STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000087	A. BUILDING _____ B. WING _____	C 08/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN NURSING HOME	5448 NORTH BROADWAY STREET CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigation: 1884853/IL104449 - F600, F689	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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that each resident receives adequate supervision and assistance to prevent accidents.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interviews and record reviews, the facility failed to follow the abuse policy by assessing and identifying the risk factors of being vunerable to abuse for 1 of 4 (R1) residents reviewed for physical abuse. These resulted in R1 being physically assaulted after wandering into R2's room, sustaining multiple punctured wounds on 10 injury sites, requiring 24 stitches.

Findings include:

A Preliminary 24 hour Incident Investigation Report was submitted via fax to Illinois Department of Public Health on 7/21/18 at 2:11 am and the final report was faxed on 7/23/18 at 9:22 am. The incident report documents:
The original allegation (note day, time, location, the specific allegation, alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries): On 7/20/18 at 11:40 am, in room 315, R1 was sleep walking into R2's room. R2 alleged that R1 was getting into R2's bed which then R2 struck R1 on top of head and facial area with hands and a plastic toy carrot. According to V9(CNA), R1 was quickly walking down hallway towards bathroom. When V9 called R1's name, R1 did not respond which V9 then logged off computer and went to redirect R1. R1 has history of sleep walking. V9 went to the end of the hallway and looked both directions and headed

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towards stairwell but did not see R1. V9 then responded to yelling in R2's room. V9 called for assistance and another V7(CNA) and V4 (Licensed Practical Nurse) responded. V9 then called code due to R2 displaying aggressive behavior towards R1. V4 called 911 due to difficulty in redirecting R2. V4 then assessed and provided first aid to (R1) ½ inch laceration to head, ½ inch laceration to right upper cheek, ½ inch laceration to right temple. Pressure applied to sites and bleeding subsided, dry dressing applied prior to 911 ambulance arriving.
Based on the known facts from medical record review and interviews, the following conclusions have been determines about the allegation:
Abuse is founded.
Based on known facts, interviews and statements and staff witnesses, a full investigation was conducted. It has been concluded that R1 was sleep walking and according to R1 ...was noted in R2's room. R2 yelled out and was verbally and physically aggressive towards R1. No injury was noted for R2. 911 called and (local) police report made #JB358527. R1 walked to ambulance and transported to (local) hospital for evaluation and was admitted for observation and treatment of facial lacerations/sutures ... R2 was placed on 1:1 monitoring by staff and was sent to the hospital for evaluation.

According to the medical records, R1 is diagnosed with but not limited to Schizoaffective disorder, major depressive disorder, peptic ulcer and conversion disorder with seizures. According to R1's Minimum Data Set assessment, with an assessment reference date of 7/9/18, R1's BIMS (Brief Interview for Mental Status) score is 15/15 (Cognitively Intact).

Interviews were conducted.

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On 7/25/18 at 3:00 pm, V11 (Certified Nursing Assistant/Security) was interviewed on a resident floor. V11 stated that at the time of the incident, V11 worked as a security guard but stayed on the first floor while V6 responded to the code that was called. V11 stated that V11 works as a Certified Nursing Assistant in R1's and R2's floor and knows R1 and R2 well. V11 stated that R1 occasionally sleepwalks during night time and when R1 sleep walks, R1 enters other resident's rooms.

On 7/25/18 at 4:30 pm, V4 was interviewed via telephone. V4 stated that V4 usually works the same unit and on the night shift. V4 stated that R1 sleep walks and goes into other residents' rooms once in a while. V4 stated that R1 tries to go into stairwell when R1 sleep walks; if R1 responds if being called - this is normal, he is awake, but if R1 does not respond to staff then R1 is sleepwalking. R1 only wanders when sleepwalking. V4 stated that on that day, R1 went into R2's room and when V9 followed R1, there was already a commotion and couldn't pull both R1 and R2 apart and that's when V9 called V4. V4 stated that V4 saw R2 holding the end of the carrot-shaped item and was poking R1 with it in head. V4 stated that R1 had injuries because carrot was hard plastic but did not see any metal part on it. V4 stated that V4 talked to R2 and tried to explain that R1 was sleepwalking but R2 stated that the room belonged to R2 and that R2 thinks that R1 was trying to sleep with R2.

On 7/25/18 at 4:42 pm, V5 (Registered Nurse) was interviewed. V5 stated that V5 responded to a code called at around 11:40 pm. V5 stated that V5 did not see the incident but took care of R1's wounds on the left eye/face area, left neck area

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and at the corner of R1's eye, "which looked like holes." V5 stated that R1 is alert and oriented x 2 and when R1 is sleep walking, R1 does not remember what has happened.

On 7/26/18 at 9:55 am, V6 (Security) was interviewed. V6 stated that V6 worked for the 11-7 shift at the time of the incident. V6 stated that V6 responded to a code that was called and stated that when V6 got to R2's room, both R1 and R2 were on the floor side by side, trying to stop each other using hands but V6 did not see any weapon used. V6 stated that V6 was trying to break R1 and R2 apart.

On 7/26/18 at 10:11 am, V8 (Certified Nursing Assistant) was interviewed. V8 stated that at the time of the incident, V8 was working on another unit during the night shift and had responded to a code. V8 stated that V8 usually works on R1's and R2's unit during the dayshift and knows both residents well. V8 stated that R1 is alert and does not wander in other residents' rooms, but during the night, V8 sleep walks, sometimes goes into the bathroom or into other resident rooms.

On 7/26/18 at 10:27 am, V7(CNA) was interviewed via telephone. V7 stated that at the time of the incident, V7 was working on the unit on R1's and R2's floor. V7 stated that R1 is alert and is able to walk independently. V7 stated that R1 is known to be sleep walking and R1 gets redirected and responds to it. V7 stated that V9 had called V7 to go to R2's room. V7 stated that when they got to the room, R1 on R2's bed and that R2 was holding R1 trying to get R1 out of bed but did not see R2 hitting R1.

On 7/26/18 at 10:45 am, V9 was interviewed via telephone. V9 stated that V9 has worked in the

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facility for one year and usually during the 11-7 shift and is familiar with R1 and R2. V9 stated that during the night shift, R1 usually gets up and uses the bathroom. V9 stated that at times, R1 sleep walks and sometimes R1 will go to other residents' rooms. V9 stated that if R1 goes to other residents' rooms, V9 has to intervene and if R1 does not get redirected, V9 stated that V9 has to call for help to physically redirect R1 to room. V9 stated that on the day of the incident, V9 was charting on computer in the middle of the hallway and R1 passed by and V9 stated that V9 had said "hi" to R1 but R1 did not respond; V9 logged off from the computer and followed R1 and attempted to go towards the stairway but did not see R1. V9 stated that V9 heard a noise at R2's room and went there. V9 stated that when V9 entered the room, R1 was on R2's bed, and that R2 was also on the bed fighting, shouting "get out of my bed." V9 stated that V9 called for help and "V7 came to help but it was too much for us to break them, so I left V7 there and called for more help." V9 stated that V9 saw R2 hitting R1 and then saw R2 grabbing something from bedside table and fight R1 with it. V9 stated that V9 saw R1 had moderate amount of bleeding on the face then V9 had noticed the carrot pen. V9 stated that V9 tried to grab it off R2. V9 stated that when the rest of the staff came (V8 and V6), they were able to break up R1 and R2 and V4 had called 911. V9 stated that the police and paramedics came, then V1 (Administrator) came. V9 stated that V9 had to do 1:1 monitoring for R2 for the rest of the shift.

On 7/26/18 at 1:30 pm, V1 was interviewed. V1 stated that staff called V1 regarding the incident between R1 and R2 and had come to the facility during that night shift to initiate the investigation. V1 stated that V1 had reported the incident to

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IDPH. V1 stated that the investigation was initiated. V1 stated that V1 had interviewed R2, who stated that R2 hit R1 and that R2 had used the carrot-shaped pen. V1 confirmed that per facility investigation, abuse was founded.

On 7/26/18 at 1:00 pm, V10 (Psychosocial Rehabilitative Services Coordinator) was interviewed. V10 stated that V10 is case manager for R1. V10 stated that R1 is alert and able to go out independently as R1 does not exhibit any behaviors. V10 stated that V10 has heard from other staff members that R1 sleep walks but is not aware that R1 goes into other resident's rooms. V10 also stated that V10 does not consider sleepwalking and wandering a part of R1's behaviors.
V10's social services notes document on 4/1/18 and 7/8/18: R1 can be also found sleep walking in the late hours of night, but is easily redirected by staff. No interventions documented.

On 7/26/18 at 3:22 pm, V3 (MDS/Care Plan Coordinator) was interviewed. V3 stated that the care plans for residents are done in collaboration with social services. V3 confirmed that care plans are updated every 3 months and should reflect individualized interventions according to resident needs. V3 confirmed that for R1, there was no specific interventions addressing R1's sleepwalking and wandering into other resident's rooms.

R1's latest care plans were reviewed. R1 did not have any individualized interventions addressing abuse risk, and sleepwalking and wandering behaviors.
V1 was interviewed via telephone on 7/30/18 at 3:20 pm and stated that resident assessment for abuse risk is done through care planning.

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According to R2's Minimum Data Set (MDS) with reference dates of 2/17/18 and 5/17/18, R2's BIMS (Brief Interview of Mental Status) score is 15/15 (Cognitively intact). R2's care plan documents: Focus- an identified offender, with moderate risk, brief summary: Aggravated battery/use of deadly weapon/great bodily harm. On 7/26/18 at 4:00 pm, R2 was interviewed in the therapy room. R2 stated that R2 had just returned from the hospital. R2 stated, "I remembered what happened that day ... I was told later that R1 was sleepwalking. I laid down at 11:00 pm but did not sleep. I always put my walker by the door so I can hear if someone comes in. At about 11:45 pm, R1 comes in and plops on top of me with shoes on! Then I said, 'buddy you're not supposed to be here.' I tried to get R1 out and pushed R1 out but R1 did not respond. R1 swings arms on me and I tried to move my head around missing R1's swings. I tried to push R1 out and R1 laid back on the pillow. I tried to pull R1 again and we both fell down and R1 was on top of me, swinging R1's arm and I took the carrot ballpoint pen from the table and started hitting R1 with it. The carrot had a pen. I screamed call the police, it took about 15 minutes for someone to get there, the staff were by the door, they must have called the police because the police was there right away and then the police tried to get (R1) off me. R1 wasn't looking straight, R1's eyes were open but it seemed like R1 didn't know what was going on. Then they took R1 out of my room."

R1's July 2018 ED (Emergency Department) records document:
7/21/18
-At 12:22 am: R1 arrived in ER (Emergency Room) at this time. Alert and oriented x 3, respirations even and unlabored. R1 was stabbed

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multiple times with a carrot shaped pen ...No tip of pen was found at site. R1 presents with multiple puncture wounds to face and neck.
-At 12:23 am: Injury notes - Puncture wounds note at the following:
1. Base of the neck left
2. above right eye
3. Right ear
4. Inferior to left maxillary
5. Lateral to left eye
6. Left mouth
7. Right parietal region
8. Left oral cavity
9. Left neck
10.2 puncture wounds to left flank
Bruising notes to right flank
Sutures completed at this time. 24 sutures placed.
-At 12:27 am:
Mechanism of injury: Penetrating
Weapon/description: Carrot-shaped pen
Injury type: Stab wound

Facility Policies were reviewed:
The facility's undated policy with the title: Episodic Behavior Monitoring, documents:
Policy: It is the facility's policy to assess, evaluate, and investigate statements voiced or otherwise communicated by residents that may be threatening to themselves or others. The facility will provide appropriate follow up intervention based upon the individual's needs. Appropriate attention will be paid to persons who are non-complaint with the rules and treatment.
Procedure:
2) Episodic behaviors observed and interventions given will be recorded on the form.
3) PRSC (Psychiatric Rehabilitation Services Coordinator) will check the "Episodic Behavior form" daily and implement change of Plan of Care

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S9999	Continued From page 9 as indicated. The facility's 11/16/18 Abuse Prevention Program Facility Procedures document under IV. Establishing a Resident Sensitive Environment: The facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive secure environment. This will be accomplished by a comprehensive quality management approach involving the following: -Resident Assessment: As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect exploitation, mistreatment or misappropriation of resident property who have needs and behaviors that might lead to conflict. Through care planning process, staff will identify any problems, goals and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis. (B)	S9999		