STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E845	A. BUILDING _____ B. WING _____	C 04/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON CARE	**4544 NORTH HAZEL STREET CHICAGO, IL 60640**

(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 Incident Report Investigation: Incident of 2-12-10 (IL46480) ==> F323 Complaint Investigation 1081416 / IL46882 ==> No deficiency An extended survey was conducted.	F 000		
F 323 SS=J	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 interview and record review, the facility failed to supervise 2 agitated residents (R2 and R4) with physical aggression towards other residents in the sample of 7 to ensure that R2 and R4 do not come in contact with other residents and physically attack them. As a result of this failure, R4 was able to attack R2 in the 4th floor dayroom which resulted in a fist fight. R2 was able to leave the 4th floor on 2/12/10 after 2 episodes of physical altercation with R4 and was able to come in contact with R3 in the	F 323		4/30/10

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

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F 323	Continued From page 1 1st floor dining room. This failure resulted in an Immediate Jeopardy on 2/12/10 when R2 went to the 1st floor dining room area unsupervised and stabbed R3 twice at the back of her neck with a piece of broken glass. The Administrator (E1) and the Director of Nursing (E2) were notified of this failure which resulted in an Immediate Jeopardy on 4/6/10. While the Immediate Jeopardy was abated on 2/12/10, the facility remains out of compliance at severity level 2 because the facility has yet to re-inservice all current staff including the new-hires on all shifts, has yet to assess if new interventions and policies are effective on possible affected residents, and the facility's evaluation of the new plan of care has yet to be conducted. Findings include: R2 has a diagnosis of schizoaffective disorder. Per facility's final investigation report on 2/12/10 at 6:50 AM, R3 approached E9 (cook) at the 1st floor dining room alleging that R2 hit her in the head. This incident report indicated that when E4 (3rd and 4th floor 11-7 nurse) examined R3, a 4 x 2 cm. cut at the back of her neck was noted, and R3 was sent out to the hospital for medical care. During 4/6/10 interview at 12:40 PM, E9 said that on 2/12/10 at around 6 - 6:15 AM, R1 came to the kitchen door and reported that R2 was hitting R4. E9 said he came out of the kitchen and went to the 1st floor dining room and saw R2 on top of	F 323		

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F 323	Continued From page 2 R4 who was lying on the floor. E9 said that at this time E2 let go of R4 already and said "She got my cigarette!" E9 continued that he helped R4 up, and E3 (11-7 CNA) took R4 upstairs. E9 continued that 15 minutes later, he heard a code yellow and so he left the kitchen and went up to the 4th floor. E9 said that by the time he got to the 4th floor, E5 (11-7 CNA) said that R4 came back for R2 but that it was taken care of already. E9 said that R4 went back to her room already, but at that time, no one knew where R2 went after the 2nd altercation with R4. E9 added that he went back to the kitchen and about 5 - 6 minutes later, R3 came to the kitchen door saying that R2 hit her at the back of her head. E9 said that he passed through the 1st floor dining room in route to the kitchen door where R3 was. E9 said that he saw that there was no staff monitoring the 1st floor dining room at that time. E9 said that he then saw that R3 was bleeding from a diamond-shaped deep cut about the size of a nickel from the back of her neck. E9 said that he didn't see R2 at the 1st floor dining room when he came out from the kitchen to see R3. When E4 was interviewed over the phone on 4/2/10, E4 said that 30 to 45 minutes prior to R2 stabbing R3 at the back of the neck, R2 also had a physical altercation with R4 in the 4th floor day room. E4 said that although he was not present during the actual altercation in the 4th floor day room, the male staff present told E4 that R2 was physically aggressive towards R4 and even towards the staff.	F 323		

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F 323	Continued From page 3 E4 denied that he knew that that same morning R2 was hitting R4 while they were at the 1st floor Dining Room. E4 also said that he wanted to send R2 out after her altercation with R4 at the 4th floor dayroom. However, when he called E10 (case management director), E10 advised him to wait for E10 to come to the facility. E4 said he did not call R2's physician despite of her aggressive behaviors and despite of not cooperating with getting a prn shot to calm R2 down. Per R2's record, she has orders for Ativan 2 mg every 6 hrs by mouth or intramuscularly as needed for agitation and Haldol 5 mg by mouth and intramuscular injection every 4 hrs as needed for agitation. Review of R2's MAR and nurses notes on 2/12/10 verified E4's statement that R2 did not receive a prn medication that day to calm her down despite of 2 incidents of a physical fight with R4 in less than an hour. Since E4 was not aware of the 1st fight between R2 and R4 in the 1st floor dining room, the staff did not ensure that both R2 and R4 were supervised to ensure that both their behaviors were addressed and to assure that both do not come in contact with each other and with other residents and cause physical harm. As there was no supervision, R4 was able to attack R2 in the 4th floor dayroom which ended in a fist fight. E4 continued that he cannot remember who stayed with R2 to do 1:1 supervision after her altercation with R4. E4 also said that he does not know how R2 managed to leave the 4th floor unsupervised and go to the 1st floor and cut R3 with a broken piece of glass.	F 323		

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F 323	Continued From page 4 Per E5 (11-7 4th floor CNA) during 4/6/10 phone interview at 10:15 AM, on 2/12/10 between 6:50 to 6:55 AM, he was standing by the door of the 4th floor day room when R4 passed by him and wrapped a cord around R2's neck. E5 said that R2 was able to remove the cord, and they (R2 and R4) started hitting each other with their fists. E5 continued that after the code yellow was called and after that altercation, R4 left while R2 went to her room. E5 further added that E3 (11-7 CNA) stayed with R2. However, while E3 was telling the female 7-3 shift CNA about the incident involving R2 and R4, R2 slipped out of the room and went to the 1st floor dining room where R3 was. E3 said that after the altercation with R4, R2 was very agitated and that her stabbing of R3 in the 1st floor dining room might not have happened if she were not agitated on the first place. E11 (7-3 CNA) said during 4/6/10 interview at 2:30 PM that she came early to work at around 5 AM on 2/12/10. E11 explained that at around 6:50 - 6:55 AM, a code yellow was called while she was on the 4th floor. However, by the time she got to the 4th floor dayroom, R4 was already going towards the stairwell, while she saw R2 walking towards her in the 4th floor hallway. E11 said she was walking towards the 4th floor dayroom during this time to respond to the code yellow. E11 said that E5 was monitoring the 4th floor dayroom, but that she didn't ask him what happened when she got there as the incident was already finished. E11 added that E4 (nurse) called her at the 4th floor nurses station initially after the incident to let her know that E3 was going to do a 1:1 monitoring with R2. E11 also	F 323		

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F 323	Continued From page 5 said that E5 called again to tell her that E3 got R2 already and is currently monitoring her 1:1. When E3 was interviewed on 4/6/10 at 10:39 AM, E3 confirmed that earlier that morning that R2 and R4 had an altercation at the 1st floor dining room that E9 broke off. E3 also said that later a code yellow was called on the 4th floor. However, by the time he got to the 4th floor, E5 and possibly E6 (11-7 CNA) already separated R2 from another resident who E3 said was R3. E6 said that the altercation on the 4th floor dayroom was between R2 and R4 during 4/6/10 phone interview. E3 further explained that E4 asked him to keep an eye on R2 who was at the dayroom. E6 also confirmed it was E3 whom E4 requested to monitor R2 after her altercation with R4 on the 4th floor dayroom. E3 said that during that time, R2 was still agitated and was walking around the dayroom where he was keeping an eye on her. E3 also added that while he was giving E7 (7-3 CNA) a report inside the 4th floor dayroom, R2 left the dayroom. E3 said that he thought she was going to her room but R2 did not. So E3 said he followed her downstairs. E3 continued that by the time he got to the 1st floor dining room, R2 had already stabbed R3 with what he heard was a broken piece of glass. E3 added that he saw R3 at the 1st floor dining room just after she stabbed R3, but said that he aided R3 instead together with E7, as R3 was bleeding from her wound. However, when E7 was interviewed on 4/6/10 at 11:30 AM, E7 denied getting a report from E3 at the 4th floor dayroom on 2/12/10. E7 said that as soon as she came in the front lobby to check her	F 323		

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F 323	Continued From page 6	F 323		

assignment, she saw E9 helping the bleeding R3 by the hallway outside of the 1st floor dining room. E7 said that she then looked at R3's wound and took her upstairs with E8 (7-3 CNA) to E4. E7 also said that she just saw E3 at the lobby and don't know what he was doing there at the time.

As confirmed by E9, there was no staff inside the 1st floor dining room when he passed by it after R3 initially made a complaint that she thought R2 just hit her at the back of the neck. E9 said that it was he who brought R3 out of the 1st floor dining room towards the lobby where E7 took over to help R3.

According to R3 during 4/2/10 interview at 11:30 AM, while she was having breakfast at the 1st floor dining room, R2 just came up behind her and stabbed her at the back of her neck with a broken piece of glass twice. R3 continued that she went to have her wound sutured at the hospital. R3 also said that several days before the stabbing, R2 threatened to kill her or beat her up outside after an argument over a cigarette.

During 4/2/10 interview, E4 said that he found a broken piece of glass on R3's shirt while he was taking care of her after the stabbing incident.

During 4/6/10 interview, E8 (7-3 CNA) said that R2 told her after the incident with R3 that she dropped the weapon after the attack and that she used a broken piece of glass. E8 also added that R2 stated that she attacked R3 because R3 blew cocaine through her body.

The Immediate Jeopardy was identified to have begun on 2/12/10 when R2 went without

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F 323	Continued From page 7 supervision from the 4th floor to the 1st floor dining room, and stabbed R3 twice at the back of the neck which resulted to a laceration that needed medical attention at the hospital. This Immediate Jeopardy was removed on 2/12/10 when the facility finally had one staff do a 1:1 monitoring while R2 was inside her room until the police came to the facility to take her to custody. The facility took the following steps to remove the Immediate Jeopardy: 1) R2 was placed on 1:1 and not allowed to leave her room until the police came to investigate and take her to custody. Other residents were assessed to determine which of them needed 1:1 monitoring to ensure they don't harm other residents. As part of their QA process, all residents will be assessed quarterly and on prn basis to ensure those needing close supervision will receive close monitoring including 1:1. 2) All staff were immediately inserviced as to how to provide proper 1:1 supervision with residents who had exhibited aggressive behaviors and had altercation with other residents or staff. The DON (Director of Nursing) conducted the in-services and will monitor compliance as part of the QA process. 3) Staff was also in serviced to immediately report altercations and behavioral escalation or any change in resident's condition to the nurses so that these behaviors can be addressed and referred to the physician. In-services were also conducted regarding behavioral assessment of residents after aggressive and violent behaviors. DON will monitor continued compliance as part of	F 323		

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F 323	Continued From page 8 their QA process. 4) Dining room policy was immediately reviewed and modified to ensure that the 1st floor dining room will be locked until meal time, when staffs are present to monitor activities inside the dining area. The Food Service Supervisor will monitor compliance as part of the QA process.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. Section 300.3240 Abuse and Neglect 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	F9999		

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F9999	Continued From page 9 of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These REGULATIONS are not met as evidenced by: Based on interview and record review, the facility failed to supervise 2 agitated residents (R2 and R4) with physical aggression towards other residents in the sample of 7 to ensure that R2 and R4 do not come in contact with other residents and physically attack them. As a result of this failure, R4 was able to attack R2 in the 4th floor dayroom which resulted in a fist fight. R2 was able to leave the 4th floor on 2/12/10 after 2 episodes of physical altercation with R4 and was able to come in contact with R3 and stab her with a piece of broken glass in the 1st floor dining room. Findings include: R2 has a diagnosis of schizoaffective disorder. Per facility's final investigation report on 2/12/10 at 6:50 AM, R3 approached E9 (cook) at the 1st floor dining room alleging that R2 hit her in the head. This incident report indicated that when E4 (3rd and 4th floor 11-7 nurse) examined R3, a 4 x 2 cm. cut at the back of her neck was noted, and R3 was sent out to the hospital for medical care. During 4/6/10 interview at 12:40 PM, E9 said that on 2/12/10 at around 6 - 6:15 AM, R1 came to the kitchen door and reported that R2 was hitting	F9999		

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F9999	Continued From page 10	F9999		

R4. E9 said he came out of the kitchen and went to the 1st floor dining room and saw R2 on top of R4 who was lying on the floor. E9 said that at this time E2 had let go of R4 already and said "She got my cigarette!" E9 continued that he helped R4 up, and E3 (11-7 CNA) took R4 upstairs. E9 continued that 15 minutes later, he heard a code yellow and so he left the kitchen and went up to the 4th floor.

E9 said that by the time he got to the 4th floor, E5 (11-7 CNA) said that R4 came back for R2 but that it was taken care of already. E9 said that R4 went back to her room already, but at that time, no one knew where R2 went after the 2nd altercation with R4. E9 added that he went back to the kitchen and about 5 - 6 minutes later, R3 came to the kitchen door saying that R2 hit her at the back of her head.

E9 said that he passed through the 1st floor dining room in route to the kitchen door where R3 was. E9 said that he saw that there was no staff monitoring the 1st floor dining room at that time. E9 said that he then saw that R3 was bleeding from a diamond-shaped deep cut about the size of a nickel from the back of her neck. E9 said that he did not see R2 at the 1st floor dining room when he came out from the kitchen to see R3.

When E4 was interviewed over the phone on 4/2/10, E4 said that 30 to 45 minutes prior to R2 stabbing R3 at the back of the neck, R2 also had a physical altercation with R4 in the 4th floor day room. E4 said that although he was not present during the actual altercation in the 4th floor day room, the male staff present told E4 that R2 was physically aggressive towards R4 and even towards the staff.

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F9999	Continued From page 11 E4 denied that he knew that that same morning R2 was hitting R4 while they were at the 1st floor Dining Room. E4 also said that he wanted to send R2 out after her altercation with R4 at the 4th floor dayroom. However, when he called E10 (case management director), E10 advised him to wait for E10 to come to the facility. E4 said he did not call R2's physician despite of her aggressive behaviors and despite of not cooperating with getting a prn (as needed) shot to calm R2 down. Per R2's record, she has orders for Ativan 2 mg every 6 hrs by mouth or intramuscularly as needed for agitation and Haldol 5 mg by mouth and intramuscular injection every 4 hrs as needed for agitation. Review of R2's MAR and nurses notes on 2/12/10 verified E4's statement that R2 did not receive a prn medication that day to calm her down despite 2 incidents of a physical fight with R4 in less than an hour. Since E4 was not aware of the 1st fight between R2 and R4 in the 1st floor dining room, the staff did not ensure that both R2 and R4 were supervised to ensure that both their behaviors were addressed and to assure that both did not come in contact with each other and with other residents and cause physical harm. As there was no supervision, R4 was able to attack R2 in the 4th floor dayroom which ended in a fist fight. E4 continued that he cannot remember who stayed with R2 to do 1:1 supervision after her altercation with R4. E4 also said that he does not know how R2 managed to leave the 4th floor unsupervised and go to the 1st	F9999		

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F9999	Continued From page 12 floor and cut R3 with a broken piece of glass. Per E5 (11-7 4th floor CNA) during 4/6/10 phone interview at 10:15 AM, on 2/12/10 between 6:50 to 6:55 AM, he was standing by the door of the 4th floor day room when R4 passed by him and wrapped a cord around R2's neck. E5 said that R2 was able to remove the cord, and they (R2 and R4) started hitting each other with their fists. E5 continued that after the code yellow was called and after that altercation, R4 left while R2 went to her room. E5 further added that E3 (11-7 CNA) stayed with R2. However, while E3 was telling the female 7-3 shift CNA about the incident involving R2 and R4, R2 slipped out of the room and went to the 1st floor dining room where R3 was. E3 said that after the altercation with R4, R2 was very agitated and that her stabbing of R3 in the 1st floor dining room might not have happened if she was not agitated in the first place. E11 (7-3 CNA) said during 4/6/10 interview at 2:30 PM that she came early to work at around 5:00 AM on 2/12/10. E11 explained that at around 6:50 - 6:55 AM, a code yellow was called while she was on the 4th floor. However, by the time she got to the 4th floor dayroom, R4 was already going towards the stairwell, while she saw R2 walking towards her in the 4th floor hallway. E11 said she was walking towards the 4th floor dayroom during this time to respond to the code yellow. E11 said that E5 was monitoring the 4th floor dayroom, but that she did not ask him what happened when she got there as the incident was already finished. E11 added that E4 (nurse) called her at the 4th floor nurses station initially after the incident to let her know that E3	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E845	A. BUILDING _____ B. WING _____	C 04/07/2010

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F9999	Continued From page 13 was going to do a 1:1 monitoring with R2. E11 also said that E5 called again to tell her that E3 got R2 already and is currently monitoring her 1:1. When E3 was interviewed on 4/6/10 at 10:39 AM, E3 confirmed that earlier that morning that R2 and R4 had an altercation at the 1st floor dining room that E9 broke up. E3 also said that later a code yellow was called on the 4th floor. However, by the time he got to the 4th floor, E5 and possibly E6 (11-7 CNA) had already separated R2 from another resident who E3 said was R3. E6 said that the altercation on the 4th floor dayroom was between R2 and R4 during 4/6/10 phone interview. E3 further explained that E4 asked him to keep an eye on R2 who was at the dayroom. E6 also confirmed it was E3 whom E4 requested to monitor R2 after her altercation with R4 in the 4th floor dayroom. E3 said that during that time, R2 was still agitated and was walking around the dayroom where he was keeping an eye on her. E3 also added that while he was giving E7 (7-3 CNA) a report inside the 4th floor dayroom, R2 left the dayroom. E3 said that he thought she was going to her room but R2 did not. So E3 said he followed her downstairs. E3 continued that by the time he got to the 1st floor dining room, R2 had already stabbed R3 with what he heard was a broken piece of glass. E3 added that he saw R3 at the 1st floor dining room just after she stabbed R3, but said that he aided R3 instead together with E7, as R3 was bleeding from her wound. However, when E7 was interviewed on 4/6/10 at 11:30 AM, E7 denied getting a report from E3 at	F9999		

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F9999	Continued From page 14 the 4th floor dayroom on 2/12/10. E7 said that as soon as she came in the front lobby to check her assignment, she saw E9 helping the bleeding R3 by the hallway outside of the 1st floor dining room. E7 said that she then looked at R3's wound and took her upstairs with E8 (7-3 CNA) to E4. E7 also said that she just saw E3 at the lobby and dis not know what he was doing there at the time. As confirmed by E9, there were no staff inside the 1st floor dining room when he passed by it after R3 initially made a complaint that she thought R2 just hit her at the back of the neck. E9 said that it was he who brought R3 out of the 1st floor dining room towards the lobby where E7 took over to help R3. According to R3 during 4/2/10 interview at 11:30 AM, R2 just came up behind her and stabbed her in the back of her neck with a broken piece of glass twice while she was having breakfast at the 1st floor dining room. R3 continued that she went to have her wound sutured at the hospital. R3 also said that several days before the stabbing, R2 threatened to kill her or beat her up outside after an argument over a cigarette. During 4/2/10 interview, E4 said that he found a broken piece of glass on R3's shirt while he was taking care of her after the stabbing incident. During 4/6/10 interview, E8 (7-3 CNA) said that R2 told her after the incident with R3 that she dropped the weapon after the attack and that she used a broken piece of glass. E8 also added that R2 stated that she attacked R3 because R3 blew cocaine through her body.	F9999		

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F9999	Continued From page 15 (A)	F9999		