S FOR MEDICARE	& MEDICAID SERVICES					OMB NO.		
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				(X3) DATE SURVEY COMPLETED		
14A057						C 07/12/2005		
NAME OF PROVIDER OR SUPPLIER ALL AMERICAN NURSING HOME				448 NORTH BROADWAY S		••••		
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL		ïх	PROVIDER'S PLAN (EACH CORRECTIVE ACT	ION SHOULD E	BE CROSS-	(X5) COMPLE DAT	TION
FINAL OBSERVAT	IONS	F9	999					
COMPLAINT: 300.1210 a)	IS ASSOICATED WITHTHIS							
services to attain or practicable physica well-being of the re- each resident 's co plan of care. Adequinursing care and per to each resident to personal care need Personal Care, as c assistance with mer bathing or other per or general supervis physical and menta who is incapable of independent reside managing his person has been appointed -120 of the Act)	r maintain the highest I, mental, and psychosocial sident, in accordance with imprehensive assessment and uate and properly supervised ersonal care shall be provided meet the total nursing and s of the resident. defined in section 300.330, is als, dressing, movement, rsonal needs or maintenance, ion and oversight of the I well-being of an individual maintaining a private, nce or who is incapable of on, whether or not a guardian d for such individual (Section 1		acility	ID: IL6000087	If contin	nuation sheet	Page 7	' of 10
	OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RICAN NURSING HO SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS FINAL OBSERVAT STATE VIOLATION COMPLAINT: 300.1210 a) 300.1210 b) 6) The facility must pro- services to attain of practicable physica well-being of the re- each resident 's co- plan of care. Adequinursing care and per to each resident 's co- plan of care. Adequinursing care and per to each resident 's co- plan of care. Adequinursing care and per to each resident to personal care need Personal Care, as co- assistance with me bathing or other per or general supervis physical and mentar who is incapable of independent reside managing his perso- has been appointed -120 of the Act)	TIDENTIFICATION NUMBER:         14A057         ROVIDER OR SUPPLIER         RICAN NURSING HOME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         FINAL OBSERVATIONS         STATE VIOLATIONS ASSOICATED WITHTHIS COMPLAINT:         300.1210 a) 300.1210 b) 6)         The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident 's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1 -120 of the Act)	OF DEFICIENCIES FOORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) N A. BU         14A057       IMA057         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREF TAC         FINAL OBSERVATIONS       F9         STATE VIOLATIONS ASSOICATED WITHTHIS COMPLAINT:       300.1210 a) 300.1210 b) 6)         The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident 's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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WING         RICAN NURSING HOME       STREET ADDRESS, CITY, STATE, 5448 NORTH BROADWAY S CHICAGO, IL 60640         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN (EACH CORRECTIVE ACT REFERENCED TO THE AP         FINAL OBSERVATIONS       F9999         STATE VIOLATIONS ASSOICATED WITHTHIS COMPLAINT:       F9999         STATE VIOLATIONS ASSOICATED WITHTHIS COMPLAINT:       F9999         300.1210 a) 300.1210 b) 6)       F9999         The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident 's comprehensive assessment and plan of care. 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(X2) OATE SL CHICAGO, IL 60640       (X2) OATE SL CHICAGO, IL 60640         SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERICENCY WILL REQULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFX       PROVIDER'S ALTO OF CORRECTION (EACH OPERICENCY ALTO OR SOULD BE CROSS. REFERENCED TO THE APPROPRIATE DEFICIENCY)         FINAL OBSERVATIONS       F9999         STATE VIOLATIONS ASSOICATED WITHTHIS COMPLAINT:       F9999         300.1210 a) 300.1210 b) 6)       The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident to meet the total nursing and personal care needs of the resident.         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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/03/2005

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/03/2005 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
14A057			B. WI	NG _		C 07/12/2005		
NAME OF PROVIDER OR SUPPLIER ALL AMERICAN NURSING HOME					REET ADDRESS, CITY, STATE, ZIP CODE 5448 NORTH BROADWAY STREET CHICAGO, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F9999	All necessary preca assure that the resi as free of accident nursing personnel s that each resident r and assistance to p Findings include: Review of R2's resi was a 71-year old r Dementia and Schi 's 02-22-1999 psyc to be confused, incleave the facility be electronic monitorir the need was base evaluation. Per R2 minimum data asse moderately cognitiv supervision. Per R was assessed to at facility incident repo- -25-2005 R2 was re was wearing an ele Per 06-25-2005 nut the facility by E4 (R notes and incident was conducted and documentation the 2005 at 2:45PM, a 00PM and the guar at 9:00AM. On 07-07-05 at 3:0	Review of R2's resident profile face sheet, R2 was a 71-year old male with diagnosis including Dementia and Schizo-Affective disorder. Per R2 s 02-22-1999 psych evaluation R2 was assessed to be confused, incoherent and had attempted to eave the facility before. R2's 02-22-1999 electronic monitoring device assessment stated the need was based on the 02-22-1999 psych evaluation. Per R2's 06-16-05 quarterly minimum data assessment R2 was assessed moderately cognitively impaired requiring supervision. Per R2's 06-16-2005 care plan R2 was assessed to attempt to leave the facility. Per facility incident report and nurse's notes dated 06 -25-2005 R2 was reported missing at 12:30PM & was wearing an electronic monitoring device. Per 06-25-2005 nurse notes R2 was last seen in the facility by E4 (RN) at 8:30AM. Per nurse's notes and incident report on 06-25-2005 a search was conducted and R2 was never located. Per documentation the police was notified 06-25- 2005 at 2:45PM, a police report was made at 4: 00PM and the guardian was notified 06-26-2005 at 9:00AM.		999				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IL6000087

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NO.	10/03/2005 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SURVEY COMPLETED C		
14A057			B. WI	NG _		07/12/2005		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ALL AME	RICAN NURSING HO	ME			5448 NORTH BROADWAY STREET CHICAGO, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F9999	included monitoring During interviews windividual stated the back door 06-25-05 stated at that time E over the intercom " door". Per E1, E2 at the security guard at door is also to resp check alarmed doo area. Per surveyor and E6 (covering for both stated they we cover the front door another door alarm responded to the ba- leaving the front door another door alarm responded to the ba- leaving the front door Per interview with E immediate search wo outside of the facilit do a floor check for with E4 it was deter unaccounted for. F report was made an facility. On 07-07-0 interviewed R1 (R2 observed by survey time and place. Or interviewed Z2 (atter psychiatrist) who bo in mental status that 07-05 and 07-12-05 detective) who state commuter train trace	t floor secretary duties which g the facility door alarms. with E1, E2 and E3 each e alarm sounded for the rear of at 12:30PM. E1, E2 and E3 E3 made an announcement would all staff check the back and E3 the facility policy is that assigned to monitor the front ond to any announcement to r as well as any staff in the interview with E7 (security) or security on 06-25-05) they ere unaware of who would r if security was to respond to . Both security officers ack door alarm on 6-25-05, or without direct observation. E1, E2, E3 and E4 (RN) an was performed around the ty. The facility proceeded to each resident. Per interview	F9	999	9			
	approached and the	en jumped in front of the train.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IL6000087

If continuation sheet Page 9 of 10

		HAND HUMAN SERVICES				FORM	10/03/2005 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	14A057		B. WI	NG .		C 07/12/2005	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALL AME	ERICAN NURSING HO	DME			5448 NORTH BROADWAY STREET CHICAGO, IL 60640		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	Continued From pa	-	F9	998	9		
	12:35PM and the c injury, train striking	onounced dead on 06-25-05 at rause of death was multiple /suicide. Per Z1, R2 was I by a label with his name in his					

Facility ID: IL6000087