R 21 is classified as a Convicted Sex Offender. Observed resident mostly lying in bed. Review of record indicates that R 21 behaviors includes " agitation, inappropriate smoking, substance abuse, and alcoholism." Review of the facilities schedule of specialized rehab programs does not indicate that R 8 is participating. Interview with R 21 on 3-17-11 at 11:15 am stated that he does not participate in any group programs.

4) Record review of R10's psychiatric rehabilitation services coordinator progress notes on 9-27-10, psychiatric rehabilitation services

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 _____	03/31/2011

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 406	Continued From page 104 coordinator will encourage R10 participation in 1:1 session 3 times weekly, goal not met residents does not think he needs treatment. Record review of psychiatric rehabilitation services coordinator progress notes on 12-22-10 recommendation to change goal and to engage R10 inconversation 3 times weekly. Record review of R10's care plan denotes on 9-10-10 and 12-10-10 resident (R10) does not attend 1:1 sessions; goal not met. Record review of the psychiatric rehabilitation services coordinator progress notes on 2-9-11; R10 re-admitted and to resume normal routine. E6 interviewed (psychiatric rehabilitation services coordinator) on 3-15-11 at 3:35 PM, states R10has not been going to group, but talked to him 1:1 about going groups. E6 states she does not have any documentation from 1:1 sessions except on 2-9-11 in the P.R.S.C. progress notes. E6 states that R10 has not attended scheduled 1:1 session, but has to seek him out. E6 states that R10's lack of involvement in group and 1:1 sessions is a problem that will be addressed in the next careplan and quarterly meeting. Record review of the facilities policy and procedure for the role of the psychiatric rehabilitation services coordinator is the outcome of each meeting will be recorded on the Specialized Services One to One Response sheet and kept in the resident's chart. Relevant information will be shared with involved professional staff. Interventions will be documented in the resident care plan.	F 406		

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 _____	03/31/2011

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 406	Continued From page 105 Interviewed E5 (psychiatric rehabilitation services director) on 3-16-11 10:20 AM states she is suppose to be informed by the psychiatric rehabilitation services coordinator that R10 was not attending 1:1 sessions and that she was not aware. 5) R1 is a 28 year old male who was admitted to the facility on 3/4/11 with diagnoses that include Schizo Affective Disorder. R1 has a previous history of elopement from another facility, auditory hallucinations coupled with paranoid delusions, physical aggression toward peers and staff, attempted suicide, and arson (attempted to set self on fire-served 3 years in prison). Nursing documents that on 3/7/11, R1 was in a physical altercation with another resident and sustained a cut lip. R1 and other resident was observed wresting on the floor. On 3/9/11 R1 was in a physical altercation with a peer on the elevator. He appeared highly agitated. On 3/14/11 R1 begin swinging fist at a peer and hit the peer in the shoulder. Nursing documents that on 3/15/11 R1 continued with unprovoked violence with peers, with homicidal ideation. R1 was sent to the hospital for a psychological evaluation. A review of R1's record failed to document that no initial plan of care was in place to assist with R1's behaviors. There was no documentation in the record indicating that R1 was attending group regularly. E21 PRSA (psych rehab service aide) stated when interviewed on 3/16/11 at 11:30 AM, that an initial care plan had not been initiated but R1 had	F 406		

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 _____	03/31/2011

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 406	Continued From page 106 been placed in group for coping skills. E21 further stated that she was unsure if R1 was attending the groups. 6) R18 is a 22 year old male that was admitted to the facility on 9/15/11 with diagnoses that include Schizophrenia, depressed type, and Asthma. The care plan originally dated 10/2010, and 1/2011 documents that R18 has a preoccupation with sexual delusions and will often falsely accuse others of approaching him for sex. R18 was given instructions that he was not to go into other residents rooms nor was R18 allowed on the 2nd floor. On 10/6/10 R18 was observed in another residents room stating that the other resident wanted R18 to have sex with him. 10/14/10, R18 attempted to leave the facility by jumping over the back fence. 10/24/10 R18 followed and attempted kiss one of the staff nurse aides. On 11/8/10 nursing documents that R18 became paranoid and threatened to do harm to others, he was sent to the hospital for an evaluation. Nursing documents that on 12/31/11 R18 was found on the 2nd floor. When staff attempted to redirect R18 he became agitated and refused to listen. R18 was sent out to the hospital. Nursing further documents from September to March 2011 that R18 continues to have sexual, aggressive behaviors. Documentation by the IOP (intensive outpatient program) documents that R18 was not assigned to their group program until 2/2011. E15 PRSC (psych rehab service coordinator) stated when interviewed on 3/17/11 at 11:10 AM, that R18 had been assigned to groups but that	F 406		

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 _____	03/31/2011

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 406	Continued From page 107	F 406		

R18 was not attending. E15 also stated that he was aware that the plan of care for R18 had not been updated since R18 had been hospitalized. E15 further stated that he was unsure if R1 was attending the groups.

7) R14 has diagnoses of Bipolar Disorder and Alcohol Abuse. R14 was admitted to the facility on 11/5/10.

During initial tour on 3/15/11 at 10:40 AM, R14 was observed in his room sitting on the chair, alert and oriented x3. When asked why he is in the room, R14 answered that he no longer go to any groups anymore because what the people in the group talk about are for kids. R14 said he only attends MISA group 3x/week now.

Per R14's undated Assessment Summary for MI Residents, the interventions to address his risk factors include MISA group , medication monitoring, mood stabilization, Symptom management. His care plan indicated he will attend MISA group 2x per weel and 1:1 with his case worker, and will attend Symptom Management Group.

R14's record does not indicate if the programs he was suppose to attend is meeting his needs as originally planned per his initial assessment. There was no cohesive goals for all his programs, there is no monitoring of his attendance and progress.

During 3/17/11 interview with E49 (case worker), it was found out that E49 does not even know R14 stopped attending his IOP or ABRS program. There was no indication in R14's record

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 _____	03/31/2011

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 406	Continued From page 108 why he is attending IOP or ABRS, and how these programs are meeting his needs at this time. E49 said R14 does not get 1:1. There also was no evidence in his record what was put in place when R14 stopped attending his Symptom Management program. 8)R11 was admitted to the facility, September 2010. Upon admission to the facility, R11 expressed a desire to complete his high school studies. He wants to take a GED course. The resident was told that he has to be medication compliant. 3/16/11, at approximately 4:30pm, E50 (LPN) was passing out medication to residents at the 3rd floor nurse ' s station. E50 was asked if she was familiar with R11 and was he medication compliant. " Yes, I don ' t have any problem giving him his medication. " R11 has not been put in a GED program.	F 406		
F 466	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure there is a written policy on procurement of water for potable and non-potable use during emergency water shortage. Findings include :	F 466		5/1/11

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 _____	03/31/2011

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 466	Continued From page 109 Review of facility's Emergency water Supply Policy Statement and contract signed on 2/24/11 by E2 (Administrator) showed no indication that that non-potable water supply for flushing of toilets, washing of dishes, etc is included in the policy. Only the water supply for drinking purposes is included in this. After this was brought up to facility during daily status meeting on 3/17/11, there was no response from the facility.	F 466		
F 490	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility administration failed to ensure: - that residents are free from abuse by staff (R's 22, 25, 26) - that CNA's (Certified Nurse Assistants), security, nursing services, agency nurses and abuse prevention committee are trained abuse prevention so that abuse allegations and incidents are identified, reported to the administrator or designated staff immediately, - that upon identification, the victims of abuse are protected from the alleged perpetrator (R22), - investigations and inservices were immediately done when a abuse allegation was reported, -that altercations between residents are	F 490		5/1/11

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 _____	03/31/2011

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 490	Continued From page 110 investigated and reported to the state agency, - that their own policy and procedures for abuse incidents was followed. This resulted in R22 being hospitalized because of injury,and then refusing to go back to the facility because he feared for his safety. This failure resulted in an Immediate Jeopardy which was determined to start when on 2/15/11 at 9 PM, E33 (nurse) physically abused R22 which resulted to R22's mouth bleeding. E1 (Administrator), E2 (Director of Nurses) were notified of the Immediate Jeopardy on 3/17/11 at 1:35PM. Findings include : 1) R22 has diagnoses of Bipolar Disorder, Schizoaffective Disorder, and Asthma. R22 was initially admitted to the facility on 8/12/10. R22 resided on the 3rd floor. The incident took place on the 3-11pm shift. Nursing notes written by E33 (nurse) on 2/15/11 at 9:35pm state that R22 was delusional and grabbed E33's hair and attacked E33 due to hearing voices. R34 stated 3/17/11 at 1 PM, that he saw R22 yell at E33 who was at the nurses station. E33 then came out from behind the station and told R22 that he was going to "kick (R22's) ass". E33 got R22 in a headlock and starting hitting him. R22 was able to get away from E33 momentarily and then E33 started hitting R22 again after a short pause. R34 said that although R22 tried to fight, "(R22) cannot do anything against E33". R34	F 490		

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 _____	03/31/2011

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 490	Continued From page 111 added that E32 (Certified Nursing Assistant - CNA) was there but was scared and was screaming for security. E36's (Security Guard) signed statement dated 2/16/11 states that around 9:30 PM of 2/15/11, E36 ran from the 2nd floor to the 3rd floor because E32 was screaming for security and he heard a commotion on the 3rd floor. When he got to the 3rd floor, he saw E33 and R22 standing in front of each other, and R22 was bleeding from his mouth. Both R22 and E33 were cursing at each other as he was walking R22 to his room. Upon reaching the double doors (which were located near the nurse's station), E33 grabbed R22 by his shirt again and pulled R22 back towards the front to give R22 a PRN (as needed) medication. E36 told E33 that he was going to take R22 to his room first to change his clothes and to cool him off. After this, E36 walked R22 back to the front, where E33 gave R22 an injection. E36 verified on 3/17/11 at 12:10 PM, that his statement was true as it was written. E36 also stated that after the incident on 2/15/11, he made a report and put it under E1's (Administrator's) door. Despite of E36's seeing R22 bleeding from the lip while facing E33, E36 did not verbally report this allegation of abuse immediately to E1 (Administrator) or other administrative staff. Review of E36's personnel file showed no evidence that E36 was given an orientation inservice on abuse policy and procedures, upon hire (12/15/10), nor had E36 attended an abuse	F 490		

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 _____	03/31/2011

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 490	Continued From page 112 inservice on 1/19/11. E32 (CNA) stated on 3/18/11 at 10:51 AM, that E33 came out of the desk and "fought R22". E32, who was present during the actual physical fight between R22 and E33, did not call and report this abuse immediately to E1 (Administrator) or any of the administrative staff. E32 stated she didn't know she was suppose to report this fight until she attended an inservice on 2/18/11 about abuse after the incident had happened . When her file was reviewed, E32 did not have any abuse training upon hire ; E32 also did not attended the inservice on abuse on 1/19/11 On 3/17/11 at 12:33 PM, Z3 (agency nurse) said that she worked on the 2nd floor on 2/15/11 and came to the 3rd floor with a security staff. Z3 said she saw that "(R22) got (E33) by the hair, and that security got between the 2 of them". Z3 she saw R22 pulling E33's hair also but did not suspect abuse despite of actual physical contact between the two. Z3 added that she did not see R22's face as the security quickly took R22 away. Z3 said she did not suspect any abuse, and did not ask E33 if he had hit R22 because Z3 said she "had no reason to". Z3 also did not assess the resident or assist the resident in any way. Z3 also admitted during above interview that she did not have any abuse inservices prior to working in the facility as an agency nurse E39 (Security Guard) stated on 3/23/11 at 11 AM, that on 2/15/11, when he got to the 3rd floor after hearing E32 screaming on the radio, the altercation between R22 and E33 was already finished. E39 said that at that time, E33 was in	F 490		

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 _____	03/31/2011

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 490	Continued From page 113 the nurses station and R22 was at the area across the nurses station with E36 in the vicinity of R22. E39 stated that R22 was still cursing, and E33 said that R22 pulled out his hair. E39 got to the 3rd floor only after the physical altercation was already over but did not inquire about what had happened or get any information. E39 did state that a fight between a staff and a resident qualifies as a abuse allegation. During interview with E2 (Assist. Adm.) on 3/17/11 at 11:05 AM, E2 said that the facility started the investigation on 2/16/11 only after R18 asked E25 (Security) if E25 heard that E33 beat up and busted R22's lip the night before. E25 confirmed this on 3/17/11 at 12:05 PM and added that R18 asked him about the fight between R22 and E33 around noon time on 2/16/11. Per review of incident reports there were 12 residents (R's 4,13,17,18, 38, 39, 41 44, 46, 50, 58, and 65) as of 2/15/11, with documented aggressive behaviors under E33's care that night. E39 said during the 3/23/11 interview at 11 AM, that all residents in the facility have probably been verbally aggressive to staff at one point. The residents with documented and potential aggressive behaviors are being taken care of on the same floor by E33. The allegation was not reported immediately to administrative staff at the time it happened and the abuser (E33) was allowed to finish his shift on 2/15/11 placing the other 79 residents on the 3rd floor at risk for abuse.	F 490		

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 _____	03/31/2011

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 490	Continued From page 114 Review of personnel staff files showed that aside from E32 and E36, the following files of security staff showed the following: a) E19 - hired 3/15/11 - no evidence of abuse prevention training/ inservice upon hire b) E40 - hired 1/12/11 - no evidence of abuse prevention training/ inservice upon hire c) E41 - hired 7/24/07 - no evidence of abuse prevention training/ inservice upon hire d) E42 - hired 9/15/07 - no evidence of abuse prevention training/ inservice upon hire e) E43 - hired 5/4/10 - no evidence of abuse prevention training/ inservice upon hire f) E43 - hired 12/6/04 - no evidence of abuse prevention training/ inservice upon hire g) E44 - hired 12/2/09 - with abuse packet in file but abuse quiz was blank. Review of facility abuse inservice dated 1/19/11, showed that E's 19, 32, 36, 40, 41, 42, 43, 44, and 45 (security staff) did not attend this inservice. There was no indication that the agency nurses used by the facility were given a inservice on abuse to ensure that they know how to identify abuse, and to ensure that they know what they are supposed to do in case there is an allegation of abuse. During 3/23/11 interview with E46 (staffing coordinator) at 11:30 AM, E46 said that upon hire, although the new staff is given a packet that includes abuse prevention policy and procedure, there is really no one in the facility who sits downs with the new hires and discusses with them, the	F 490		

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 _____	03/31/2011

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 490	Continued From page 115 contents of the packet. The inservices on abuse were not started until 2/18/11 and ended with only 57 employees out of 133 attending. Those who did not get the inservice included E36, E39, and Z3. E46 said she "did not get all of the staff as some did not pick up their checks and did not attend the inservice". Review of the staff orientation packet given to new hires showed abuse policy and procedures including types of abuse, immediate reporting, separating abusers from the residents, immediate investigation, removing of the employee from further resident contact, etc. . E1 (Administrator) and E2 were made aware of the abuse incident between E33 and R22 on 2/16/11. The facility did not immediately inservice the staff on abuse to ensure that allegations are reported immediately, that allegations are investigated immediately, and that the victims of the alleged abuse are protected from perpetrator. 2) On 3/17/11 at 10:30 AM, E23 (smoking monitor) was observed standing in the hall of the main lobby of the facility near the elevator. E23 was observed yelling at R26 in a disrespectful tone. E23 yelled "pull your pants up and pull them up right now". R26 was observed wearing a belt on his pants. The pants were observed to be low around R26's mid buttocks area. E23 stated when interviewed at this time that he	F 490		

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 _____	03/31/2011

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 490	Continued From page 116	F 490		

did not mean to yell at R26 and speak to the resident in a disrespectful manner.

At 2:30 PM on 3/17/11 E23 was observed dispensing cigarettes to the residents on the smoking patio. R25 was observed to approach E23 and ask for a cigarette. E23 began to yell at R25 in a loud voice stating "didn't I tell you that you don't have any more cigarettes, now get out of line".

E23 stated when interviewed after the incident and stated that he was aware of the abuse policy of the facility and that he was aware that residents are not to be yelled at or spoken to in an disrespectful tone. E23 also stated that he was also aware that this was verbal abuse.

The above incident was reported to E23's direct supervisor, E22 (director of activities) at 2:45 PM. E22 stated that she would have a talk with E23. E22 further stated when interviewed at 3:20 PM, that she had spoken to E23 concerning his verbal abuse against R25 and R26. E22 failed to state that the above incidents were documented and reported to the facility's abuse coordinator per facility policy.

E1 (administrator) stated when interviewed on 3/18/11 at 12:20 PM, that the above incident had been reported to her on 3/17/11 at 3:00 PM. E1 further stated that E23 had been sent home at 3:15 PM on 3/17/11. E1 stated that she had not documented the incidents or sent a copy of the initial report to the department of public health, nor had E1 begun an investigation into the verbal abuse incidents. .

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 _____	03/31/2011

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 490	Continued From page 117 3) Per review of the facility's abuse files the following incidents involving 12 sampled residents (R4, 5, 9, 10, 11, 13, 15, 17, 18, 19, 22) and 33 residents outside of the sample (30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 60, 61, 62, 63, 64, 65, 66 and 67) were noted to have not been investigated as abuse allegations. The facility as a result did not notify IDPH of the initial and final report of the investigation to determine if there really was abuse, nor had the facility investigated to determine if the physical altercations and allegations of abuse were willful and intentional or just part of the residents psychiatric diagnoses. Examples are as follows: a) R30 hit R15 on 12/31/10 because R15 called R30 names. R15 sustained 2 lacerations above the eye. b) Per incident report dated 1/14/11, R13 accused R41 of hitting him. Per incident report, there was redness to R13's left jaw. c) R13's 12/26/10 incident report indicated R13 hit his roommate R42 with a shoe. Per report, R13 said he was mad because he did not get his date. d) Per incident report dated 1/10/11, R35 alleged that R15 put her hand on her (R35's neck. No abuse investigation was done nor was IDPH notified. e) R36 alleged that she was hit 3-4 times by a 3rd floor resident while she was in bed. There was no accompanying report that the facility investigated this to determine the identity of this	F 490		

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 _____	03/31/2011

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 490	Continued From page 118	F 490		

resident to ensure that other residents are protected from this unknown perpetrator. No abuse investigation was done nor the IDPH was notified.

f) R5 struck a staff member on 1/2/11 and punched a CNA (certified nurse aide) in the head on 12/12/10, per incident reports. No evidence in the abuse files that this was investigated, to ensure that staff as a result did not hit resident back.

g) R22 stomped R31's foot and punched R31 on 1/2/11. No abuse investigation nor IDPH notification was done.

h) R19 accused a resident of beating her face and head and hit her on the right shoulder with a fan on 2/8/11. On 12/10/10, R19 alleged that she was punched by R67. For both these incidents, there were abuse investigations and IDPH notifications noted in the facility's abuse files.

i) On 2/14/11, R37 got up of her chair and hit another resident without provocation. There was no abuse investigation and IDPH notification noted for this incident. There also was no indication in the incident report of who this other resident is.

j) On 2/18/11, R44 attacked and wrestled R38. R44 said he wrestled R38 because R38 of spitting on his face and R38 denied the allegation. There was no abuse investigation noted nor was there IDPH notification.

k) On 12/8/10, R44 alleged that he was hit by another resident after saying " Kirk Douglas" .

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 _____	03/31/2011

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 490	Continued From page 119	F 490		

The other resident was just identified with initials but incident report does not indicated who this other resident is. No abuse investigation no IDPH notification was found.

On 12/11/10, R66 swung at R44 after R66 alleged that R44 threatened R66 and was at R66's face. Although R44 denied he threatened R66, a staff saw R44 threatened R66 and walked right to R66's face. No evidence of abuse investigation was found nor IDPH notification.

l) R40 hit R46 on 2/26/11. R40 said she hit R46 because R46 won't share her food. R40 also threatened and cursed staff. No abuse investigation was found and no IDPH notification was done.

m) On 12/2/10, R47 kicked R48 on her left leg because R48 wouldn't give R47 her coleslaw. No abuse investigation or IDPH notification was made.

n) R37 punched R49 on the left jaw without provocation while standing at the medication line on 2/14/11. There was no abuse investigation noted nor was there IDPH notification.

Per facility's policy and procedure on abuse, " Any incident concerning a resident that appears to be abuse or neglect will be reported immediately to the administrator or designee for further investigation. Resident alleging abuse must be protected from harm. The accused perpetrator must be immediately separated from the alleged victim. Employees will be immediately suspended and all consultants and vendors will be asked to leave the building."

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 _____	03/31/2011

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 492	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to notify local law enforcement involving 1 of 24 sampled residents(R21), who is an identified offender, who was involved in using an illegal substance while in the facility: Findings Include: Review of the PRSC(Psyche Rehab Social Coordinator) note dated 10-7-10 indicates that " resident(R21) is noted for smoking in his room and having a cigarette lighter." Immediate intervention, " resident was counseled by PRSC on smoking restrictions." Further record review indicates that no plan of care regarding the incident was initiated. There is no further documented evidence of continued monitoring of R 21 regarding inappropriate smoking. There is no documented evidence of the facility contacting the local law enforcement agency of the incident. R 21 medical diagnosis includes Bipolar Disorder, and Chronic Mental Illness, and Schizoid Paranoid Type. Interview with E 1(Administrator) on 3-18-11 at 3:30pm, when asked, why wasn't a careplan immediately initiated on 10-7-10? E 1 stated that because R 21 was smoking	F 492		5/1/11

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 _____	03/31/2011

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 492	Continued From page 121 Marijuana, not a nicotine cigarette, and that it was only a one time thing that did not require a careplan.	F 492		
F 496	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced	F 496		5/1/11

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 _____	03/31/2011

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 496	Continued From page 122 by: Based on record review and interview, the facility failed to ensure that prior to starting work a CNA / certified nurse aide (E29) as a direct care provider, his status should be checked first with the Illinois Nurse Aide Registry. Findings include : E29 was hired and worked as a CNA on 12/2/10. However, his status as a CNA in the Illinois Nurse Aide registry was only checked on 12/3/10. Furthermore, during the registry check on 12/3/10, E46 (staffing coordinator) indicated that this name in the registry was not found. During 3/23/11 interview at 11:30 AM, E46 said that E29 did not show in the registry because he was a CNA from Georgia originally. Per E46's record, E29 was finally in the registry as of 12/21/10 per the Livescan log.	F 496		
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		5/1/11

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 _____	03/31/2011

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 514	Continued From page 123 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete and accurate clinical records on one (R7) of the 24 sampled residents. This deficient practice has the potential to affect all 146 residents that reside in the facility. R7 was admitted to the facility on 2/19/2011 with a diagnosis of schizoaffective disorder. R7 ' s medications include Lithium carbonate 300mg twice a day, Zyprexa 20mg at hour of sleep, Invega susten 156mg monthly. On 3/15/2011 record review of R7 ' s AIMS (Abnormal Involuntary Movement Scale) was noted as incomplete in the medical record. 3/15/2011 at 2:55 p.m., interviewed E3, DON (Director of nurses), when should the AIMS be completed, E3 stated that it should be completed upon admission and then every six months. E3 stated that it is the responsibility of the admission nurse to complete the assessment. E3 reviewed the incomplete AIMS and stated " I will have it completed today " .	F 514		