		I AND HUMAN SERVICES					APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E160	B. WIN	NG _		03/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F	000			
F 152	Licensure Survey for An extended survey	y was conducted. IGHTS EXERCISED BY	F	152	2		5/1/11
	under the laws of a jurisdiction, the righ	ident adjudged incompetent State by a court of competent its of the resident are erson appointed under State esident's behalf.					
	incompetent by the surrogate designate	ident who has not been judged State court, any legal ed in accordance with State ne resident's rights to the State law.					
	by: Based on interview failed to obtain perr	NT is not met as evidenced w and record review, the facility mission for annual flu and the guardian for 1 of residents.					
	Findings include:						
	include Bipolar, Hy Hypothyroidism. D record the facility d injections for influer vaccinations had be 10/18/10 and that F	d male with diagnoses that pertension, Dementia, and uring a review of R13's clinical ocumented that immunizations nza, and pneumococcal een offered to R13 on R13 signed the consent form vas refusing the injections.					
		CER/SUPPLIER REPRESENTATIVE'S SIG					(X6) DATE

DRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 05/17/2012

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

		AND HUMAN SERVICES & MEDICAID SERVICES				-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E160	B. WIN	۱G _		03/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 152	2:30 PM, stated that Z4 further stated the sound decisions to stated that he has a	ge 1 d in an interview on 3/17/11 at it he is R13's legal guardian. at R13 does not always make protect R13's health. Z4 also asked the facility in the past to with regards to health care	F 1	152			
F 154	483.10(b)(3), 483.1 HEALTH STATUS, The resident has the language that he or her total health stat his or her medical of The resident has the advance about care changes in that care the resident's well-b This REQUIREMEN by: Based on record re facility failed to info sampled residents (the medication Risp administering. This affect all residents to medications. Findings Include: 1) R8 is a 47 year of facility on 11-8-10 v includes Schizophre	e right to be fully informed in and treatment and of any e or treatment that may affect	F1	154			5/1/11

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 154 Continued From page 2 F 154 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 167 483.10(g)(1) RIGHT TO SURVEY RESULTS -F 167 5/1/11 READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by

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		I AND HUMAN SERVICES				FORM	05/17/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14E160	B. WIN	NG _		03/3 [,]	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
F 167	correction in effect The facility must ma examination and ma	ige 3 rveyors and any plan of with respect to the facility. ake the results available for ust post in a place readily ents and must post a notice of	F	167	7		
	by: Based on observat facility failed to ensu facility's previous ar	NT is not met as evidenced tion and record review, the ure that the posting of the nnual survey is complete.					
	Findings include :						
	facility's previous ar floor hallways was r	on on 3/15/11 at 1:40 PM, the nnual survey posted on the 1st noted to be incomplete. The d a F167 tag and partial pages					
		er Report 0003D indicated that lity was cited F167, F250, and F406.					
F 223	Meeting on 3/15/11 residents must have pages.	strator) during Daily Status , it's always complete and the e taken the rest of the survey c)(1)(i) FREE FROM FARY SECLUSION	F:	223	3		5/1/11
	sexual, physical, an	e right to be free from verbal, nd mental abuse, corporal voluntary seclusion.					

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		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/17/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	Continued From pa	ge 4	F	223	3		
		ot use verbal, mental, sexual, corporal punishment, or on.					
	by: Based on interview failed : - to ensure 3 reside sample of 24 are freverbal abuse from s - to protect R22, and the 3rd floor, after a 2/15/11 by allowing finish working the s - to report the abuse immediately when in - to have staff who habuse protocols and - to report R22's ab investigate and report possible abuse. This resulted in R22 of injury, and then r facility because he This failure resulted which was determin 9 PM, E33 (nurse) resulted to R22's m (Administrator), E2	d other residents residing on abuse had taken place on the abuser (E33 -nurse) to hift, e incident to Administration t happened on 2/15/11, had been properly trained in d reporting of abuse, use to the state agency, and ort 45 other incidents of 2 being hospitalized because efusing to go back to the feared for his safety. d in an Immediate Jeopardy hed to start when on 2/15/11 at physically abused R22 which					

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		I AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SL COMPLE	JRVEY
		14E160	B. WI	√G _		03/3 ²	1/2011
	ROVIDER OR SUPPLIER		·	1	REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	1) R22 has diagnos Schizoaffective Dis resided on the 3rd f place on the 3-11pr Nursing notes writte at 9:35pm state tha E33's hair, and atta voices. R34 stated 3/17/11 at E33 who was at	ses of Bipolar Disorder, order, and Asthma. R22 floor and this incident took m shift. en by E33 (nurse) on 2/15/11 t R22 was delusional, grabbed cked E33 due to hearing at 1 PM, that he saw R22 yell the nurses station. E33 then	F	223			
	that he was going to R22 in a headlock a was able to get awa then E33 started him pause. R34 said tha "(R22) cannot do an added that E32 (Ce	ind the station and told R22 o "kick (R22's) ass." E33 got and starting hitting him. R22 ay from E33 momentarily and tting R22 again after a short at although R22 tried to fight, nything against E33". R34 ertified Nursing Assistant - t was scared and was rity.					
	2/16/11 states that E36 ran from the 2r because E32 was s heard a commotion to the 3rd floor, he front of each other, his mouth. Both R2 each other as he w Upon reaching the located near the nu R22 by his shirt aga towards the front to	ard) signed statement dated around 9:30 PM of 2/15/11, nd floor to the 3rd floor screaming for security and he on the 3rd floor. When he got saw E33 and R22 standing in and R22 was bleeding from 2 and E33 were cursing at as walking R22 to his room. double doors (which were rse's station), E33 grabbed ain and pulled R22 back give R22 a PRN (as needed) d E33 that he was going to					

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

PRINTED:	05/17/2012
FORM /	APPROVED
OMB NO.	0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	1ULT	FIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDI	NG	COMPLE	TED	
		14E160	B. WI	NG _		03/3	1/2011	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/3	1/2011	
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 223	and to "cool him off back to the nurses an injection. E36 verified on 3/1' statement was true stated that after the a report and put it u door. E1 later deni Despite of E36's se while facing E33, E allegation of abuse (Administrator) or of Review of E36's pe evidence that E36 v inservice on abuse hire (12/15/10), nor inservice on 1/19/1 E32 (CNA) stated of E33 came out of th E32, who was press fight between R22 a report this abuse im (Administrator) or a E32 stated she didu report this fight unti 2/18/11 about abus happened . When her file was n any abuse training attended the inservi-	 m first to change his clothes m first to change his clothes m first to change his clothes station, where E33 gave R22 7/11at 12:10 PM, that his as it was written. E36 also e incident on 2/15/11, he made inder E1's (Administrator's) ed getting this report. eeing R22 bleeding from the lip E36 did not verbally report this immediately to E1 other administrative staff. rsonnel file showed no was given an orientation policy and procedures, upon had E36 attended an abuse 1. on 3/18/11 at 10:51 AM, that e desk and "fought R22". ent during the actual physical and E33, did not call and mediately to E1 ony of the administrative staff. n't know she was suppose to I she attended an inservice on the after the incident had reviewed, E32 did not have upon hire; E32 also did not ice on abuse on 1/19/11 B PM, Z3 (agency nurse) said 	F	223	3			
		3 PM, Z3 (agency nurse) said the 2nd floor on 2/15/11 and						

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 223 Continued From page 7 F 223 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

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FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 223 Continued From page 8 F 223 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

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E160	B. WI	IG		03/3 ²	1/2011
					REET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH ALBANY		
SACRED	HEART HOME			С	CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
TAG F 223	Continued From par file but abuse quiz v Review of facility at showed that E's 19 and 45 (security sta inservice. There was no indica used by the facility abuse to ensure that abuse, and to ensure are supposed to do of abuse. During 3/23/11 inter coordinator) at 11:3 hire, although the n includes abuse pre- there is really no or with the new hires a contents of the pac The inservices on a 2/18/11 and ended 133 attending. Tho inservice included E E46 said she "did n did not pick up their inservice". Review of the staff new hires showed a	ge 9 was blank. buse inservice dated 1/19/11, , 32, 36, 40, 41, 42, 43, 44, aff) did not attend this ation that the agency nurses were given a inservice on at they know how to identify re that they know what they in case there is an allegation rview with E46 (staffing 60 AM, E46 said that upon ew staff is given a packet that vention policy and procedure, he in the facility who sits downs and discusses with them, the ket.	_	223		OPRIATE	
		from the residents, immediate ving of the employee from tact, etc.					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 223 Continued From page 10 F 223 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 velled at or spoken to in an disrespectful tone. E23 also stated that he was also aware that this was verbal abuse.

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		I AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E160	B. WI	NG _		03/3 [,]	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	Continued From pa	ge 11	F	223	3		
	supervisor, E22 (din E22 stated that she E22 further stated w that she had spoke abuse against R25 that the above incid reported to the facil facility policy.	was reported to E23's direct rector of activities) at 2:45 PM. would have a talk with E23. when interviewed at 3:20 PM, n to E23 concerning his verbal and R26. E22 failed to state lents were documented and ity's abuse coordinator per					
	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.						
	following incidents i (R4, 5, 9, 10, 11, 1 residents outside of 37, 38, 39, 40, 41, 50, 51, 52, 53, 54, 8 64, 65, 66 and 67) investigated as abu The facility as a res initial and final repo determine if there re facility investigated altercations and alle and intentional or ju psychiatric diagnos	e facility's abuse files the involving 12 sampled residents 3, 15, 17, 18, 19, 22) and 33 f the sample (30, 31, 35, 36, 42, 43, 44, 46, 47, 48, 49, 55, 56, 57, 58, 60, 61, 62, 63, were noted to have not been use allegations. Bult did not notify IDPH of the ort of the investigation to eally was abuse, nor had the to determine if the physical egations of abuse were willful ust part of the residents es. Examples are as follows: n 12/31/10 because R15					

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		I AND HUMAN SERVICES & MEDICAID SERVICES		FORM	05/17/2012 APPROVED 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG .		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	 above the eye. b) Per incident reaccused R41 of hitting there was redness for accused R41 of hitting there was redness for a c) R13's 12/26 R13 hit his roommare report, R13 said here get his date. d) Per incident for alleged that R15 purpled that R15 purpled. e) R36 alleged the 3rd floor resident was no accompany investigated this to resident to ensure the protected from this abuse investigation notified. f) R5 struck a star punched a CNA (con head on 12/12/10, previdence in the abur investigated, to ensure the accused for the abur investigated, to ensure the accused for the abur investigated the accused for the abur investigated for the abu	R15 sustained 2 lacerations eport dated 1/14/11, R13 ing him. Per incident report, to R13's left jaw. 6/10 incident report indicated ate R42 with a shoe. Per was mad because he did not report dated 1/10/11, R35 it her hand on her (R35's estigation was done nor was hat she was hit 3-4 times by a hile she was in bed. There ing report that the facility determine the identity of this hat other residents are unknown perpetrator. No was done nor the IDPH was aff member on 1/2/11 and ertified nurse aide) in the ber incident reports. No ise files that this was ure that staff as a result did	F	223			
	notification was dor	e investigation nor IDPH ne. a resident of beating her face					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/17/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ²	1/2011
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED I	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	fan on 2/8/11. On 12 was punched by R6 there were abuse in notifications noted i i) On 2/14/11, R3 another resident wit no abuse investigat noted for this incide indication in the inci- resident is. j) On 2/18/11, R4 R44 said he wrestle spitting on his face There was no abuse there IDPH notificat k) On 12/8/10, R4 another resident aft The other resident aft The other resident aft On 12/11/10, R66 alleged that R44 thr R66's face. Althoug R66, a staff saw R4 right to R66's face. investigation was four l) R40 hit R46 on because R46 won't threatened and curs	er on the right shoulder with a 2/10/10, R19 alleged that she 67. For both these incidents, investigations and IDPH in the facility's abuse files. 67 got up of her chair and hit thout provocation. There was ion and IDPH notification int. There also was no ident report of who this other 64 attacked and wrestled R38. Ed R38 because R38 of and R38 denied the allegation. E investigation noted nor was ion. 64 alleged that he was hit by ther saying " Kirk Douglas" . 65 wung at R44 after R66 reatened R66 and was at h R44 denied he threatened R66 and walked No evidence of abuse out indication. 66 Swung at R44 after R66 reatened R66 and walked No evidence of abuse out indication. 72/26/11. R40 said she hit R46 share her food. R40 also	F	223			

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		I AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E160	B. WI	\G		03/3 ²	1/2011
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>		REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	Continued From pa	ige 14	F	223			
	because R48 would	R47 kicked R48 on her left leg dn't give R47 her coleslaw. No or IDPH notification was					
	provocation while s	R49 on the left jaw without tanding at the medication line vas no abuse investigation e IDPH notification.					
	while she was stan station. The identity shown in this incide	43 was hit by another resident ding in front of the nurses of the other resident wasn't ent report. There was no abuse nor was there IDPH					
	her shoulder and th	9 alleged that R11 hit her on hus she hit him back. There stigation noted nor was there					
	for no reason. This	nat on 3/1/11, R17 pushed him resulted in a fight. There was tion noted nor was there IDPH					
	they were in the bar remove R52's purs wash her hands, bu	R51 in the arm on 3/4/11 while throom. R51 said she tried to e from the sink so R51 could at was slapped by R52. There stigation noted nor was there					

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		I AND HUMAN SERVICES				FORM	05/17/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	NG _		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	Continued From pa	.ge 15	Fź	223	3		
	became verbally ag on the right jaw after on. No abuse inves determine is staff re	le in the cigarette line, R53 ggressive and punched a staff er staff told her to put a coat tigation was done to etaliated back. There was no noted nor was there IDPH					
	R4 on the chest and confirmed this. R18	4 alleged that R18 punched d arm. Another resident 3 said he was just playing. e investigation noted nor was tion.					
	grabbed a pole fron	o sign AMA on 3/19/11, n the tent and hit the security. e investigation noted nor was tion.					
		R55 on the face on 3/11/11 was no abuse investigation e IDPH notification.					
	would not move out mutual pushing. Th	R58 pushed R57 after R57 t of R58's way. This resulted to ere was no abuse nor was there IDPH					
		R41 put his hands around R4 sh him away. R41 was					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 223 Continued From page 16 F 223 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

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CENTER	RS FOR MEDICARE	I AND HUMAN SERVICES				FORM OMB NO.	05/17/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	√G _		03/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	with a butter knife a R64 scratched R65 R65 said R64 keep to do something so was no abuse inves IDPH notification. While the Immediae the facility remains level 2, because the the new hires on all new interventions a the possible affecte evaluation of the ne conducted. The facility took the Immediate Jeopard 1) E33 was termina abuse was substan investigation which working day was or 3-11 shift after the a 2) All scheduled stat inserviced on abuse Social service Conso on immediate repor protection of reside 3:00 PM This will be designee for compl 3) No staff member until they had been 4) All agency nurse	and a fork and threatened her. is on his face in self defense. is on bugging him, so he had she leaves R65 alone. There stigation noted nor was there cy was removed on 3/23/11, out of compliance at severity e facility has yet to inservice I shifts, has yet to assess if and policies are effective on ed residents, and the facility's ew plan of care has yet to be e following steps to correct the dy: atted after the allegation of tiated by the facility started 2/16/11. E33's last n 2/15/11, when he finished his abuse incident. aff were immediately e prevention policy by the sultant, E1 and E3, focusing rting of abuse allegations and nts. This started on 3/17/11 at e monitored by E1 or her iance. r will be scheduled to work inserviced on abuse. s will be inserviced by their	F	223			
	4) All agency nurse						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 223 Continued From page 18 F 223 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 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) F 225 5/1/11 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

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 19 F 225 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 bv: 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,

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		BERTH TOATTOI TOMBER.	A. BUI	DING	·			
		14E160	B. WIN	IG		03/31/2011		
	ROVIDER OR SUPPLIER		•	15	EET ADDRESS, CITY, STATE, ZIP CODE 50 SOUTH ALBANY HICAGO, IL 60623			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 225	that he was going t R22 in a headlock a was able to get awa then E33 started hi pause. R34 said the "(R22) cannot do a added that E32 (Ce CNA) was there bu screaming for secu E36's (Security Gu 2/16/11 states that E36 ran from the 2 because E32 was heard a commotion to the 3rd floor, he front of each other, his mouth. Both R2 each other as he w Upon reaching the located near the nu R22 by his shirt aga towards the front to medication. E36 to take R22 to his roo and to cool him off. back to the front, w injection. E36 verified on 3/1 statement was true stated that after th a report and put it u door. Despite of E36's se	ind the station and told R22 o "kick (R22's) ass". E33 got and starting hitting him. R22 ay from E33 momentarily and tting R22 again after a short at although R22 tried to fight, nything against E33". R34 ertified Nursing Assistant - t was scared and was	F2	225				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 22 F 225 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

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		AND HUMAN SERVICES & MEDICAID SERVICES				-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	۱G		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	Continued From particle same floor by E The allegation was administrative staff the abuser (E33) w 2/15/11 placing the floor at risk for abus Review of personne from E32 and E36, staff showed the fo a) E19 - hired 3/2 prevention training/ b) E40 - hired 1/2 prevention training/ c) E41 - hired 7/2 prevention training/ d) E42 - hired 9/2 prevention training/ e) E43 - hired 5/2 prevention training/ f) E43 - hired 12 prevention training/ g) E44 - hired 12 file but abuse quiz v Review of facility at showed that E's 19 and 45 (security st inservice. There was no indicu- used by the facility abuse to ensure that abuse, and to ensure	ge 24 33. not reported immediately to at the time it happened and as allowed to finish his shift on other 79 residents on the 3rd se. el staff files showed that aside the following files of security llowing: 15/11 - no evidence of abuse inservice upon hire 12/11 - no evidence of abuse inservice upon hire 24/07 - no evidence of abuse inservice upon hire 15/07 - no evidence of abuse inservice upon hire 4/10 - no evidence of abuse inservice upon hire 4/10 - no evidence of abuse inservice upon hire /6/04 - no evidence of abuse inservice upon hire /2/09 - with abuse packet in		225	DEFICIENCY)		
	of abuse.						

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		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/17/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 7 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 25	F	225	5		
	coordinator) at 11:3 hire, although the n includes abuse prev there is really no on	rview with E46 (staffing 30 AM, E46 said that upon ew staff is given a packet that vention policy and procedure, he in the facility who sits downs and discusses with them, the ket.					
	2/18/11 and ended	buse were not started until with only 57 employees out of se who did not get the E36, E39, and Z3.					
		ot get all of the staff as some r checks and did not attend the					
	new hires showed a including types of a separating abusers	orientation packet given to abuse policy and procedures buse, immediate reporting, from the residents, immediate ving of the employee from ttact, etc.					
	the abuse incident h 2/16/11. The facility the staff on abuse to reported immediate investigated immed	and E2 were made aware of between E33 and R22 on did not immediately inservice o ensure that allegations are ely, that allegations are liately, and that the victims of are protected from perpetrator.					
	monitor) was obser main lobby of the fa	D:30 AM, E23 (smoking ved standing in the hall of the acility near the elevator. E23 ng at R26 in a disrespectful					

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		AND HUMAN SERVICES				FORM	05/17/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ²	1/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	tone. E23 yelled "p them up right now".	oull your pants up and pull	F	225	5		
		wearing a belt on his pants. served to be low around R26's					
		terviewed at this time that he I at R26 and speak to the pectful manner.					
	dispensing cigarette smoking patio. R25 E23 and ask for a c R25 in a loud voice	7/11 E23 was observed es to the residents on the 5 was observed to approach cigarette. E23 began to yell at e stating "didn't I tell you that more cigarettes, now get out					
	and stated that he w of the facility and th residents are not to an disrespectful ton	terviewed after the incident was aware of the abuse policy hat he was aware that be yelled at or spoken to in he. E23 also stated that he tt this was verbal abuse.					
	supervisor, E22 (dir E22 stated that she E22 further stated v that she had spoke abuse against R25 that the above incid	was reported to E23's direct rector of activities) at 2:45 PM. would have a talk with E23. when interviewed at 3:20 PM, in to E23 concerning his verbal and R26. E22 failed to state dents were documented and lity's abuse coordinator per					
		stated when interviewed on M, that the above incident had					

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	alleged that R15 pur neck. No abuse inve IDPH notified. e) R36 alleged th 3rd floor resident wi was no accompany investigated this to resident to ensure t protected from this abuse investigation notified. f) R5 struck a sta punched a CNA (ca head on 12/12/10, p evidence in the abu investigated, to ens not hit resident back g) R22 stomped on 1/2/11. No abuse notification was dor h) R19 accused a and head and hit he fan on 2/8/11. On 1 was punched by R6 there were abuse in notifications noted i i) On 2/14/11, R3 another resident with no abuse investigat	At her hand on her (R35's estigation was done nor was hat she was hit 3-4 times by a hile she was in bed. There ing report that the facility determine the identity of this hat other residents are unknown perpetrator. No was done nor the IDPH was aff member on 1/2/11 and ertified nurse aide) in the ber incident reports. No use files that this was sure that staff as a result did k. R31's foot and punched R31 e investigation nor IDPH	F	225			

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		I AND HUMAN SERVICES				FORM	05/17/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 [.]	1/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACREE	HEART HOME				550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	j) On 2/18/11, R4 R44 said he wrestle spitting on his face There was no abus there IDPH notificat k) On 12/8/10, R another resident aff The other resident is but incident report of other resident is. N notification was four On 12/11/10, R6 alleged that R44 th R66's face. Althoug R66, a staff saw R4 right to R66's face. investigation was four because R46 won't threatened and cur investigation was four was done. m) On 12/2/10, F because R48 would abuse investigation made. n) R37 punched provocation while s on 2/14/11. There w	 44 attacked and wrestled R38. ad R38 because R38 of and R38 denied the allegation. e investigation noted nor was tion. 44 alleged that he was hit by ter saying " Kirk Douglas" . was just identified with initials does not indicated who this o abuse investigation no IDPH nd. 6 swung at R44 after R66 reatened R66 and was at the R44 denied he threatened the threatened R66 and walked No evidence of abuse bund nor IDPH notification. 2/26/11. R40 said she hit R46 share her food. R40 also sed staff. No abuse bund and no IDPH notification R47 kicked R48 on her left leg dn't give R47 her coleslaw. No or IDPH notification was R49 on the left jaw without tanding at the medication line was no abuse investigation 	F	225			

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		14E160	B. WI	NG _		03/3 ²	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	 while she was stand station. The identity shown in this incide investigation noted notification. p) On 2/28/11, R⁴ her shoulder and th was no abuse invest IDPH notification. q) R50 alleged th for no reason. This no abuse investigat notification. s) R52 slapped F they were in the bat remove R52's purse wash her hands, bu was no abuse invest IDPH notification. t) On 3/8/11, whill became verbally ag on the right jaw after on. No abuse invest determine is staff reference. 	ge 30 ding in front of the nurses of the other resident wasn't ent report. There was no abuse nor was there IDPH 9 alleged that R11 hit her on hus she hit him back. There stigation noted nor was there hat on 3/1/11, R17 pushed him resulted in a fight. There was tion noted nor was there IDPH R51 in the arm on 3/4/11 while throom. R51 said she tried to e from the sink so R51 could at was slapped by R52. There stigation noted nor was there here in the cigarette line, R53 gressive and punched a staff er staff told her to put a coat tigation was done to etaliated back. There was no noted nor was there IDPH	F	225			
		4 alleged that R18 punched d arm. Another resident					

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		HAND HUMAN SERVICES				FORM	05/17/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WINC	G		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER		ç		EET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				50 SOUTH ALBANY HICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	confirmed this. R18	said he was just playing. ie investigation noted nor was	F 22	25			
	grabbed a pole from	o sign AMA on 3/19/11, m the tent and hit the security. se investigation noted nor was tion.					
		R55 on the face on 3/11/11 was no abuse investigation e IDPH notification.					
	would not move our mutual pushing. Th	R58 pushed R57 after R57 t of R58's way. This resulted to here was no abuse nor was there IDPH					
	to choke him or pus agitated, delusional said it is because R	R41 put his hands around R4 sh him away. R41 was I, and hard to redirect. R41 R4 touched R41's hair. There stigation noted nor was there					
	provocation. R60 sa	R60 hit R63 without aid he doesn't not like R63 that no abuse investigation noted I notification.					
	aa) R61 scratche	ed a resident on the right neck					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 32 F 225 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

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		14E160	B. WI	۷G		03/3 ²	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	evaluation of the ne conducted.	w plan of care has yet to be following steps to correct the	F	225			
	1) E33 was termina abuse was substan investigation which working day was on 3-11 shift after the a	ted after the allegation of tiated by the facility started 2/16/11. E33's last 2/15/11, when he finished his abuse incident.					
	inserviced on abuse Social service Cons on immediate repor protection of reside	aff were immediately e prevention policy by the sultant, E1 and E3, focusing ting of abuse allegations and nts. This started on 3/17/11 at e monitored by E1 or her iance.					
		will be scheduled to work inserviced on abuse.					
	agency on the facili procedure prior to b facility. They will no facility, until written	s will be inserviced by their ty's abuse policy and being scheduled to work at the ot be allowed to work at the proof of abuse inservice the facility. This was 11.					
	abuse inservice tha and resident protec staff. This will be m	t be allowed to work until t includes policy on reporting tion is completed by the new onitored by the Administrator/ e a part of the facility's weekly					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 34 F 225 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 226 483.13(c) DEVELOP/IMPLMENT F 226 5/1/11 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 bv: 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,

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/31	1/2011
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	prevention training/ b) E40 - hired 1/1 prevention training/ c) E41 - hired 7/2 prevention training/ d) E42 - hired 9/1 prevention training/ e) E43 - hired 5/2 prevention training/ f) E43 - hired 12 prevention training/ g) E44 - hired 12 file but abuse quiz w Moreover, review of 1/19/11, showed tha 43, 44, and 45 did r During 3/23/11 inter coordinator) at 11:3 hire, although the n includes abuse prev there is really no on with the new hires a contents of the pact Review of the staff new hires showed a including types of a separating abusers investigation, remov further resident con After E1 and E2 we abuse incident betw did not immediately	¹ inservice upon hire 12/11 - no evidence of abuse inservice upon hire 24/07 - no evidence of abuse inservice upon hire 15/07 - no evidence of abuse inservice upon hire 4/10 - no evidence of abuse inservice upon hire 2/6/04 - no evidence of abuse inservice upon hire 2/2/09 - with abuse packet in was blank. If facility abuse inservice dated at E's 19, 32, 36, 40, 41, 42, not attend this inservice rview with E46 (staffing 30 AM, E46 said that upon new staff is given a packet that vention policy and procedure, ne in the facility who sits downs and discusses with them the ket. orientation packet given to abuse policy and procedures abuse, immediate reporting, from the residents, immediate ving of the employee from	F	226	6		

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 38 F 226 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

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	NG _		03/3 [,]	1/2011
NAME OF P	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	facility investigated altercations and alle and intentional or jup psychiatric diagnost a) R30 hit R15 or called R30 names. above the eye. b) Per incident re accused R41 of hitt there was redness f c) R13's 12/26 R13 hit his roomma report, R13 said he get his date. d) Per incident n alleged that R15 pun neck. No abuse inv IDPH notified. e) R36 alleged th 3rd floor resident w was no accompany investigated this to resident to ensure t protected from this abuse investigation notified. f) R5 struck a sta punched a CNA (co head on 12/12/10, p	to determine if the physical egations of abuse were willful ust part of the residents es. Examples are as follows: In 12/31/10 because R15 R15 sustained 2 lacerations eport dated 1/14/11, R13 ing him. Per incident report, to R13's left jaw. 6/10 incident report indicated ate R42 with a shoe. Per was mad because he did not report dated 1/10/11, R35 it her hand on her (R35's estigation was done nor was hat she was hit 3-4 times by a hile she was in bed. There ing report that the facility determine the identity of this that other residents are unknown perpetrator. No was done nor the IDPH was aff member on 1/2/11 and ertified nurse aide) in the per incident reports. No use files that this was sure that staff as a result did	F	226	6		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WIN	IG		03/3 [/]	1/2011
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				550 SOUTH ALBANY HICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	Continued From pa	ige 40	F 2	226			
		R31's foot and punched R31 e investigation nor IDPH ne.					
	and head and hit he fan on 2/8/11. On 1 was punched by Re there were abuse i	a resident of beating her face er on the right shoulder with a 2/10/10, R19 alleged that she 57. For both these incidents, investigations and IDPH in the facility's abuse files.					
	another resident wi no abuse investiga noted for this incide	37 got up of her chair and hit thout provocation. There was tion and IDPH notification ent. There also was no ident report of who this other					
	R44 said he wrestle spitting on his face	44 attacked and wrestled R38. ed R38 because R38 of and R38 denied the allegation. e investigation noted nor was tion.					
	another resident af The other resident but incident report	44 alleged that he was hit by ter saying " Kirk Douglas" . was just identified with initials does not indicated who this o abuse investigation no IDPH nd.					
	alleged that R44 th R66's face. Althoug R66, a staff saw R4 right to R66's face.	6 swung at R44 after R66 reatened R66 and was at gh R44 denied he threatened 44 threatened R66 and walked No evidence of abuse bund nor IDPH notification.					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 41	F	226	;		
	because R46 won't threatened and curs	2/26/11. R40 said she hit R46 share her food. R40 also sed staff. No abuse ound and no IDPH notification					
	because R48 would	R47 kicked R48 on her left leg dn't give R47 her coleslaw. No or IDPH notification was					
	provocation while s	R49 on the left jaw without tanding at the medication line vas no abuse investigation e IDPH notification.					
	while she was stand station. The identity shown in this incide	43 was hit by another resident ding in front of the nurses of the other resident wasn't ent report. There was no abuse nor was there IDPH					
	her shoulder and th	9 alleged that R11 hit her on us she hit him back. There stigation noted nor was there					
	for no reason. This	hat on 3/1/11, R17 pushed him resulted in a fight. There was tion noted nor was there IDPH					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 42 F 226 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

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WING	·	03/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME			1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	investigation noted notification.	nor was there IDPH	F 22	26		
	to choke him or pus agitated, delusional said it is because R	R41 put his hands around R4 sh him away. R41 was , and hard to redirect. R41 4 touched R41's hair. There stigation noted nor was there				
	provocation. R60 sa	R60 hit R63 without aid he doesn't not like R63 that no abuse investigation noted I notification.				
	on 11/23/10. R61 s by this other reside other resident was and there was no in	ed a resident on the right neck tated she was being bothered nt, calling R61 a Hub. The only identified with an initial KK adication in the report who this buse investigation noted nor tification.				
	spat at her face. Re R63 said she was j spat at her and thre no abuse investigat notification. cc) R10 arrived from scabs on both knee that hospital securit Although facility cal	R62 threw a chair at R63 and 52 said that R63 hit him first. ust sitting in line when R62 ew a chair at her. There was tion noted nor was there IDPH m a hospital with scrapes and es on 12/27/10. R10 alleged by threw him on the ground. led the hospital and got in coordinator who said the				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG		03/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	7) Nurse consultant a month to monitor compliant with the r Social Service Con abuse of the agenc with the weekly QA	ge 46 t will come to the facility twice if facility and administration is monthly inservicing of staff by sultant, with the inservicing on y staff prior to working, and process to ensure new hires use inservice prior to start.	F	220	6		
F 241	: 483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F	24	1		5/1/11
	manner and in an e	omote care for residents in a environment that maintains or ident's dignity and respect in					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 [,]	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 241	Continued From pa full recognition of hi	ge 47 is or her individuality.	F	241	1		
	by: Based on observat interview, the facility 3 sampled (R7, R1	NT is not met as evidenced tion, record review, and y failed to ensure the dignity of 0 and R13) and 1 outside of This failure has the potential idents in the facility.					
	Findings Include:						
	days of the survey (observed R 27 enter same shirt on. Also resident(Female) is breasts are visibly of Review of R 27 card prefers not to wear to change clothing.' " make sure resider blouses/shirts that of a bra." This was not 4:45pm, during the	on of the dining room on 3 of 4 (March 15 th, 16 th, and 17 th), ering the dining room with the ponoted that the without a bra. The resident's putlined under her shirt. eplan indicates that R 27" a bra and sometimes refuse "Interventions noted includes int wears appropriate do not show she isn't wearing of done. On 3-17-11 at Daily Status Meeting, the d of the observations.					
	observed R10 in his	r on 3-15-11 at 10:08 AM s room with black stained blue in R10's room three empty xt to his bed.					
	Record review of ph R10 re-admitted 2-8	hysicians order sheet denotes 9-11.					
		3-15-11 at 10:10 AM, states t been returned since he has					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 50	F	250	0		
	services to attain or	ovide medically-related social r maintain the highest I, mental, and psychosocial resident.					
	by: Based on record re failed to ensure that provided to assess interventions for 8 s R6, R7, R9, R10, R	NT is not met as evidenced eview and interview the facility t social services were and develop necessary sampled residents (R2, R4, 13, R15, and R16) in the dress their psychiatric er issues					
	Finding include:						
	services coordinato states R10 has not talked to him 1:1 at she does not have a sessions. E6 states in the P.R.S.C. prog re-admitted. E6 stat scheduled 1:1 sess for 1:1. E6 states th in group and 1:1 se be addressed in the meeting. Record review of th	(psychiatric rehabilitation or) on 3-15-11 at 3:35 PM, been going to group, but oout going groups. E6 states any documentation from 1:1 a she did document on 2-9-11 gress notes when R10 was tes that R10 has not attended ion, but has to seek him out hat R10's lack of involvement essions is a problem that will a next care plan and quarterly the psychiatric rehabilitation or progress notes on 2-9-11;					
		or progress notes on 2-9-11; Id to resume normal routine.					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 250 Continued From page 51 F 250 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 gualify 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

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		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/17/2012 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 250	Continued From pa	ae 52	F	250			
		heets. R4 and R6 names did	-				
		sychosocial groups does not as belonging to any groups.					
		5 pm R4 stated, " went to ago. Not right now in groups.					
	Rehabilitation Coun R4, "Not attending to one's. He does The interdisciplinary	pm E15 (Psychosocial iselor) stated with regards to group. Try to engage in one n ' t talk when meets with you. y team has not met to discuss with groups and how to been here. "					
	Rehabilitation Servi						
	On 3/15/11 at 11:45 participate in group	5 pm R6 stated, " Don ' t want s. "					
	stated, " I do one o attending groups. H Do one to one ' s in review for R6 does assist in gaining R6 at psychosocial gro place to get R6 to a	bilitation counselor for R6) in one 's with (R6) He 's not le qualifies for Subpart S. " stead of groups. " Care plan not include interventions to compliance with attendance ups. Facility has no plan in ittend groups.					
	3) R13 is a 69 year	old male with diagnoses that					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	NG .		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	٦IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 56	F	25(0		
	service case worke who will attend his g follow up or remind session. E25 said t the case responsibil attend the group. E consistently not atter will delete them from 6) According to R18 diagnosis of Bipolar current plan of care is identified with the of peers motives wi to assist R15 in get attend social skills g week. R15 is also and agitated along become physically interventions to incl skills, social skills a 2 times a week. R1 demonstrate behavior attempting to devel with male peers, wi attending behavior skills, and coping sl On 3/18/11 at 12:00 R15 said that she d group therapy. R15 to group. R15 iden R15 said that she d E14 does not encor	oup leader), said that social r give names of the residents groups. E25 said that he don't residents to attend the group that it is the residents and/or ility to ensure the resident 25 said that if a resident is ending the group session he m the group. 5's clinical record R15 has a r disorder. According to R15's e updated January, 2011 R15 e problem of being suspicious ith intervention to include 1:1's ting along with people, and to group sessions 2 times a identified as being anxious with being delusional, and can / verbally abusive, with ude participating in coping and anger management groups 15 is also identified to ior symptoms concerning daries in the form of op inappropriate relationships th interventions to i include management group, social kills group 2 times a week. Dpm before the lunch meal lon't attend any psycho-social 5 said that she don't like going tified E14 as her case worker. Ion't meet , with E14, and that urage her to attend the groups. arely talks with her.					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 250 Continued From page 57 F 250 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.

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		HAND HUMAN SERVICES				FORM	05/17/2012 APPROVED 0938-0391
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		14E160	B. WI	NG		03/3 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG F 250	Continued From pa clothed in a blue sw On 3/15/2011 at 2:3 regarding R7 ' s pro Rehabilitation Servi R7 " refuses to par because he thinks I that she placed R7 a focus on motivation Record review on 3 documentation of a 3/17/2011 at 2:42 p one on one docume stated " I don ' t ha	age 60 veatshirt and khaki pants. 37 p.m., interviewed E6, bgrams E6, PRSC (Psychiatric ices Coordinator), stated that rticipate in any programs he is a psychiatrist " E6 stated in a one on one program with on and building rapport. 3/15/2011 revealed no iny One on One session. On o.m., interviewed E6 regarding entation with R7 and she we any documentation of my hs, I was going start that this	1	250			
	Based on observati	ailed to ensure that 4 of 24					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 250 Continued From page 63 F 250 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. 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

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 250 Continued From page 64 F 250 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

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

<u>CENTE</u>	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO.	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULT	IPLE CONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER:	A. BUI	LDIN	IG	COMPLE	TED
		14E160	B. WI	NG _		03/3	1/2011
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
SACRE	HEART HOME				550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	session. On 3/17/ that R15 don't attername is on the rost On 3/18/11 at E14 said that R15 is curi identified R15 as his physically / verbally said that R15 has bis psycho-social grou skills, anger managern he was aware that psycho-social grou excitable at times in E14 was asked wh R15 when excitable 1:1 therapy with R1 therapy he provides informal. E14 was the outcomes of the measured in the psi attends. E14 said facility's one on one was asked if the fa E14 responded yes the consequences group therapy, and that R15 was on ar for not following fac R15 don't attend th group he encourag According to R16's identified with mod	11 E25 (group leader), said and the group even though her ter. (social service case worker), rrently on his caseload, aving behavior of accusatory, aving behavior of accusatory, aggressive at times E14 been assessed and enrolled in p therapy to include, coping gement, social skills, and hent skill group. E14 said that R15 don't attend the p, but said that R15 becomes n groups and may not do well. at was the next plan of care for e, and E14 said that the 1:1 s is not documented, it is asked how does he measure e therapy, E14 said it is sycho-social group R15 that he was aware of the e session progress notes. E14 cility has behavior contracts s. E14 was asked what was for not attending psycho-social E14 said none. E14 denied by type of behavior contracts cility's protocol. E14 said that if e schedule psycho-social	F	250			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 250 Continued From page 66 F 250 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

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 250 Continued From page 67 F 250 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 253 483.15(h)(2) HOUSEKEEPING & F 253 5/1/11 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.

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DEPART CENTER	PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
14E160			B. WI	NG _		03/31/2011	
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED HEART HOME					1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 253	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		F	253	3		

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 253 Continued From page 69 F 253 the unit. -The laminate counter top in the snack was in poor condition. Large section was missing. F 272 483.20(b)(1) COMPREHENSIVE F 272 5/1/11 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.

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DEPART CENTEF	PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
14E160			B. WI	NG _		03/31/2011	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED HEART HOME					CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 70	F	272	2		
	by: Based on interview failed to include psy	NT is not met as evidenced and record review, the facility and record review, the facility chiatric evaluation in the sessment for 1 (R17) of 24 d residents.					
	Findings include:						
	2/8/11. R17 has Bi On 3/17/11 E14 (Ps Counselor for R17)	uments admission date of polar Affective Disorder. sychosocial Rehabilitation stated, " He (R17) is Subpart chiatrist evaluation. "					
F 276	evaluation during da 3/18/11.	d of lack of psychiatrist aily status meeting on RLY ASSESSMENT AT	F	276	8		5/1/11
	quarterly review ins	ss a resident using the trument specified by the State MS not less frequently than ns.					
	by: Based on interview	NT is not met as evidenced and record review, the facility npletion of Psychiatric					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 276 Continued From page 72 F 276 Facility was advised of lack of Quarterly update during daily status on 3/17/11. F 278 483.20(g) - (j) ASSESSMENT F 278 5/1/11 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

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		I AND HUMAN SERVICES					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	NG _		03/3 [,]	1/2011
	PROVIDER OR SUPPLIER	1550 SOUTH ALBANY					
				(CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	-	F	279			
		the results of the assessment and revise the resident's n of care.					
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable stables to meet a resident's nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise §483.25 but are not provided s exercise of rights under the right to refuse treatment b).					
	by: Based on record re facility failed to initia psych meds, and to sampled resident (I	NT is not met as evidenced eview, and interview, the ate care plans for smoking, behavioral issue involving 3 R5, R7 and R 21) of 24 and 1 outside the sample (
	Findings Include:						
	Coordinator) note o	RSC(Psyche Rehab Social lated 10-7-10 indicates that " r smoking in his room and					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 279 Continued From page 76 F 279 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

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	05/17/2012 APPROVED 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
	14E160	B. WIN	NG _		03/3 ⁻	1/2011
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED HEART HOME				CHICAGO, IL 60623		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280 Continued From page	e 78	Fź	280			
by: Based on record revi failed to review and revi interdisciplinary appro- sampled residents (F and R18) in a sample Findings include: 1) Record review of F 9-10-10 and 12-10-10 attend 1:1 sessions; g of psychiatric rehabi progress notes on 12 change goal and to e times weekly. Record review of the procedure for the role rehabilitation services of each meeting will b Specialized Services sheet and kept in the information will be sh professional staff. Inte documented in the re E6 interviewed (psych coordinator) on 3-15- has not been going to about going groups. E any documentation fr 2-9-11 in the P.R.S.C	R10's care plan denotes on 0 resident (R10) does not goal not met. Record review ilitation services coordinator 2-22-10 recommendation to engage R10 in conversation 3 e facilities policy and e of the psychiatric s coordinator is the outcome be recorded on the cone to One Response e resident's chart. Relevant hared with involved terventions will be					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/17/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	NG _		03/3 ²	1/2011
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	indicates that R16 r smoking. A review of R16's c plan of care indicate of unsafe smoking r On 3/18/11 at 1:30p aware that R16 had E14 said that he wa 2/25/11, but was un E14 said that he wa 2/25/11, but was un E14 said that he me behavior of unsafe denied smoking uns he review the smok that he didn't initiate with intervention to the facility's smokin verbalize why he did R16's behavior of u A review of R16's c progress dated 2/28 behavior of unsafe Son 3/18/11 1:55pm said that residents a smoker, are placed said that social serv plan of care with int supervise R16 and smoking. 6) R7 was admitted with a diagnosis of s 3/15/2011 record re	s smoking policy. The note equires supervision while urrent care plan there was no ed to address R16's behavior noted. om E14 said that he was I a history of unsafe smoking. as aware of the note dated h-aware of who wrote the note. et with R16 1:1 regarding his smoking. E14 said that R16 safely, however E14 said that ing policy with R16. E14 said e or develop a plan of care ensure R16 complies within g policy. E14 was unable to dn't develop a plan of care for nsafe smoking. urrent 1:1 intervention and B/11 note failed to note R16's	F	280			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY	
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	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY CHICAGO, IL 60623	ſE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 7 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 280	PRSC will seek out session 3x weekly. interviewed E6 rega documentation with have any documen	resident for one on one On 3/17/2011 at 2:42 p.m.,	F	280)			
	failed to revise and for 2 of 24 sampled intervention after R suicidal ideation, ar unsafe smoker. Findings include: According to R15' 1/10/11 hospitalizat discharged to the h psychiatric evaluati nurses note R15 ca stating that she did can't take it anymon R15 made other su not identify any reas According to another	and record review the facility implement the plan of care residents R15/R16 with new 15 was hospitalized for and R16 was assess to be a s social service notes dated tion note indicate that R15 was ospital from the facility for on. The note indicates per ame to the nurses station n't want to live anymore. "I re". The note indicates that icidal statements, though did son for these statements. er social service note dated icates that R15 told social						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 85 F 280 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 guarterly, and when new behaviors are observed or required treatment. E 5 said that she would expect E14 to initiate a plan of care for

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 86 F 280 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

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	NG _		03/31	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 285	pre-admission scree program under Meet the maximum exter duplicative testing a A nursing facility m January 1, 1989, an (i) Mental illness a (i) of this section, u authority has detern independent physic performed by a per State mental health (A) That, becaus condition of the ind the level of services and (B) If the individu services, whether the specialized services (ii) Mental retardation (m)(2)(ii) of this sector retardation or deven has determined price (A) That, becaus condition of the ind the level of services and (B) If the individu services, whether the condition of the ind the level of services and (B) If the individu services, whether the	dinate assessments with the ening and resident review dicaid in part 483, subpart C to and effort. ust not admit, on or after by new residents with: is defined in paragraph (m)(2) nless the State mental health mined, based on an al and mental evaluation son or entity other than the authority, prior to admission; e of the physical and mental ividual, the individual requires s provided by a nursing facility; hal requires such level of he individual requires s for mental retardation. tion, as defined in paragraph ction, unless the State mental lopmental disability authority or to admission e of the physical and mental ividual, the individual requires s provided by a nursing facility;	F	285			
	(i) An individual is	considered to have "mental lual has a serious mental					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 285 Continued From page 89 F 285 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

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		AND HUMAN SERVICES				FORM	05/17/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14E160	B. WI	NG _		03/3 ²	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 285	outcome summary facility level of care the survey. On 3/17/11 at 9:45a meeting E1 (admini provided the survey information she had screening. 2)R6 and R17 were 7/24/08 and 2/8/11 sheets document R Schizophrenic and On 3/17/11 during of R17 was requested titled " interagency results for long term document is not a F PASRR screening i and outlines specia required by the resi Based on record re failed ensure that the resident review was sampled residents for mental illness diagon	available, nor was the nursing determination available during am during the morning istrator), said that she y team with all of the d for R9's pre-admission e admitted to the facility on respectively. Physician order to is diagnosed as R17 as Bipolar disorder. daily status, PASRR of R6 and f. Facility presented document certification of screening in care, for R6 and R17. This PASRR screening. is required prior to admission lized rehabilitative services ident. view and interview the facility he pre-admission screen and s complete, for 1 of 24 R9. R9 is identified with a nosis.	F	285			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 285 Continued From page 91 F 285 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 312 483.25(a)(3) ADL CARE PROVIDED FOR F 312 5/1/11 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

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		14E160	B. WI	NG _		03/31	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	 by: Per observation an failed to assist 1 sa R28) outside the sa Findings include : 1) During observation 3/16/11, R13 was of that were at least a R13's was observed out of the shoes witt was observed 3/15/ large amount of fac When interviewed of stated that he did no stated that he did no stated that he is sha they have not given of days. E3 (director of nurs on 3/16/11 at 4:00 F staff. 2) On 3/15/11 and be wearing the sam yellow tee shirt was black and brown sta stained. R28 was of pants up with his ha When interviewed a 	and record review, the facility impled resident (R13), and 1 (ample of 24. ons made on 3/15/11 and observed wearing gym shoes size too large for his feet. d with his feet slipping in and th each step. In addition, R13 /11 and 3/16/11 to have a sial hair (3/15/11 and 3/16/11). on 3/16/11 at 3:45 PM, R13 ot shave himself. R13 further aved by a staff member but him a shave in the last couple ing) stated when interviewed PM, that R13 is shaved by the 3/16/11 R28 was observed to be clothing. The oversized, s observed to be stained with ains. R28's pants were also observed to be holding his and. at that time R28 stated that his lown because he did not have	F	312	2		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 312 Continued From page 93 F 312 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 323 483.25(h) FREE OF ACCIDENT F 323 5/1/11 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, "

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		14E160	B. WII	NG _		03/3 [,]	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	from facility. It says maintenance and s resident via car and Per 3/18/11 inte at 3:15 PM, R23 wa he eloped. E49 add go out for 14 days of On 1/11/11, per that R23 was at his II Based on observe facility failed to ens sampled residents(hazards and failed associated with ina of 24 sampled residents(hazards and faile	 taff member while eloping that 2 security guards, social service staff pursued d foot but was not found. rview with E49 (case worker) as at the facility for 2 days then ded that he is not suppose to upon admission. nurses notes, E3 indicated mother's house. vation, and interview, the ure that the room of 1 of 24 (R 3), was free of accident to initiate interventions ppropriate smoking involving 1 dents(R21). tour on 3-15-11, entered the d that between the bedroom athroom is a 2 inch floor drop pathroom. This non level area in the bedroom and the tentiate a tripping hazard. On during the daily status v was informed of the concern. 	F	323			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	NG _		03/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED HEART HOME					1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 97	F	323	3		
F 329	failed to ensure the chemicals on the se secured. The failur residents residing of Findings include: During the initial to E26 (nurse supervis the laundry/soiled u closet should be loo residents form havi hazardous chemica On 3/15/11 during t E26 (nurse superv bleach was observe There was 2 bottle of acid bath cleaned 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the	ur on the second floor with sor), the survey team opened tility closet. E26 said that the cked at all times, to keep ng access to potentially ils. he initial tour at 10:00am with isor), the 3 open bottles of ed open in the utility closet. of glass cleaner, and (1) bottle r. EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F	329			5/1/11

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		14E160	B. WI	NG _		03/3 ²	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				1550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and d record; and residen drugs receive gradu behavioral intervent contraindicated, in a drugs. This REQUIREMEN by: Based on record re facility failed to have medication involving 21). Findings Include: Review of R 21's r receives Ambien 5 when necessary. R Orders Sheet) indic is May of 2010. Arr Hypnotic. Accordin Handbook for Nursi Ambien is used for insomnia." Review Administration Reco MDS(Mini-Data-Set and Psychiatrist Pro- indicate Insomnia a	T is not met as evidenced eview, and interview, the e adequate indication for 1 g 1 of 24 sampled residents (R record indicates that he milligrams every hours sleep Review of the POS(Physician eates that the initial order date bien is classified as a g to the Drug Information ing , 10 th edition, 2009, " short term treatment of of the POS, MAR(Medication ord), Careplans, t), Physician Progress Notes, pgress Notes , does not as a medical diagnosis. Also,	F	329			
	there is no docume	nted evidence of any previous					

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		14E160	B. WI	1G		03/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER	L			REET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART HOME				550 SOUTH ALBANY CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 366	Continued From pa	ige 101	F:	366			
F 372	at 10:30 am indicat available for lunch a E 10(Food Service 11:00 am stated tha no substitute plan a 483.35(i)(3) DISPO PROPERLY	ty substitute policy on 3-16-11 es that food substitutes are and dinner only. Interview with Supervisor) on 3-16-11 at at at this present time, there is available for breakfast meals. SE GARBAGE & REFUSE spose of garbage and refuse	FS	372			5/1/11
	by: Based on observat maintain the outsid sanitary manner. A	NT is not met as evidenced tion, the facility failed to e dumpster area in a clean n odor, garbage and debris ne surrounding dumpster area.					
	during the environm E37 (Maintenance (Housekeeping Sup 11:20am. The outs located right off the area. An odor com observed as you wa a large accumulation the ground surroum cardboard dumpste	bervisor) which started at ide garbage dumpsters are resident 's outside smoking ing from the dumpsters was alked toward them. There was on of garbage and debris on ding the dumpsters. Three ers were overflowing with a stored in the area, had					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER SACRED HEART HOME THE SUPPLIER COMPLETED STREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY CHICAGO, IL 60623 STREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY CHICAGO, IL 60623			I AND HUMAN SERVICES & MEDICAID SERVICES				-	APPROVED 0938-0391
Image of provider or supplier Street Address, City, State, Zip code SACRED HEART HOME STREET ADDRESS, CITY, STATE, ZIP CODE (Mai) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MIST BE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MIST BE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING, INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) Company (MS), Company (EACH DEFICIENCY) Company (MS), Company (EACH DEFICIENCY) Company (MS), Company (EACH DEFICIENCY) Company (MS), Company (EACH DEFICIENCY) Company (MS), Company (MS), Company (EACH DEFICIENCY) Company (MS), Compa	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SU	JRVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SACRED HEART HOME STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE F 406 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES ID PREFIX TAG PROVIDER PLAN OF CORRECTION MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 406 F 406 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES F 406 5/1/11 If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services; or obtain the reguired services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. F 406 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 (f1 1, R3, R8, R10, R11, R14, R18, and R 21) with history of mental illness and classified as identified offenders. Street ADDRESS, CITY, STATE, ZIP CODE			14E160	B. WI	NG _		03/3	1/2011
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 406 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES F 406 F 406 If specialized rehabilitative services such as, but not limited to, physical 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 for 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. ID PREFIX F 406 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES) Completion (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. ID DEFICIENCY					1	1550 SOUTH ALBANY		
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.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
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	REHAB SERVICES If specialized rehab not limited to, physi pathology, occupati health rehabilitative and mental retardar resident's compreh must provide the re required services fr accordance with §4 provider of specialis This REQUIREMEN by: Based on observati interview, the facilit rehab services invo 24 sampled resider R14, R18, and R 27 and classified as id Findings Include: 1) R3 is a 60 year of facility on 2-4-09 wi includes Bipolar Aff Substance Abuse, a classified as a Com Observed resident his bed followed by Record review indic includes "poor med times, inappropriate poor impulse contro having an mental ill	 ilitative services such as, but cal therapy, speech-language onal therapy, and mental services for mental illness tion, are required in the ensive plan of care, the facility quired services; or obtain the om an outside resource (in 83.75(h) of this part) from a zed rehabilitative services. NT is not met as evidenced ion, record review, and y failed to provide specialized diving 7 sampled residents of nts(R 1, R3, R8, R10, R11, 1) with history of mental illness entified offenders. Nd resident admitted to the the medical diagnosis which ective Disorder, Poly and Hepatitis. R 3 is also victed Sex Offender. spending most of the time in walking thruout the facility. cates that R 3 behaviors ication compliance, and at a sexual behavior related to ol, anxiety, and denial of ness." Review of the facilities 	F	406			5/1/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		14E160	B. WI	B. WING		03/31/2011	
NAME OF PROVIDER OR SUPPLIER SACRED HEART HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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		(EACH CORRECTIVE ACTION SHO	SHOULD BE COMPLETION	
F 406	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 103 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		F	CHICAGO, IL 60623 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO			
	rehabilitation services coordinator progress notes on 9-27-10, psychiatric rehabilitation services						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 406 Continued From page 104 F 406 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.

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 490 Continued From page 112 F 490 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

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 490 Continued From page 113 F 490 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.

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		I AND HUMAN SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		14E160	B. WI	\G		03/3 ²	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH ALBANY		
SACRED	HEART HOME				CHICAGO, IL 60623		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ige 114	F	490			
		el staff files showed that aside the following files of security llowing:					
	prevention training/ b) E40 - hired 1/2 prevention training/ c) E41 - hired 7/2 prevention training/ d) E42 - hired 9/2 prevention training/ e) E43 - hired 5/2 prevention training/ f) E43 - hired 12 prevention training/ g) E44 - hired 12 file but abuse quiz to	15/11 - no evidence of abuse inservice upon hire 12/11 - no evidence of abuse inservice upon hire 24/07 - no evidence of abuse inservice upon hire 15/07 - no evidence of abuse inservice upon hire 4/10 - no evidence of abuse inservice upon hire 2/6/04 - no evidence of abuse inservice upon hire 2/2/09 - with abuse packet in was blank.					
	showed that E's 19	, 32, 36, 40, 41, 42, 43, 44, aff) did not attend this					
	used by the facility abuse to ensure tha abuse, and to ensu	ation that the agency nurses were given a inservice on at they know how to identify ire that they know what they o in case there is an allegation					
	coordinator) at 11:3 hire, although the n includes abuse pre- there is really no or	rview with E46 (staffing 30 AM, E46 said that upon new staff is given a packet that vention policy and procedure, the in the facility who sits downs and discusses with them, the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E160	B. WI	NG _		03/31/2011		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY			
SACRED	HEART HOME				CHICAGO, IL 60623			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 490	Continued From pa contents of the pacl	-	F	490)			
	2/18/11 and ended	buse were not started until with only 57 employees out of se who did not get the E36, E39, and Z3.						
		ot get all of the staff as some checks and did not attend the						
	new hires showed a including types of a separating abusers	orientation packet given to abuse policy and procedures buse, immediate reporting, from the residents, immediate ving of the employee from tact, etc.						
	the abuse incident b 2/16/11. The facility the staff on abuse to reported immediate investigated immed	and E2 were made aware of between E33 and R22 on did not immediately inservice o ensure that allegations are ely, that allegations are liately, and that the victims of are protected from perpetrator.						
	monitor) was observed main lobby of the far was observed yellin	D:30 AM, E23 (smoking ved standing in the hall of the acility near the elevator. E23 ag at R26 in a disrespectful ull your pants up and pull						
		wearing a belt on his pants. served to be low around R26's						
	E23 stated when inf	terviewed at this time that he						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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 velled 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.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14E160	B. WI	NG _		03/31/2011		
NAME OF PROVID	ER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
SACRED HEART HOME					1550 SOUTH ALBANY CHICAGO, IL 60623			
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
resic prote abus notif f) punc head evid inves not h g on 1 notif h) and fan c was there notif i) anot resic j) R44 spitti There there k)	ected from this se investigation fied. R5 struck a sta ched a CNA (ce d on 12/12/10, p lence in the abu stigated, to ens hit resident back g) R22 stomped /2/11. No abuse fication was don) R19 accused a head and hit he on 2/8/11. On 12 punched by R6 e were abuse in fications noted in On 2/14/11, R3 ther resident wit abuse investigat ed for this incide cation in the incide cation in the incide cation in the incide cation his face re was no abuse e IDPH notificat	hat other residents are unknown perpetrator. No was done nor the IDPH was aff member on 1/2/11 and ertified nurse aide) in the ber incident reports. No ise files that this was ure that staff as a result did k. R31's foot and punched R31 e investigation nor IDPH ne. a resident of beating her face er on the right shoulder with a 2/10/10, R19 alleged that she b7. For both these incidents, nvestigations and IDPH n the facility's abuse files. B7 got up of her chair and hit thout provocation. There was ion and IDPH notification ent. There also was no ident report of who this other 14 attacked and wrestled R38. ed R38 because R38 of and R38 denied the allegation. e investigation noted nor was	F	490				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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. I) 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."

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		I AND HUMAN SERVICES					APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E160	B. WI	NG _		03/31/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET 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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 492	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in		F	492	2		5/1/11
	local laws, regulation accepted profession	applicable Federal, State, and ons, and codes, and with nal standards and principles sionals providing services in					
	by: Based on record re facility failed to notii involving 1 of 24 sa an identified offend	NT is not met as evidenced eview, and interview, the fy local law enforcement mpled residents(R21), who is er, who was involved in using e while in the facility:					
	Findings Include: Review of the PRS Coordinator) note d resident(R21) is no and having a cigare intervention, " resid on smoking restrict indicates that no pla incident was initiate documented evider R 21 regarding inap no documented evid the local law enforc R 21 medical diagn and Chronic Mental Paranoid Type. Intr on 3-18-11 at 3:30p careplan immediate	C(Psyche Rehab Social lated 10-7-10 indicates that " ted for smoking in his room atte lighter." Immediate ent was counseled by PRSC ions." Further record review an of care regarding the ed. There is no further nee of continued monitoring of opropriate smoking. There is dence of the facility contacting rement agency of the incident. osis includes Bipolar Disorder, I Illness, and Schizoid erview with E 1(Administrator) om, when asked, why wasn't a ely initiated on 10-7-10? E 1					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 14E160 03/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1550 SOUTH ALBANY** SACRED HEART HOME CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 492 Continued From page 121 F 492 Marijuana, not a nicotine cigarette, and that it was only a one time thing that did not require a careplan. F 496 483.75(e)(5)-(7) NURSE AIDE REGISTRY F 496 5/1/11 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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/17/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		14E160	B. WI	NG .		03/31/2011		
NAME OF PROVIDER OR SUPPLIER SACRED HEART HOME					TREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY CHICAGO, IL 60623			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 496	by: Based on record refailed to ensure that / certified nurse aide provider, his status the Illinois Nurse Ai Findings include : E29 was hired a 12/2/10. However, h Illinois Nurse Aide r 12/3/10. Furthermo on 12/3/10, E46 (st that this name in the During 3/23/11 in said that E29 did no he was a CNA from record, E29 was fin 12/21/10 per the Liv 483.75(I)(1) RES RECORDS-COMPILE The facility must mater standards and prace accurately document systematically organ The clinical record re information to ident resident's assessments services provided; to	 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. 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB 		49 6			5/1/11	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU	(X3) DATE SURVEY COMPLETED	
		14E160	B. WI	NG _		03/31/2011		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
SACRED	HEART HOME				550 SOUTH ALBANY CHICAGO, IL 60623			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 514	Continued From pa	ige 123	F	514				
	by: Based on record re failed to maintain c records on one (R7 This deficient pract all 146 residents th R7 was admitted tu a diagnosis of schi: medications include twice a day, Zyprex Invega susten 156r record review of R7 Involuntary Movem incomplete in the m 2:55 p.m., interview nurses), when show stated that it should admission and ther that it is the respon to complete the ass	NT is not met as evidenced eview and interview, the facility omplete and accurate clinical of the 24 sampled residents. ice has the potential to affect at reside in the facility. To the facility on 2/19/2011 with coaffective disorder. R7 's e Lithium carbonate 300mg a 20mg at hour of sleep, mg monthly. On 3/15/2011 T 's AIMS (Abnormal ent Scale) was noted as hedical record. 3/15/2011 at ved E3, DON (Director of uld the AIMS be completed, E3 d be completed upon n every six months. E3 stated sibility of the admission nurse sessment. E3 reviewed the nd stated " I will have it						

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