STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E160	A. BUILDING _____ B. WING _____	03/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART HOME	1550 SOUTH ALBANY CHICAGO, IL 60623

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F 496	Continued From page 123 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.	F 496		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete and accurate clinical records on one (R7) of the 24 sampled residents. This deficient practice has the potential to affect all 146 residents that reside in the facility. 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 3/15/2011 record review of R7 ' s AIMS (Abnormal Involuntary Movement Scale) was noted as incomplete in the medical record. 3/15/2011 at	F 514		5/1/11

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F 514	Continued From page 124 2:55 p.m., interviewed E3, DON (Director of nurses), when should the AIMS be completed, E3 stated that it should be completed upon admission and then every six months. E3 stated that it is the responsibility of the admission nurse to complete the assessment. E3 reviewed the incomplete AIMS and stated " I will have it completed today " .	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.695b)1) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240e) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be	F9999		

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F9999	Continued From page 125	F9999		

reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.695 Contacting Local Law Enforcement

b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:
1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor;

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a

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F9999	Continued From page 126 resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to follow their policy on abuse prevention, and to prevent resident abuse by failing to: - ensure 3 residents (R22, 25, and 26) in the sample of 24 are free from physical abuse and verbal abuse from staff, - 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, - have staff report the abuse incident to Administration immediately when it happened on 2/15/11, -have staff who had been properly trained in	F9999		

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F9999	Continued From page 127 abuse protocols and reporting of abuse, - report the abuse to the state agency and investigate and report 45 other incidents of possible abuse Findings include : 1) 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." R22 has diagnoses of Bipolar Disorder, Schizoaffective Disorder, and Asthma. R22 resided on the 3rd floor and this incident took place on the 3-11pm shift. Nursing notes written by E33 (nurse) on 2/15/11 at 9:35pm state that R22 was delusional, grabbed E33's hair, and attacked E33 due to hearing voices. R34 stated 3/17/11 at 1:00 PM, that he saw R22 yell at E33 who was at the nurses station. E33 then came out from behind the station and told R22 that he was going to "kick (R22's) ass." E33 got R22 in a headlock and starting hitting him. R22 was able to get away from E33 momentarily and then E33 started hitting R22 again after a short pause. R34 said that although R22 tried to fight, "(R22) cannot do anything against E33." R34 added that E32 (Certified Nursing Assistant -	F9999		

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F9999	Continued From page 128 CNA) was there but was scared and was screaming for security. E36's (Security Guard) signed statement dated 2/16/11 states that around 9:30 PM on 2/15/11, E36 ran from the 2nd floor to the 3rd floor because E32 was screaming for security and he heard a commotion on the 3rd floor. When he got to the 3rd floor, he saw E33 and R22 standing in front of each other, and R22 was bleeding from his mouth. Both R22 and E33 were cursing at each other as he was walking R22 to his room. Upon reaching the double doors (which were located near the nurse's station), E33 grabbed R22 by his shirt again and pulled R22 back towards the front to give R22 a PRN (as needed) medication. E36 told E33 that he was going to take R22 to his room first to change his clothes and to "cool him off." After this, E36 walked R22 back to the nurses station, where E33 gave R22 an injection. E36 verified on 3/17/11at 12:10 PM, that his statement was true as it was written. E36 also stated that after the incident on 2/15/11, he made a report and put it under E1's (Administrator's) door. E1 later denied getting this report. Despite E36 seeing R22 bleeding from the lip while facing E33, E36 did not verbally report this 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 that was given on 1/19/11.	F9999		

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F9999	Continued From page 129 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 did not know she was supposed 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 attend 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 said 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 R22 or assist R22 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 11:00 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	F9999		

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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 11:00 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

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F9999	Continued From page 131 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 file but abuse quiz was blank. Review of facility abuse inservice dated 1/19/11, showed that E's 19, 32, 36, 40, 41, 42, 43, 44, and 45 (security staff) did not attend this inservice. There was no indication that the agency nurses used by the facility were given an 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. During 3/23/11 interview with E46 (staffing coordinator) at 11:30 AM, E46 said that upon hire, although the new staff is given a packet that includes abuse prevention policy and procedure, there is really no one in the facility who sits downs with the new hires and discusses with them the contents of the packet. The inservices on abuse were not started until	F9999		

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F9999	Continued From page 132 2/18/11 and ended with only 57 employees out of 133 attending. Those who did not get the inservice included E36, E39, and Z3. E46 said she "did not get all of the staff as some did not pick up their checks and did not attend the inservice." Review of the staff orientation packet given to new hires showed abuse policy and procedures including types of abuse, immediate reporting, separating abusers from the residents, immediate investigation, removing of the employee from further resident contact, etc. . 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 the 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 stated that he did not mean to yell at R26 and speak to	F9999		

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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 stated that he was aware of the abuse policy of the facility and that he was aware that residents are not to be yelled 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 incidents 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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F9999	Continued From page 134 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. As a result, the facility 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 alleged that R15 put her hand on her (R35's neck. No abuse investigation was done nor was IDPH notified. e) R36 alleged that she was hit 3-4 times by a 3rd floor resident while she was in bed. There was no accompanying report that the facility investigated this to determine the identity of this	F9999		

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resident to ensure that other residents are protected from this unknown perpetrator. No abuse investigation was done nor the IDPH was notified.

f) R5 struck a staff member on 1/2/11 and punched a CNA (certified nurse aide) in the head on 12/12/10, per incident reports. No evidence in the abuse files that this was investigated, to ensure that staff as a result did not hit resident back.

g) R22 stomped R31's foot and punched R31 on 1/2/11. No abuse investigation nor IDPH notification was done.

h) R19 accused a resident of beating her face and head and hit her on the right shoulder with a fan on 2/8/11. On 12/10/10, R19 alleged that she was punched by R67. For both these incidents, there were no abuse investigations and IDPH notifications noted in the facility's abuse files.

i) On 2/14/11, R37 got up of her chair and hit another resident without provocation. There was no abuse investigation and IDPH notification noted for this incident. There also was no indication in the incident report of who this other resident is.

j) On 2/18/11, R44 attacked and wrestled R38. R44 said he wrestled R38 because R38 spit on his face and R38 denied the allegation. There was no abuse investigation noted nor was there IDPH notification.

k) On 12/8/10, R44 alleged that he was hit by another resident after saying "Kirk Douglas." The

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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.

l) R40 hit R46 on 2/26/11. R40 said she hit R46 because R46 will not 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 would not 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.

o) On 2/14/11, R43 was hit by another resident while she was standing in front of the nurses station. The identity of the other resident was not shown in this incident report. There was no abuse investigation noted nor was there IDPH notification.

p) On 2/28/11, R9 alleged that R11 hit her on her shoulder and thus she hit him back. There was no abuse investigation noted nor was there

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IDPH notification.

q) R50 alleged that on 3/1/11, R17 pushed him for no reason. This resulted in a fight. There was no abuse investigation noted nor was there IDPH notification.

r) 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.

s) 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.

t) 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.

u) 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.

v) R56 slapped R55 on the face on 3/11/11 unprovoked. There was no abuse investigation noted nor was there IDPH notification.

w) On 11/27/10, R58 pushed R57 after R57

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would not move out of R58's way. This resulted in mutual pushing. There was no abuse investigation noted nor was there IDPH notification.

x) On 11/24/10, R41 put his hands around R4 to choke him or push him away. R41 was 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.

y) On 11/24/10, R60 hit R63 without provocation. R60 said he does not not like R63 that is why. There was no abuse investigation noted nor was there IDPH notification.

z) 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.

aa) 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.

bb) 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,

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F9999	Continued From page 139 there was no facility investigation, follow up and reporting sent to IDPH. cc) 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. (A) 300.625q) 300.625p) Section 300.625 Identified Offenders p) Incident reports shall be submitted to the Division of Long-Term Care Field Operations in the Department's Office of Health Care Regulation in compliance with Section 300.690 of this Part. The facility shall review its placement determination of identified offenders based on incident reports involving the identified offender. In incident reports involving identified offenders, the facility must identify whether the incident involves substance abuse, aggressive behavior, or inappropriate sexual behavior, as well as any other behavior or activity that would be reasonably likely to cause harm to the identified offender or others. If the facility cannot protect the other residents from misconduct by the identified offender, then the facility shall transfer or discharge the identified offender in accordance with Section 300.3300 of this Part.	F9999		

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F9999	Continued From page 140 q) The facility shall notify the appropriate local law enforcement agency, the Illinois Prisoner Review Board, or the Department of Corrections of the incident and whether it involved substance abuse, aggressive behavior, or inappropriate sexual behavior that would necessitate relocation of that resident. These Requirements were not met as evidenced by: Based on record review, and interview, the facility failed to notify local law enforcement involving 1 of 24 sampled residents(R21), who is an identified offender, and who was involved in using an illegal substance within the facility. Findings include: Review of the PRSC (Psyche Rehab Social Coordinator) note dated 10-7-10 indicates that "resident (R21) is noted for smoking in his room and having a cigarette lighter." Immediate intervention, "resident was counseled by PRSC on smoking restrictions." Further record review indicates that no plan of care regarding the incident was initiated. There is no further documented evidence of continued monitoring of R21 regarding inappropriate smoking. There is no documented evidence of the facility contacting the local law enforcement agency of the incident. R21's medical diagnosis includes Bipolar Disorder, and Chronic Mental Illness, and Schizoid Paranoid Type. Interview with E1 (Administrator) on 3-18-11 at 3:30pm, when asked why a care plan was not immediately initiated on 10-7-10, E1 stated it was because R 21 was smoking Marijuana, not a nicotine	F9999		

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F9999	Continued From page 141 cigarette, and that it was only a one time thing that did not require a careplan. (B) 300.661 Section 300.661 Health Care Worker Backgroung Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). Findings include : 1) E32 (CNA/ Certified Nurse Aide) was hired as a direct care provider on 10/7/10. Per record review of her file, her police background check was only initiated on 11/29/10. 2) E47 was hired as a CNA on 11/5/10. Her HCWBC was only done on 12/8/10. 3) E48 was hired as a CNA on 12/15/10 but her HCWBC was only done on 1/15/11. Per E46 (staffing coordinator) during 3/23/11 interveiw at 11:30 AM, the police background check through Livescan is done within 10 days of hiring. (B)	F9999		

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F9999	Continued From page 142 300.4030a) Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed: 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others); 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation; 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and 4) Other known factors having an impact on the resident's condition (e.g., family involvement, social interaction patterns, cooperation with	F9999		

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F9999	Continued From page 143 treatment planning). These Requirements were not met as evidenced by: Based on record review and interview, the facility failed to initiate a care plan for a resident (R1) with a history of elopement, physical aggression, attempted suicide and arson prior to admission. R1 continued to have aggreessive behviors toward other reisdents after admission. In addition, the facility failed to obtain a PASSAR screening for two residents (R6, R17), and failed to obtain a complete OBRA-1 screen for one resident (R9). Findings include: 1) R1 is a 28 year old male who was admitted to the facility on 3/4/11 with diagnoses that include Schizo Affective Disorder. R1 has a previous history of elopement from another facility, auditory hallucinations coupled with paranoid delusions, physical aggression toward peers and staff, attempted suicide, and arson (attempted to set self on fire-served 3 years in prison). Nursing documents that on 3/7/11, R1 was in a physical altercation with another resident and sustained a cut lip. R1 and other resident were observed wresting on the floor. On 3/9/11 R1 was in a physical altercation with a peer on the elevator. He appeared highly agitated. On 3/14/11 R1 begin swinging fist at a peer and hit the peer in the shoulder. Nursing documents that on 3/15/11 R1 continued with unprovoked violence with peers, with homicidal ideation. R1 was sent to the hospital for a psychological	F9999		

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evaluation.

A review of R1's record failed to document that an 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 whether R1 was attending the groups.

2) R6 and R17 were admitted to the facility on 7/24/08 and 2/8/11 respectively. Physician order sheets document R6 is diagnosed as Schizophrenic and R17 as Bipolar disorder.

On 3/17/11 during daily status, PASSRR of R6 and R17 was requested. Facility presented document titled "interagency certification of screening results for long term care," for R6 and R17. This document is not a PASSRR screening.

PASSRR screening is required prior to admission and outlines specialized rehabilitative services required by the resident.

3) According to R9's current physician order sheet R9 has a diagnosis of bipolar disorder.

According to R9's clinical record dated 3/14/06 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 3/2/06 indicating R9 was identified with mental illness

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F9999	Continued From page 145 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. (B) 300.4030h) 300.4030o) Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment	F9999		

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plan.

o) The PRSC shall assess the reason for the failure to attend whenever a resident fails to attend at least 50 percent of any programs included in his or her ITP over a 30 day period. Within 14 days after noting this failure, the PRSC shall document why the resident's attendance was less than 50 percent and that the resident's attendance is, at the time of the documentation, more than 50 percent, or the PRSC shall conduct an IDT meeting. This IDT meeting shall result in a change in components of the resident's treatment plan or shall indicate why a change is not needed.

These Requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure that 4 of 24 sampled residents (R2,R9, R15, R16) attend scheduled therapeutic psycho-social therapy group. All 4 residents are identified with diagnosis of mental illness. In addition, the facility failed to intervene for 2 residents (R5, R6) out of 24 sampled Subpart S residents for non-attendance at psychosocial groups.

Findings include:

1) According to the clinical record current minimum data set and physician orders, R2 is a resident in the facility identified with a mental illness of schizophrenia. On 3/15/11 during the initial tour at 10:05am, R2 was observed to be alert and oriented with some confusion. R2 was able to identify staff by name. According to R2's

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current care plan no plan was noted developed for R2's mental illness. R2's current care plan did include his delusional thoughts and his denial of his mental illness, with interventions to include 1:1 session to discuss R2's likes and dislikes.

On 3/15/11 during the initial tour at 10:00am, R2 said that he does not participate in any group therapies. R2 was able to verbalize E21 as his case worker.

On 3/16/11 at 1:30pm in the conference room, E21 (social service aide) said that R2 was a resident on her current case load. E21 said that R2 was alert and oriented with delusional thoughts, and that R2 does not believe he needs to be at the facility and that R2 does not believe that he is a human being. E21 said that she is aware that R2 has the diagnosis of schizophrenia. E21 said that R2 is currently not enrolled in any psycho-social group therapy. E21 said that R2 is not enrolled in any psycho-social group therapy because R2 does not believe he needs therapy. E21 said that she has been working in the current position for 4.5 years. E21 said that she stops by and provides 1:1 sessions daily with R2. E21 said the sessions may last about 5 to 10 minutes a session. E21 said that this is all of the interaction that R2 receives daily, and that R2 stays in his room most of the time, except for meals. E21 said that there was no current plan in place to address R2's isolative behaviors.

According to R2's clinical record specialized service one to one progress note, R2 last received 1:1 services on 1/24/11. The 1:1 session and progress note gives a description of

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F9999	Continued From page 148 R2's behaviors, but no therapeutic intervention documented. On 3/16/11 at 1:30pm in the conference room, E21 was unable to verbalize why R2's last 1:1 session given was 1/24/11. E21 was unable to provide survey team with updated 1:1 session notes during the survey period. 2) According to the clinical record physician orders sheet R9 is identified to have a diagnosis of Bipolar disorder. According to R9's care plan R9 was admitted to the facility with a diagnosis of Biplor disorder, with an intervention to include coping skills group. According to R9's plan of care R9 has been assessed with a problem of refusing medication at times. R9's plan of care intervention includes resident to attend medication management group, and 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	F9999		

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up with R9 to ensure she attends. E31 said that she does not go to the group sessions to see if R9 attends the groups. E31 also said that she provides R9 with daily 1:1 sessions but does not 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 shows R9 attended 1 group session dated 3/15/11.

On 3/15/11 at 10:30am with E26 (nurse supervisor), R9 said that she does not attend the psycho-social groups, but does like art activities.

On 3/16/11 E25 (group leader) said that social service case worker gives names of the residents who will attend his groups. E25 said that he does not follow up or remind residents to attend the group session. E25 said that it is the resident's and/or the case worker's responsibility to ensure the resident attends the group. E25 said that if a resident is consistently not attending the group session he will delete them from the group.

3) 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

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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 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 does not attend any psycho-social group therapy. R15 said that she does not like going to go to group. R15 identified E14 as her case worker. R15 said that she does not 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, surveyor attended the anger management psycho-social group and noted that R15 was not present at either session. On 3/17/11 E25 (group leader) said that R15 does not 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 and 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 does not attend the

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	14E160	A. BUILDING _____ B. WING _____	03/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 151 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 provides 1:1 therapy with R15. E14 said that the 1:1 therapy he provides is not documented, it is informal. E14 was asked how he measures 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 were 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 does not attend the scheduled psycho-social group, he encourages her to attend. 4) According to R16's clinical record R16 has a diagnosis of Bipolar disorder and Depression. According to R16's current care plan R16 is identified with moderate intense anger issues, related to paranoid delusions. R16 is identified in 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	F9999		

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F9999	Continued From page 152	F9999		

and discuss socially/sexually appropriate behaviors.

On 3/18/11 at 12:45pm R16 said that he does not 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. Based on 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 has not been going to social skill psycho-social group. E14 said that he does not attend the psycho-social groups, and does not follow up to see if R16 attended the psycho-social group that day. E14 said that when R16 has a behavior he 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.

5) R5 and R6 are diagnosed as Bipolar and

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F9999	Continued From page 153 Schizophrenic respectively and qualify as Subpart S. R5's 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's 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, R5 and R6 did not attend any psychosocial groups. Facility forwarded copies of 1 month psychosocial group attendance sheets. R5 and R6's names did not appear on any sign in sheet. Facility roster for psychosocial groups does not list either R5 or R6 as belonging to any groups. On 3/15/11 at 12:15 pm R5 stated, "went to group 5 - 6 months ago. Not right now in groups. I don ' t go." On 3/16/11 at 1:00 pm E15 (Psychosocial Rehabilitation Counselor) stated with regards to R5, "Not attending group. Try to engage in one to one's. He doesn't talk when meets with you. The interdisciplinary team has not met to discuss his non-compliance with groups and how to address since I've been here." R5 last documented quarterly Psychiatric Rehabilitation Services Coordinator Summary is dated 10/13/10. That quarterly documents Social Skills and Coping Skills as Psychiatric	F9999		

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F9999	Continued From page 154 Rehabilitation priorities. On 3/15/11 at 11:45 pm R6 stated, "Don't want participate in groups." On 3/16/11 at 10:30 am E14, PRSC (psychosocial rehabilitation counselor for R6) stated, "I do one on one's with (R6). He's not attending groups. He qualifies for Subpart S. Do one to one's instead of groups." Care plan review for R6 does not include interventions to assist in gaining R6's compliance with attendance at psychosocial groups. Facility has no plan in place to get R6 to attend groups. (B) 300.4020a) 300.4020b)1) Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment. These requirements were not met as evidenced by: Based on interview and record review, the facility	F9999		

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F9999	Continued From page 155 failed to ensure completion of Psychiatric Rehabilitation Services Coordinator Quarterly Progress Note Summary for 1 (R5) out of 24 sampled residents in Subpart S. In addition, the facility failed to include psychiatric evaluation in the Comprehensive Assessment for 1 (R17) of 24 Sub-part S sampled residents. Findings include: 1) Facility Quarterly psychosocial rehabilitation Summary includes goals and evaluation of progress toward goals. R5's last quarterly summary was dated 10/13/10. On 3/16/11 at 1:00 pm E15 (psychosocial rehabilitation counselor) for R5 stated, " I m here since January 14. I don't see Quarterly has been updated." Facility was advised of lack of Quarterly update during daily status on 3/17/11. 2) R17's facesheet documents admission date of 2/8/11. R17 has Bipolar Affective Disorder. On 3/17/11 E14 (Psychosocial Rehabilitation Counselor for R17) stated, " He (R17) is Subpart S. I don ' t see psychiatrist evaluation." Facility was advised of lack of psychiatrist evaluation during daily status meeting on 3/18/11. (B)	F9999		