STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010136	A. BUILDING: _____ B. WING _____	C 11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CTR WOODSTOCK	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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S 000	Initial Comments Facility Reported Incident of 10-31-2021/IL140047	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210d)6) 300.1220b)9) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to supervise a resident with escalating behaviors for two of three residents (R1, R2) reviewed for safety and supervision in the sample of three. This failure resulted in R1 being punched in the right cheek and experiencing physical pain. The findings include: R1's Face Sheet shows he was admitted to the facility on 3/21/2020 with diagnoses including history of Covid, dependence on Renal Dialysis, Anemia, Alzheimer's Disease, and Depressive Disorders. R1's MDS (Minimum Data Set) dated 8/17/21 shows R1 is cognitively intact. R1's Care Plan initiated 1/6/21 shows, "[R1] displays behavioral symptoms related to: resident has a diagnosis of Depression and Anxiety.	S9999		

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S9999	Continued From page 2 Intervene when any inappropriate behaviors are observed. Communicate that the resident is responsible for exercising control over impulses and behavior." R2's Face Sheet shows he was admitted to the facility on 9/9/21 with diagnoses including: Alcoholic Cirrhosis of Liver, Chronic Viral Hepatitis C, Adjustment Disorder with Anxiety, and Cognitive Communication Deficit. R2's MDS dated 9/16/21 shows R2 is cognitively intact. R2's Care Plan initiated 9/10/21 shows "[R2] demonstrates significant mood distress related to: Adjustment Disorder. [R2] has demonstrated difficulty in adjusting to long term care placement related to: Adjustment Disorder with Anxiety." R2's Psychiatry note dated 9/15/21 shows, "[R2] is quickly agitated, somewhat unkept." R2's Nurses Notes dated 10/31/21 at 3:33 AM shows, "At 12:15 AM, resident was witnessed by staff nurse falling out of his wheelchair slowly by the nurses' station. 911 was activated and transported resident to (local emergency room) for evaluation secondary to fall and possible intoxication...this writer and evening shift nurse were in the middle of shift-to-shift narcotic counts and resident [R2] came out of his room with his leg rest and demanded to put his leg rest on. He was instructed that staff will assist him once staff done with counting the narcotics. Resident became angry and threw his leg rests on the floor. Resident phone camera on and recording the staff. Both nurses suspected resident under the influence of alcohol due to his unruly behavior. Resident was very belligerent,	S9999		

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S9999	Continued From page 3 argumentative, and calling staff names. Three bottles of 1.75 ml (milliliters) of vodka found in resident room. One bottle was half empty, the other bottle was 1/4 empty and the other was full..." On 11/8/21 at 11:39 AM, V4 CNA (Certified Nursing Assistant) said, early in the morning on 10/31/21, R2 hit R1's wheelchair and R1 said to R2 "If you would turn around you would see where the f**k you were going." R2 stopped and V4 said she stepped in between the two residents. V4 said she told R2 to keep going through the dining room. V4 said she reported this incident to V5 RN (Registered Nurse) but that she doesn't know where the report went from there. V4's written signed statement obtained by the facility dated 10/31/21 shows, "[V4] states that she observed [R2] in his wheelchair in the main dining room back up into [R1] who was stationary in his wheelchair. [R1] said 'If you turned around you could see where the f**k you were going.' [R2] then said, 'If you'd get out of the way that wouldn't happen.' [V4] said that [R1] cursed as he spoke but did not call [R2] names. [R2] was already propelling away and [V4] told him 'Just keep going.' and he did. [V4] then stood by [R1] to block his view so that neither would be antagonized. [R1] remained in the main dining room and [R2] went to his room." R1's Nurses Note dated 10/31/21 at 7:56 AM, written by V3 RN (Registered Nurse) shows, "This writer was approached by resident [R1] saying another resident had hit him in the face while he was outside in the courtyard smoking. Resident stated [R2] asked [R1] if he wanted to fight, then hit him in the face-pointing to his right	S9999		

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S9999	Continued From page 4 cheek. Body assessment-right cheek noted with redness. No other redness or bruising noted in other parts of the body. DON (Director of Nursing) [V2] and POA (Power of Attorney) made aware. Non-emergency police called-responded to facility and interviewed resident [R1] and [R2]." On 11/8/21 at 9:29 AM, V1 interim administrator/nurse consultant said (in regards to incident that occurred 10/31/21 between R1 and R2), R1 got punched in the right cheek by R2. R1 said if R2 leaves the facility he would not press charges. Initially R2 denied hitting R1 and R2 denied it to the police. V1 said she reviewed the camera footage and there was a brief exchange of words between R1 and R2. R2 went up to R1 and struck him with his right hand onto R1 right cheek. The two residents exchanged words again, both residents were swinging again at each other with little to no contact. The two residents exchanged words again and R2 hit R1 on the right cheek again. V1 said that there may have been a trigger for the incident. V1 said that she received reports from staff that the two residents were yelling at each other prior to this incident. V1 said earlier that morning the two residents (R1, R2) bumped wheelchairs. R1 was in the dining room stationary and R2 bumped into R1's wheelchair and words were exchanged then. At 12:02 PM V1 said she would have wanted V4 to report any negative exchanges between residents. V1 said she would expect staff to report any negative exchange between residents right away or report it to the nurse or the director of nursing. V1 said prior to the physical altercation, R1 and R2 were unsupervised smokers. On 11/8/21 at 11:48 V5 RN said she was told that someone had mentioned that R2 had bumped	S9999		

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S9999	Continued From page 5 R1's wheelchair unintentionally. But V5 said that she cannot remember who told her. On 11/8/21 at 10:31 AM, V3 RN said early morning on 10/31/21 she was at the nurse's station and she could hear R1 and R2 yelling at each other shortly before the physical altercation that occurred between R1 and R2. V3 said that she could not hear what the residents were saying but could hear them yelling. V3 said that at some point both R1 and R2 went outside to smoke. The facility's Investigation Report dated 11/5/21 shows, "Asked [R2] what happened between him and [R1] and [R2] said, "It was nothing." [R2] again denied striking [R1] (previously denied striking [R1] when questioned by officer). Informed him [R2] we have camera footage that shows he struck the other resident. [R2] then said he did strike [R1]. When asked why, he said their wheelchairs had bumped into each other earlier that morning and [R1] said something to him [R2]. [R2] did not give details of the conversation (other than to say [R1] called him [R2] a name) but stated, "Where I come from you stand up for yourself and you hit them before they can hit you." "Review of camera footage supports interview with [R1] that on the morning of 10/31/21 [R1] was outside in his wheelchair in the smoking area. No one else was present. [R2] exited the building in his wheelchair and propelled himself up to [R1] and said something (footage does not have audio) and then raised his right hand and struck [R1] on the right cheek. The two then exchange words and swung at each other making minimal contact at times. However, [R2] does strike [R1] on his right cheek again. [R2] then propels himself in his wheelchair over to another table and [R1] propels himself into the	S9999		

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S9999	Continued From page 6 facility." On 11/8/21 at 2:29 PM, R1 said that R2 came outside and asked R1 if he wanted to fight. (R1 raised his voice to signify that R2 raised his voice when he asked R1 if he wanted to fight) R1 said that R2 then punched R1. (R1 made a motion with his fist to the right side of his face). When R1 was asked how many times he got punched, R1 said, "I don't remember. I don't want to remember." R1 said he feels safe in the facility now. R1 said that if R2 stayed in the facility, "I'd feel like s**t. I would find another place to live." On 11/8/21 at 12:57 PM, R2 (when asked about the incident between R1 and R2) said, "I got into a fight with a guy with a big mouth." R1's Nurses Note dated 10/31/21 at 2:47 PM shows, "[R1] complains of some pain to the face below right eye. States he was hit by a resident. Area slightly red, no swelling noted. Did give two Tylenol for pain." The facility's Behavior Emergency Policy not dated shows, "The goal of the facility is to provide a safe, secure environment. In order to foster a safe environment, a consistent staff approach to behavioral problems and emergencies are necessary. Initiate 1:1 observation/monitoring until the resident is calm. After the incident document in the nursing notes: The resident's behavior and/or symptoms at the onset. The events and/or reasons potentially contributing to the resident's behavior. An assessment of the resident. Each intervention utilized. Notification of family/physician and subsequent orders." (B)	S9999		