DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, <i>i</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		14E845	B. WING _			C 09/11/2015		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				45	544 NORTH HAZEL STREET			
WILSON				С	HICAGO, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	SHOULD BE COMPLETION			
F 000	INITIAL COMMENTS		FC	000				
	Complaint Investigati	on						
	1584328/ IL79292- N	o deficiency						
	1584263/ IL79217- R	efer to F281, F309						
	1584589/ IL79586- N	-						
	1584661/ IL79663- N	-						
F 281 SS=D	1584677/ IL79687- N 483.20(k)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET	F 2	281				
		d or arranged by the facility al standards of quality.						
	by: Based on observation review the facility faile medication as order, of given and the reason given according to the	is not met as evidenced n, interview and record ed to administer a document a medication was why a medication was not e facility's policy for two of R2) reviewed for medication						
	Findings include:							
	specified by the resider routine medications s scheduled. The nurse	n part that unless otherwise ent's attending physician, hould be administered as administering the rd such information on the						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 09/17/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/17/2015 M APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, í			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		14E845	B. WING				C / 11/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					4544 NORTH HAZEL STREET		
WILSON	CARE				CHICAGO, IL 60640		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 281	medication. The nursi medications must initi the appropriate line a day. The facility policy, Me dated 12/20/2013 doo medications must be in the manner and me physician. In the eve be given, the reason in Nurses Medication Ne Progress Notes, and MAR. On 9/2/15 at 2:10 pm Z2(Physician) ordered sleep. R1 also states Trazodone at night fo cannot fall asleep unt does not sleep well w On 9/3/15 at 11:00am requested Ativan num the nurses tell me that At the medication can Practical Nurse) on 9/ was no Trazodone 10 R1 and no Ativan 1mg time that she has give evening she worked f also stated she gave (9/2/15) and ordered delivered until late ev she could not explain	istering the next resident's e administering the ial the resident's MAR on nd date for that specific edication Administration, cuments in part that all administered to the resident ethod prescribed by the nt that a medication cannot must be documented in the otes on the MAR or the time frame circled on the R1 states that he d Trazodone to help him is he has not been given r over two weeks, and il after 1:00am, and then rithout it.	F	281			

Facility ID: IL6010045

If continuation sheet Page 2 of 8

CENTER STATEMENT AND PLAN OF	1		· <i>`</i>	s	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 4544 NORTH HAZEL STREET CHICAGO, IL 60640 PROVIDER'S PLAN OF CORRECTION	FORM OMB NC (X3) DATE COMP	D: 09/17/2015 MAPPROVED D. 0938-0391 SURVEY PLETED C 111/2015
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 281	Administration Record On 9/3/15 at 1:30pm stated that they received Trazodone 100 mg. th (Physician) for R1 on medications in the even started the Trazodone requested a refill on 8 and the insurance cor The facility never sent 9/3/15 at 1:24pm. The refill requests to refill not sent Trazodone 10 If the medication was last dose would have On 9/4/15 at 10:25am that they received the Sheet) on 8/11/15 for (Physician) never sign faxed the facility and the sheet one time with no it is the facility's respon unsigned prescription. On 9/3/15 at 2:30pm I Nursing) stated that the pharmacy and there is Trazodone. E2 also st medication should be not aware of the probi- the difference betwee the MAR (Medication	d). via phone Z1(Pharmacist) ved a new prescription for hirty tablets written by Z2 7/21/15. We deliver the ening so R1 would have a on 7/22/15. The facility 8/8/15 but it was too soon mpany denied the request. t another refill request until e facility has to call or fax this medication. We have 00 mg for R1 since 7/21/15. administered correctly the been given on 8/21/15. administered correctly the been given on 8/21/15. a Z5 (Pharmacist) stated e POS (Physician's Order Ativan 1 mg for R2, but Z2 ned the prescription. We the physician the sign off o response. Z5 also stated onsibility to follow up on s. We never received the E2 DON (Director of he facility only uses one s no house stock for tated that problems with reported to the DON. I was lems and I cannot explain en the pharmacy records and Administration Record) for e unaware R1 had not	F	281			

Facility ID: IL6010045

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		14E845	B. WING) 11/2015		
NAME OF P	ROVIDER 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)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	LD BE COMPLETION			
F 281 F 309 SS=D	On 9/4/15 at 10:10am he is at the facility even informed him there we R2's medication. I all phone calls until 9/2/1 Ativan prescription ha anxiety and requires A down. R1 has insomm mental illness, and Tr sleep. The MAR (Medication documents that on 8/2 8/29, 9/1, 9/2, E6 LPN 100mg at 9:00pm. Th 8/23 and 8/30 at 9:00 The MAR documents Trazodone 100mg 8/2 MAR documented a " missed dose of Trazo The POS (Physician's that Ativan 1mg every needed was ordered 2 The MAR dated 8/10/ documents that Ativar administered to R2. 483.25 PROVIDE CA HIGHEST WELL BEIN Each resident must re provide the necessary or maintain the higher mental, and psychoso	a 22 (Physician) stated that ery Tuesday and no one ere problems with R1 and so have not received any 5 when I was informed R2's ad not been filled. R2 has Ativan to help calm him hia, which is part of his azodone is given to help R1 Administration Record) 22, 8/24, 8/25, 8/26, 8/28, N administered Trazodone e MAR has no notation for pm for Trazodone 100 mg. that E5 LPN administered 27, and 8/31 at 9:00pm. The 2" on 9/3/15 indicating a done 100mg for R1. c Order Sheet) documents of four hours by mouth as Z2 by on 8/11/15 for R2. 15 through 9/9/15 in 1mg has never been RE/SERVICES FOR NG eceive and the facility must of care and services to attain at practicable physical,		309					

Facility ID: IL6010045

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PRINTED: 09/17/2015

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 09/17/2015 APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	LETED
		14E845	B. WING		_		_ 11/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
	CARE			544 NORTH HAZEL STRE HICAGO, IL 60640	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	: 4	F 309				
	by: Based on observation review the facility faile medications as ordered and sleep disorder for R2) reviewed for med Findings include: 1. On 9/2/15 at 2:10 p (Physician) ordered T R1 also stated he has at night for over two w asleep until after 1:00 sleep well On 9/3/15 at 1:30pm stated, they received Trazodone 100 mg. th (Physician) for R1 on medications in the even started the Trazodone requested a refill on 8 and the insurance con The facility sent anoth 1:24pm. The facility h requests to refill this r sent Trazodone 100 r the medication was an last dose would have The MAR (Medication documents that on 8/2 8/29, 9/1, 9/2, E6 LPM 100mg at 9:00pm. Th	Trazodone to help him sleep. s not been given Trazodone veeks, and cannot fall vam, and then does not via phone Z1(Pharmacist) a new prescription for hirty tablets written by Z2 7/21/15. We deliver the ening so R1 would have e on 7/22/15. The facility b/8/15 but it was too soon mpany denied the request. her refill request on 9/3/15 at					

Facility ID: IL6010045

If continuation sheet Page 5 of 8

		D HUMAN SERVICES					FORM): 09/17/2015 APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		14E845	B. WING			_	C 09/11/2015		
NAME OF P	ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
WILSON	CARE				544 NORTH HAZEL STRE CHICAGO, IL 60640	ET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Trazodone 100mg 8/2 MAR documented a " missed dose of Trazo On 9/3/15 at 5:45pm of the medication cart hat tablets in the cart for 1 that she has given R1 she worked for the participation of the stated she gave the lat and ordered a refill with until late evening 9/3/ not explain the differe records and the MAR Record). On 9/4/15 at 10:10am stated he is at the fact one informed him the and R2's medication. part of his mental illust to help R1 sleep. Interview on 9/3/15 at of Nursing) stated that pharmacy and there is Trazadone. E2 also s had not received Trazo were delivered on 7/2 for Trazodone 100 mg 2. On 9/3/15 at 11:00	that E5 LPN administered 27, and 8/31 at 9:00pm. The 2" on 9/3/15 indicating a done 100mg for R1. while E6 LPN was present, ad no Trazodone 100 mg R1. E6 stated at this time Trazodone every evening ist two weeks. E6 also ast tablet last night (9/2/15) nich would not be delivered 15. E6 stated that she could nce between the pharmacy (Medication Administration a via phone Z2 (Physician) ility every Tuesday and no re were problems with R1 R1 has insomnia, which is ess, and Trazodone is given 2:30pm E2 (DON/ Director t the facility only uses one is no house stock for tated she was unaware R1 codone as scheduled. cation delivery sheet for R1 done 100 mg, 30 tablets 2/15 and the next delivery g, 30 tablets was 9/4/15.	F	309					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 09/17/2015 APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14E845	B. WING _			C 09/11/2015		
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
	ARE				544 NORTH HAZEL STREET HICAGO, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 309	Continued From page	9 6	F 3	809				
	-	while E6 LPN was present, ad no Ativan 1mg for R2.						
	The pharmacy's medi documents that the fin (Ativan) 1mg, 30 table	st delivery for lorazepam						
	stated that they receiv Order Sheet) on 8/11/ but Z2 (Physician) ne We faxed the facility a off sheet one time wit stated it is the facility'	a via phone Z5 (Pharmacist) ved the POS (Physician's (15 for Ativan 1 mg for R2, ver signed the prescription. and the physician the sign h no response. Z5 also s responsibility to follow up tions. We never received the						
	stated he is at the fac one informed him the and R2's medication. phone calls until 9/2/1 Ativan prescription ha	n via phone Z2 (Physician) ility every Tuesday and no re were problems with R1 I also have not received any 5 when I was informed R2's id not been filled. R2 has Ativan to help calm him						
	was not aware of the explain the difference							
		s Order Sheet) documents r hours by mouth as needed n 8/11/15 for R2.						

Facility ID: IL6010045

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/17/2015 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14E845	B. WING			_		C 11/2015
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WILSON	CARE				1544 NORTH HAZEL STRE CHICAGO, IL 60640	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	The MAR dated 8/10/ documents that Ativar administered to R2. The facility policy, Ad undated documents in specified by the resid routine medications s scheduled. The nurse medication must reco resident's MAR before resident's medication the medications must	15 through 9/9/15 n 1mg has never been ministration of Drugs, n part that unless otherwise ent's attending physician, hould be administered as	F	309				

Facility ID: IL6010045

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