		AND HUMAN SERVICES				FORM	08/07/2009 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G116	B. WI	B. WING		03/23/2009	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMO	ND HOUSE				3701 SOUTH MORGAN CHICAGO, IL 60621		
(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)	ULD BE	(X5) COMPLETION DATE
W 369 W9999	Anti-Gas into a med surveyor 5ml of Anti Surveyor asked wh answered, "Two tea to give R8 her Anta asked to look at the Surveyor and E6 lo medication bottle, ti tablespoons". E6 th into the medication R8. R8's Physician Ord through 2/28/09 wa Antacid suspension two tablespoons by indigestion." FINAL OBSERVAT LICENSURE VIOLA 350.1210 350.1210 350.1220e) 350.1220e) 350.1220e) 350.1230d)1)2) 350.1230e) 350.3240a) Section 350.1210 H The facility shall pro- maintain each resid These services incl following: b) Nursing services	dicine cup. E6 showed tacid suspension in the cup. hat R8's dosage was. E6 aspoons." E6 then proceeded acid. Surveyor stopped E6 and e dosage in the bottle's label. hoked at the label on the he label states "Two nen poured 30ml of Antacid cup and gave the medicine to lers Sheet dated 2/1/09 as reviewed. R8's current in Anti-gas order states, "Take mouth two times a day for TIONS ATIONS Health Services ovide all services necessary to dent in good physical health. lude, but are not limited to, the s to provide immediate	W s	369 9999			
		health needs of each resident					

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		AND HUMAN SERVICES				FORM	08/07/2009 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SU COMPLE	JRVEY
		14G116	B. WI	NG _		03/23/2009	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMO	ND HOUSE				6701 SOUTH MORGAN CHICAGO, IL 60621		
(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
W9999	Continued From pa	ige 20	W9	999	9		
	by a registered prot practical nurse, or t	fessional nurse or a licensed he equivalent.					
	Section 350.1220 F	Physician Services					
		Il be seen by their physician ary to assure adequate health					
	of any accident, injuction of any accident, injuction that threat welfare of a resider the presence of inc	notify the resident's physician ury, or change in a resident's tens the health, safety or nt, including, but not limited to, ipient or manifest decubitus oss or gain of five percent or d of 30 days.					
	Section 350.1230 N	Nursing Services					
	are not limited to, th 1) Detecting signs of maladaptive behavi nursing or psychos	of illness, dysfunction or ior that warrant medical, ocial intervention. ired to meet the health needs					
	shall be available, v practical nurses an	priately qualified nursing staff which may include licensed d other supporting personnel, ious nursing service activities.					
	Section 350.3240 A	Abuse and Neglect					
		ee, administrator, employee / shall not abuse or neglect a 2-107 of the Act)					
	These Regulations	were not met as evidenced					

Facility ID: IL6003990

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		AND HUMAN SERVICES				FORM	: 08/07/2009 APPROVED : 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		LTIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		14G116	B. WI	NG	;	03/2	3/2009
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	E	
НАММО	ND HOUSE				6701 SOUTH MORGAN CHICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	۶IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W9999	Continued From pa by:	ige 21	W9	99	99		
	neglected to provid nursing follow up in	eview and interview, the facility e nursing services and a a timely manner for 1 of 1 estained a dislocated right y failed to:					
		sing staff assess and essment of R2 immediately.					
	notified of the poss	psychiatrist was immediately ible side effect that R2 was ew psychotropic medication.					
	the physician or by	was immediately evaluated by emergency personnel when pain interfered with her					
	Findings include:						
	6/7/08, is a 39 year diagnoses includes	al Information Form dated old ambulatory female whose Severe Mental Retardation, ulse Control Disorder.					
	Illinois Department was reviewed. It inc R2 was admitted to dislocated right sho 2/27/09, R2 started pain in her right arr and staff was instru- pain, warm compre- arm, a warm bath a for any changes. O	axed by the facility to the of Public Health dated 3/5/09 cludes, "On Thursday 3/5/09, o a local hospital for a pulderOn 2/26/09 and l exhibiting muscle rigidity and n. The nurse was informed ucted to give R2 Ibuprofen for esses/massages to her right and to continue to monitor her n 3/2/09, R2 started to exhibit t forearm/elbow. The nurse					

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

PRINTED: 08/07/2009
FORM APPROVED
OMB NO. 0938-0391

CENTER	<u> RS FOR MEDICARE</u>	E & MEDICAID SERVICES				OMB NO.	0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE		
		14G116	B. WI	B. WING		03/2:	3/2009
NAME OF F	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
НАММО	ND HOUSE			(6701 SOUTH MORGAN		
	T			(CHICAGO, IL 60621		
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa	age 22	W99	999			
		came by the facility to do an					
		nurse examined R2 from head					
	to toe and there we injuries, just the sw	eren't any other apparent					
		he meantime, the nurse has					
		hiatrist to inform her about					
		be the side effects that R2 was					
		/3/09, the psychiatrist returned					
		arding R2, but the psychiatrist er for medication to help with					
	0	ed to be the side effects of the					
		ne psychiatrist stated to the					
		I't think that R2 was					
		effects of the new medication ffects wouldn't be limited to					
		e body and that R2 wouldn't					
	-	of the new medication this					
		rist recommended that R2					
		th her primary care physician					
		n 3/5/09, R2 saw her physician					
		her right forearm/elbow. The x-ray of her right shoulder. The					
		slocated right shoulder"					
		-					
		Observation/Progress Notes					
		26/09 through 3/5/09 were wing documentation and dates					
	are noted as follow						
	"2/26/09 3rd shift -	R2 complained of pain in					
		area. A pain pill was given					
	from house stock.	She didn't have any other					
	issues						
	2/27/09 3rd shift - 9	She wasn't feeling well She					
		r right arm was still sore. She					
	was given a pain p	ill					
	2/28/09 3rd shift - F	R2 didn't eat her breakfast.					

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		I AND HUMAN SERVICES				FORM	08/07/2009 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G116	B. WI	NG .		03/2:	3/2009
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMO	ND HOUSE				6701 SOUTH MORGAN CHICAGO, IL 60621		
(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
W9999	Continued From pa Staff had to assist F right arm hurt very	R2 in bathing. R2 said that her	W99	99	9		
	2/28/09 2nd shift - ⁻ right arm	There was a bruise on her					
	her right arm sore a	Staff help her eat, because of and swollen, warm compress ghout the afternoon					
		athe with supervision. No arm still swollen, staff after bath					
		2 's bruise on her right arm is her arm is still tender					
	(Residential Service	2's arm is swollen. E2 es Director) looked at it. Nurse ain medication. R2 had an ice right arm today					
	3/3/09 2nd shift - ba is swelling in lower	athed with supervision, there right arm					
	3/4/09 2nd shift - R upper arm"	2 has swelling in the right					
		ated Progress Notes were wing dates and entries were					
	of pain in her right unurse, and E2 was	am) 6:00am -R2 complained upper arm. Staff called the also informed. R2 was given 0mg from the house stock					
		2 complained of pain in her aff gave her an Ibuprofen tab					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/07/2009 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
		14G116	B. WI	۱G		03/23	3/2009
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	ND HOUSE			-	3701 SOUTH MORGAN CHICAGO, IL 60621		
(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
W9999	Continued From pa 200mg from house	-	W99	999			
	2/27/09 8:00am - R	2 didn't eat her breakfast					
	because she compl	ven an Ibuprofen at 8:30pm ained about her upper right here was a little swelling and a vas called					
	what appeared to b psychotropic medic experiencing some stated to massage compress to the are	9, the nurse was called about e a side effect of the ation. R2 appears to be muscle rigidity. The nurse the rigid areas, warm eas and a hot bath. The nurse cts should subside					
	muscle rigidity. The for a prescription fo	was called regarding R2's nurse called the psychiatrist r Cogentin to help cure the sychiatrist was out of the					
	she arrived from we elbow and forearm touchThe nurse the facility to condu examined R2 from on her right elbow a any other problems staff to give her Ace stock. R2 was able but she is stiff. The go to the emergence monitor her	aff checked R2's arms when orkshop. Her right arm by the was swollen and warm to the was called and she came to ct an examination. The nurse head to toe, R2 had swelling and forearm. There weren't found. The nurse stated for etaminophen out of house to perform her basic functions nurse stated R2 didn't need to y room just continue to					
	3/2/09 3:30pm - R2 swollen"	's right upper elbow arm was					

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		I AND HUMAN SERVICES				FORM	08/07/2009 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G116	B. WI	NG _		03/2	3/2009
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	ND HOUSE				6701 SOUTH MORGAN CHICAGO, IL 60621		
(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
W9999	Continued From pa	ige 25	W99	999	9		
		ok was reviewed. The I entries are as follows:					
	was tense due to a	staff, R2's right arm muscle side effect of her medicine. ain pill this morning. Nurse was notified					
	eye on R2. Staff has she can't hardly mo	m) - Attention staff. Keep an Id to feed her. She act(ed) like ove her arm. Staff also gave help her out so just keep an					
		All staff: R2 appears to be effect of her new medications idity					
	about R2's muscle the side effect of he better. In the mean	all staff: I spoke to E3 (nurse) rigidness (stiff). R2 stated that er new medications should get time E3 stated that staff could that's stiff and apply a warm					
	her right arm. It loo	staff: R2 have a red bruise on k like it is swollen. I called the said to give her an Ibu monitor her					
	stop the warm com R2's right arm per r	Il staff: Effective today please presses and massages to nurse, E3. E3 stated to apply t elbow and forearm for the					
		was interviewed on 3/12/09 at "That evening (2/26/09) R2					

Facility ID: IL6003990

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		HAND HUMAN SERVICES				FORM	08/07/2009 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G116	B. WI	√G _		03/23	3/2009
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMO	ND HOUSE			-	6701 SOUTH MORGAN CHICAGO, IL 60621		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	acted like she could say she's in pain. R (regular activities a difficulty in dressing pain but she couldn't ra she could and durin arm by the center of sling." E5 (Program Aide) 7:27am. E5 stated, hurting and no, she When she was dreau up to put it inside the no problem dressin help. She didn't ask having difficulty dreat a couple of days the and she normally fi E8 (Program Aide) 2:50pm. E8 stated, raise her arm up to what's wrong and s R2 can raise her ar E9 (Program Aide) 2:02pm. E9 stated, arm, normally she of E11 (Program Aide) asked her to hold h couldn't raise above continued, "Normal	dn't feed herself, but she didn't R2 was maneuvering around it t home), she had a little bit of g. R2 never told me she was in n't move it (right arm). That aise her right arm, normally ng that time she would put her of her body like she was in a was interviewed on 3/12/09 at "R2 kept saying her arm was e didn't point to where it hurts. ssing she couldn't lift her arm ne sleeves. Normally she have ng at all. That time she needed k for help, I just observed her essing herself. There was also at R2 didn't finish her food,	W9	999			

Facility ID: IL6003990

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

PRINTED: 08/07/2009
FORM APPROVED
OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
14G116		B. WIN	B. WING		03/23/2009		
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
					6701 SOUTH MORGAN		
HAMMO	ND HOUSE				CHICAGO, IL 60621		
							0(5)
(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 COM PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa	age 27	W99	990			
	asked me to help h	-					
	E4 (cook) was interviewed on 3/11/09 at 11:30am. E4 stated, "R2 had a little problem lifting her arm up to feed herself. She didn't eat a lot those couple of dates"						

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

PRINTED: 08/07/2009
FORM APPROVED
OMB NO. 0938-0391

	JARE	: & MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
14G116		B. WI	B. WING		03/23/2009		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMOND HOUSE					CHICAGO, IL 60621		
PREFIX (EACH DEFI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENC		JLD BE	(X5) COMPLETION DATE
movement in time we thoug medication. R with the psych psychiatrist be effect of the n relief measure assessed R2, below should fingers. No sw verified that th 2/27/09 and r 3/3/09 to 3/17 E3 (nurse) wa 10:27am. E3 know when it muscle rigidity a side effect of I told them tha and left a mea called to repo arm." Surveyo E3 answered, elbow. It was the psychiatri reported and medication." S R2 was movin "R2 was guar asked why E3 evaluate/asset that she had of know it was o Z1 (Pharmaci 3/12/09 at 12) exhibiting mu	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						

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		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/07/2009 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G116	B. WII	NG _		03/2:	3/2009
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMO	ND HOUSE			-	6701 SOUTH MORGAN CHICAGO, IL 60621		
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	Continued From page 29 MD (Medical Doctor) immediately."		W9	999			
	Z2 (Medical Doctor on 3/12/09 at 12:30 R2 and she couldn' really in pain then. her shoulder and R shoulder." Z2 adde something out of th started on new med called the MD imme Emergency Depart don't wait to look at explain what is goir Z3 (Psychiatrist) wa 3/13/09 at 10:07am a side effect typical body." Z3 added, "\ with functioning (su had to feed R2 and						

Facility ID: IL6003990

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