STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. BUILDING _____ B. WING _____	C 06/17/2010

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

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F 323	Continued From page 5	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.3240a) 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 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	F9999		

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F9999	Continued From page 6 or agent of a facility shall not abuse or neglect a resident. (Section 2-107 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 are not met as evidenced by: Based on observation, interview and record review the facility failed to provide supervision for one aggressive resident (R1) toward another resident (R2), and allowing him (R1) to attack a second resident (R3) approximately 1 and 1/2 hours later. As a result of this failure, R2 sustained bruises to his left arm and neck and R3 suffered redness around her neck as evidence by statements in interviews. R2 and R3 suffered mental anguish from unprovoked attacks. This failure has the potential to affect all 118 residents in the facility. Findings include: During an interview on 6/11/10 at approximately 2:25 PM, R6 stated that when she (R6) went out	F9999		

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F9999	Continued From page 7	F9999		

on the facility's patio, she (R6) observed R1 going through R5's purse. R6 stated she told R1 to get out of her purse. R6 stated that R1 "spit" at her and she spit back and walked back into the facility.

On 6/11/10, R2 stated that he was sitting out on the patio on 5/29/10 and that he saw the incident as described by R6. R2 stated that after R6 left the area, R1 came over, grabbed his (R2) quad cane and started "hitting me across the arm, shoulder and neck. I put my arm across my head to prevent him from hitting me on my head." Another resident, "I can't remember who" yelled at him (R1) and told him to stop. R1 then tossed my cane up on the roof. "I was really shook up after that."

During an interview with E3 (RN) on 6/11/10, E3 stated that R6 ran up to her (E3) and told her that R1 was hitting R2 with a cane. E3 stated that she was told that R1 was asking other residents on the patio for cigarettes and when they refused he (R1) grabbed R2's cane and starting hitting R2 on the arm and side of his neck with the cane. "It was all over when I arrived." E3 stated that R1 quieted down and he (R1) was instructed to go to his room. I (E3) notified his psychiatrist for orders to send him out. E3 stated that this was approximately 7:00 PM. E3 stated that she did not see R1 any more until about 8:00 PM when he (R1) came out for a snack. (This statement is in contradiction of E3's statement in the facility's written report.) R1 was observed to return to his room at approximately 8:15 PM. At approximately 8:30 PM, I was sumoned to the patio again. When I arrived R4 was observed holding R1 down. He (R4) let him go when I arrived. When R1 got up "he seemed calm." I

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F9999	Continued From page 8	F9999		

called a "code yellow." I do not know who called 911. E3 stated that she was focused on R2's and R3's physical condition and that she did not think she needed to provide crisis intervention for any emotional harm.

During an interview with R3 on 6/11/10 at approximately 12:30 PM, R3 stated that he (R1) came up to me and asked me for a cigarette, he asked me three times and I said no. He then went around me and got his hands around my neck and started choking me. It was so tight that I could not yell. "I thought he (R1) was going to kill me. I was so scared. I was nervous for 2 days after that." R4 came up and stopped him. "No staff was out on the patio. They were sitting in the dining room and they did nothing."

An interview with R4 revealed that R4 was sitting out on the patio. He saw R1 walk behind R3 and grabb her around the throat and start choking her. I ran up behind him (R1) and put him down on the ground and held him there until he stopped moving. I stayed on top of him until one of the nurses came out.

An observation made of the facility's patio in relation to the dinning room noted that there is no full visual view of the patio unless you are sitting at the table that is directly in front of the patio door.

During an interview with E1 (Administrator), E1 stated that there are cameras on the patio that can be viewed in the nurses' station. There was no one in the nurses' station at the time of the incidents.

A record review revealed that R1 is a 47 year old

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F9999	Continued From page 9 male admitted to the facility on 4/22/10 with diagnoses which include Schizo Affective disorder, Hypothyroidism, Hepatitis C and a history of polysubstance abuse. A review of the facility's Social Admit Note dated for 4.25/10, read that R1 stated "I had trouble at the other place," but would not elaborate. During a telephone interview with Z1 (Administrator at a facility where R1 resided before admit to this facility), Z1 denied any incidents of aggressive behaviors for R1. A review of the facility's staffing for 5/29/10 on the second shift noted that 6 CNAs and 2 licensed nurses were assigned. (A) .	F9999		