

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

PRINTED: 01/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G384		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015	
NAME OF PROVIDER OR SUPPLIER MCNERNEY HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 6300 NORTH RIDGE AVENUE CHICAGO, IL 60660			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS			W 000			
	Inspection of Care						
	Annual Licensure and Certification Survey						
W 247	Fundamental Survey 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN			W 247			10/2/15
	The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure individuals were provided the opportunity to pour their own drinks for 10 of 10 individuals who were observed during dinner in the dining room (R1 to R10).						
	Findings include:						
	On 8/31/15, during dinner observation, from 5:05 p.m. to 5:30 p.m. R1, R2, R3, R4, R5, R8, R9, R10, R11, and R12 were observed to be seated in the dining room around the dining table. E3 (Direct Support Person) was observed to pour water into the cups of all the individuals sitting in the dining room.						
	On 9/2/15, at 1:50 p.m., E1 (Administrator) stated, "some of the individuals are capable of pouring the drinks themselves while others may require hand-over-hand assistance in pouring."						
	On 9/1/15, at 2:15 p.m., E1 (Administrator) stated, "all individuals are supposed to be encouraged to be as independent as they are able to." E1 confirmed that R1 to R5 and R8 to R12 should have been given the opportunity to						

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

TITLE

(X6) DATE

09/02/2015

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

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W 247	Continued From page 1 pour their own water.	W 247			