STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. BUILDING ______ B. WING ______	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOLIET TERRACE	2230 MCDONOUGH JOLIET, IL 60436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification. LICENSURE SURVEY FOR SUBPART S: SMI	F 000		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment 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	F 225		6/29/11

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

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

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that an allegation of abuse involving R18 was immediately reported to the administrator which resulted in a delay in their investigation. Findings include: R18 is a 50 year old male with diagnoses including Schizophrenia and Cerebral Palsy. Review of R18's record included nursing documentation of 04/30/11 which noted: 04/29/11- resident was found to have another resident's cell phone on his person. Resident gave staff the phone and it was returned to it's rightful owner. 04/30/11- resident telling other resident that staff abused him and roughed him up while searching for above item. E1 (administrator and Abuse Coordinator) was asked on the afternoon of 05/18/11about the nurses note of 04/30/11. E1 stated that she was unaware that R18 had made an allegation of abuse by a staff member because it had not been reported to her. E1also stated that she would have initiated an investigation immediately if she had been informed. E1 further stated that she would now initiate an immediate investigation after learning about the allegation.	F 225		
F 252	483.15(h)(1)	F 252		6/29/11

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F 252	Continued From page 2 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain environment safe, clean and comfortable. This is for R2 in the sample and two residents (R25 and R26) from the supplemental sample. Also affect the residents in Rooms (D1, D8, C8, C9, A1, and C2). Findings include: On 5/17/11 during the initial tour of the facility the following observations were made: Three sofa chairs are torn at the seat and arm rests and foam was exposed. Towel bar missing in room D1. Bath room door bottom corroded, and sharp wood exposed. Wall Base board missing in Room D1 and D8 bath room. Bath room wall tiles missing in room C8. Several pillows have no pillow covers, and wide spread dark brownish stains noted on pillows, specially in room C9. Toilet grab bar is loose in room C2. Offensive urine odors noted in 'C' hall and 'E' hall. The bath room floors have cracks.	F 252		

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F 252	Continued From page 3 On 5/17, 5/18, and 5/19/11 patio smoking area has cigarette butts on the floor and grass area. Residents (R2, R25 and R26) were observed collecting cigarette butts to smoke the left over tobacco cigarettes. These residents were seen their finger tips and nails are stained with cigarette burn marks. There was no staff to direct the residents not to engage in such behavior. On 5/17, 5/18 and 5/19/11 the survey team discussed the concern with E1, the facility administrator. E1 stated she has approved plan to replace floor tiles in hall ways and bath rooms.	F 252		
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		6/29/11

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F 279	Continued From page 4	F 279		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure an individualized plan of care is developed with specific interventions to prevent self harm and suicidal behavior and smoking cessation.

This is for two of two residents (R18 and R20) in the sample of 24 who are at risk for suicidal ideations, and one resident (R14) in the sample for smoking cessation.

Findings include:

1. R20's admission psychiatric evaluation (May 2010) indicated she had suicidal ideations. The facility did not conduct a comprehensive assessment of circumstances surrounding her history of suicidal ideations.

On 5/19/11 R20 who is alert and oriented 41 year old female stated prior to her moving to this state she lost her pastor, which she could not cope with and ended up in hospital when took overdose of medications.

The facility did not develop any plan of care for suicidal ideations.
R20's Psychiatric Rehabilitation Services Counselor (PRSC) stated R20 was admitted to the facility prior to her having R20 in her case load.

On 5/19/11 the survey team made aware of the administration staff (E1, E2 and E3). E3 the Psychiatric Rehabilitation Service Director

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F 279	Continued From page 5 (PRSD) stated the facility will develop system (assessment and development of care plan) for all the residents in the facility who have the history of suicidal ideations. 2. R14 a 61 year old female admitted with multiple diagnoses including Coronary Artery Bypass Graft (CABG), Cerebral Vascular Accident (CVA), Chronic Pulmonary Obstructive Disease (COPD) and Anemia. R14's physician order noted to 'stop smoking.' The facility had no plan of care for R14 to stop smoking. On all days of the survey R14 was observed in patio collecting cigarette butts to smoke. On 5/17/11 R14 stated she is collecting wet cigarette butts to dry them so she could smoke. On 5/19/11 the survey team informed the administration staff about R14's smoking concern. 3. According to the medical record R18 is a 50 year old ambulatory male who was admitted to the facility on 03/16/11. His diagnoses include Schizophrenia and Cerebral Palsy. R18 ' s PAS (Preadmission screening) was reviewed. R18 ' s behavioral areas of concern include: self-injurious behaviors - chronic suicidal ideations and numerous past overdose attempts. Level -high, timeframe-ongoing. R18 ' s interim mental health history notes that when stress increases, his depression gets worse and he starts having suicidal ideations.	F 279		

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F 279	Continued From page 6 However, when R18 was assessed by the facility on 03/31/11, for evaluation of self harm / suicide he was scored as minimal or low risk. The facility did not conduct a comprehensive assessment of risk factors surrounding R18 ' s history of suicidal ideations. The facility listed symptom management skills as a priority training objective. Areas to be addressed include coping skills that will prevent suicidal ideation and prevent need for psychiatric hospitalization. R18 ' s care plan for self harm was initiated on 03/31/11. His goals are to share thoughts and feelings especially concerning fears of self-harm with a facility staff member as necessary; and voice any concerns of harming self and what might be causing these beliefs. Coping skills are not addressed and approaches in the care plan are not individualized to address the identified risk factors that trigger suicidal ideations.	F 279		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the residents bath tubs are equipped with Nurse Call lights in 30 of 30 bath tub areas. This failure has potential for accident hazard and	F 323		6/29/11

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F 323	Continued From page 7 potential to affect all the residents who use bath tub. Findings include: On 5/17/11 during initial tour of the facility it was observed that 30 of 30 bath tubs in five separate wings, the resident bath tub area had no access to nurse call system whey they take shower or bath. If the residents are taking shower or a bath the residents have to come out of the bath tub to the toilet area to initiate nurse call light. Residents in individual interview and group interview stated that some residents take shower, some residents take a bath and some use community shower. It would be convenient to have a call system in the bath tube so the residents who need staff assistance call for help. As of the survey date 104 of 116 has severe mental illness in the facility. These residents use psychotropic medications including: antidepressants, antipsychotics, anxiolytics, and there are residents who use medications for blood pressure and seizures which predispose them for falls. In the absence of having an effective nurse call system has potential to increase the harm level should some experience a fall in the bath tub area. On 5/17/11 the survey team notified the facility administration about the nurse call system. On 5/18/11 the Administrator (E1) presented a letter having contacted their vendor and presented a quotation for installing nurse call system near bath tub.	F 323		
F 371	483.35(i) FOOD PROCURE,	F 371		6/29/11

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F 371	Continued From page 8	F 371		

STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation and facility policy the facility failed to maintain foods on the steam table at 140 degrees fahrenheit and failed to date foods after removing from delivery cartons. This has the potential to effect all residents in the facility.

Findings Include:

On 5/17/11 at 12:30 pm on the steam table the meat in the first pan of Barbeque Po boy sandwiches read 110 degrees Fahrenheit. Numerous attempts were made by E2 (dietary manager) taking the temperature in various areas of the sandwiches none of which were above 110 degrees. This tray of sandwiches was removed. A second tray of Barbeque Po boy sandwiches was placed on the steam table. The tempearture of the meat was 130 degrees Fahrenheit on the second tray.

Review of facility policy indicates the holding temperature of hot foods is 135 degrees Fahrenheit.

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F 371	Continued From page 9 During the initial tour on 5/17/11 at 11:30 am 13 bags of french fries, 20 bags of vegetables and 20 boxes of vegetables were removed from the original delivery carton and stored in the freezer without delivery dates. Also 22 containers of spices were stored in a cabinet without delivery dates. Review of facility policy indicates to label food with the delivery date and the date to be discarded.	F 371		