DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. GENESIS SENIOR LIVING, ALEDO, D/B/A, GENESIS SENIOR LIVING, ALEDO, Respondent.	)))))))))	Docket No. NH 18-S0506

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on November 05, 2018, at Genesis Senior Living, Aledo, 309 NW 9th Avenue, Aledo, Illinois 61231. On January 03, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Genesis Senior Living, Aledo, 309 NW 9th Avenue, Aledo, Illinois 61231 on March 30, 2018. The Facility's current license number is 0052118. The term of the conditional license shall be from February 03, 2019 to August 02, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON FEBRUARY 03, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.686a)4), 300.686b), 300.686e)2)3), 300.1210b), 300.1210d)1)3, 300.3210a), 300.3240a) and 300.3240b). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.686, 300.1210b), and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 03rd day of January, 2019.

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PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Ted Rogalski
Licensee Info:	Genesis Senior Living, Aledo
Address:	409 NW 9th Avenue Aledo, Illinois 61231

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 03rd day of January, 2019.

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006076	A. BUILDING: _____ B. WING _____	11/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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) COMPLETE DATE
S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.686a)4) 300.686b) 300.686e)2)3) 300.1210b) 300.1210d)1)3) 300.3210a) 300.3240a) 300.3240b) 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 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 used: 4) without adequate indications for its use; or b) Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106.1(b) of the Act) e) For the purposes of this Section: 2) "Psychotropic medication" means medication that is used for or listed as used for antipsychotic, antidepressant, antimanic or antianxiety behavior modification or behavior management purposes in the latest edition of the AMA Drug Evaluations (Drug Evaluation Subscription, American Medical Association, Vols. I-III, Summer 1993), United States Pharmacopoeia Dispensing Information Volume I (USP DI) (United States Pharmacopoeial Convention, Inc., 15th Edition, 1995), American Hospital Formulary Service Drug Information 1995 (American Society of Health Systems Pharmacists, 1995), or the Physician's Desk Reference (Medical Economics Data Production Company, 49th Edition, 1995) or the United States Food and Drug Administration approved package insert for the psychotropic medication. (Section 2-106.1(b) of the Act) 3) "Antipsychotic drug" means a neuroleptic drug that is helpful in the treatment of psychosis and has a capacity to ameliorate thought disorders. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999		

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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 resident care plan. 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.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3210 General

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall

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S9999	Continued From page 3 immediately report the matter to the facility administrator. These regulations were not met as evidence by: Findings include: Based on observation, interview and record review, the facility failed to do the following: 1. protect a resident (R15) from involuntary seclusion 2. failed to ensure a resident (R15) was offered the right to refuse an intramuscular psychotropic medication or provided the least restrictive means of medication intervention 3. failed to ensure a resident (R15) had the right to refuse treatment 4. failed to identify an episode of involuntary seclusion as potential abuse 5. The facility also failed to encompass response procedures to occurrences of abuse, neglect, exploitation or misappropriation of property into their abuse policy. these failures affected one resident (R15) for one of two allegations of abuse reviewed. These failures resulted in the following: V11 (Licensed Practical Nurse) instructed V12 (Certified Nursing Assistant) to lock R15's bathroom door after R15 pressed the bathroom call light multiple times, leaving R15 without access to her personal restroom, causing R15 to become upset. R15's restroom door remained locked for the remainder of V11 and V12's shift, causing R15 to be incontinent of stool, and was then verbally abused by V11. R15 was then chemically restrained with an intramuscular injection of Ativan, causing extreme emotional distress to R15 that still continues.These failures also resulted in R15 suffering extreme emotional distress, that still continues today.	S9999		

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The facility's Abuse Prevention policy (revised 02/15/17) documents the following: "Identification: Staff are trained to report the following occurrences or events: Any incident which staff believe may indicate that abuse, neglect, mistreatment, involuntary seclusion, and/or theft may have occurred." The same policy documents, "All allegations of abuse, neglect, misappropriation of resident property, or unauthorized photographs or recordings reported incidents shall be investigated by the Abuse Coordinator, documented and reported in writing to (State Agency) within two hours of bodily injury or within 24 hours of no bodily injury." The policy documents the definition of Involuntary Seclusion as follows: "The separation of a resident from other residents or from his/her room, or confinement to his/her room against the resident's will or the will of the resident's legal representative."

The facility's Abuse Prevention policy (revised 02/15/17) does not document any procedures to respond to occurrences of abuse, neglect, exploitation, or misappropriation of property, such as analyzing the occurrences to determine what changes are needed, if any, to facility policies and procedures to prevent further occurrences.

On 10/30/18 at 12:40 PM, V1 (Administrator) verified that the facility's current abuse policy does not document any procedures to respond to occurrences of abuse, neglect, exploitation, or misappropriation of property.

The facility's Resident's Bill of Rights policy (dated 12/01/17) documents the following: "Resident's Bill of Rights contains: Be free from physical or mental abuse, sexual abuse, corporal

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punishment, involuntary seclusion, degradation related to unauthorized photograph/social media exposure and any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms unless pursuant to written physician's orders for a specific limited period of time to ensure the physical safety of the resident or other residents or as a result of certain emergency circumstances established under federal law."

R15's Abuse Investigation (dated 05/30/18) documents that V1 was notified by V4 (Licensed Practical Nurse) at 08:55 AM that R15 complained the morning of 05/30/18 about staff working afternoon of 05/29/18. R15 had been having loose stools for a few days and had been instructed to pull the emergency cord in her bathroom every time she had a bowel movement by one of the charge nurses, which R15 had been doing. On 05/29/18, R15 continued to pull the call light, and was instructed by V11 (Licensed Practical Nurse) that the call light was only to be pulled in an emergency. V11 then instructed V12 (Certified Nursing Assistant) to lock R15's private bathroom door, and instructed R15 that she had to use the unit's central restroom when needed. R15 was then incontinent of stool and again pushed the call light. R15 was instructed to walk down to the unit's central shower area in order to get cleaned up. Since R15 had been incontinent, stool was visually soiled through R15's pants and running down R15's leg. R15 became upset, began yelling and shaking her finger at V11 and V12. V12 assisted R15 to clean up, while V11 phoned V17 (R15's physician) and obtained the following orders: Ativan 2 milligrams inject intramuscularly one time only for severe agitation/aggression; Haldol inject 5 milligrams

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intramuscularly for severe agitation/aggression. Give one time only if no relief from the Ativan.

R15's most recent Brief Interview of Mental Status documents a score of 15, indicating R15 is cognitively intact

V18's (Care Transition Supervisor) first undated written statement documents the following: "Referral to talk with (R15) about formally reporting a concern about (V11, Licensed Practical Nurse). (R15) stated she wanted to voice her concern. She stated that all day (V11) was acting 'high and mighty.' (R15) was told she couldn't use her bathroom and had to use central bathroom. (R15) voiced concern of not being able to make it in time. (V12, Certified Nursing Assistant) who locked (R15's bathroom door) said she was just doing what she's supposed to. (R15) was still unsure why she couldn't use her bathroom. (R15) felt she didn't do anything wrong. (R15) kept saying 'I am doing what I am supposed to do' by pulling the call light in the bathroom. (R15) voiced 'Never having anyone act like that to me before.' (R15) said she didn't understand what (V11) was telling her to go to the central bathroom. 'I just didn't understand what (V11) wanted me to do. I thought I was doing everything right.' (R15) went back to her room and since she was confused and didn't know what to do, she stayed seated concerned she would do the wrong thing. R15 stated, '(V11) was just so high and mighty,' and kept repeating this. After her incontinence issue, she had to take a shower." (R15) stated, 'I took a shower and was told to sit on the toilet. I don't know when I got up.' (R15) was told to sit in a chair in the sitting room and didn't want to. While this was happening, (R15) was told she was going to get a shot to be calm and 'be the way I should be.' (V11) then

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stated (to R15) 'You (R15) need to be in a mental institute.' I (V18) asked (R15) how that made her feel. She said 'Stunned. She (V11) was just so high and mighty.'" This written statement also documents, "(R15) stated 'I thought all night about her telling me I needed to be in a mental institute. I couldn't stop thinking about it. I just thought what's the matter women? You need to be in a mental institute.' Overall, (R15) feels this happened because she did something wrong, but doesn't know what. Just states, 'I try to do what I am supposed to do.'"

V18's second written statement (dated 05/31/18) documents the following: "I spoke with (R15) regarding yesterday's incident. I asked (R15) how she felt today, she stated the exact same as yesterday. I said, so you are upset and (R15) stated 'I told you already. I feel the same way as yesterday and I will feel that way everyday.' I (V18) told her that I was sorry this happened and she stated, 'I don't know what else you want me to say.' I told her I just wanted to make sure she felt better. (R15) stated, 'I feel the same. No one has ever treated me like that here.' I said we are making sure that doesn't happen again or to anyone else. (R15) again stated that she is just stunned. I told (R15) that staff would be talking to her to follow up. (R15) didn't care for the idea because she said she has nothing to change it and will feel the same way day after day. (R15's) concern is that she never wants anyone to lock the bathroom door on her again, she doesn't want to feel that way again. As I left, (R15) said, 'I don't know what you want me to say. I will always feel this way."

This same written statement documents the following note written by V18 to V1 (Administrator): "When I (V18) spoke with (R15)

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you could tell her day was interrupted and it made her uncomfortable. Her story was unchanged from yesterday. She just didn't understand what is going on with asking her how she feels. I (V18) am concerned continuing to talk to with her daily only brings it up and makes her feel uncomfortable. (R15) stated multiple times her feelings won't change. Her major concern of the bathroom being locked and I assured her we wouldn't do it again. I am concerned there would be no benefit to her for continued conversation."

V3's (Licensed Practical Nurse) written statement (dated 05/30/18) documents the following: V3 was working another unit in the facility on 05/29/18 and received a call from V11(Licensed Practical Nurse) asking what injectable medications were available in the medication back up. V11 then asked if the back up had Ativan and V3 replied "yes." V11 called V3 back and asked if V3 could bring over the Ativan. This statement also documents, "(V11) told me (V3) that (R15) had been combative, yelling, argumentative with staff and out of control. (V11) stated that she wanted to know what we had in back up so she could relay it to the doctor if/when asked. I saw an order for Ativan on a piece of paper by the nurses paperwork and computer. (V11) stated that they may need help giving (R15) the shot due to her being combative and if I (V3) minded giving her the shot, I stated 'no.' (V11) drew up the Ativan. (R15) was in the central shower room sitting on a shower chair with (V12). All three staff members (V11, V12 and V3) and (R15) were in the shower room. (R15) was sitting on shower chair calmly. (V11) told (R15) we were going to give her a shot. I can't recall what (R15) said. But I think something was said about (R15) needed to (something). (V11 and V12) were still in front of (R15) and I gave the shot in her left

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gluteus. (V11) signed the narcotic sheet and stated that we had 0 vials left. I corrected (V11) stating we had half a vial left. (V11) stated about me taking the vial with me and I said 'No you might need it again' (V11) said 'No. It was a one time order.' (V11) stated to me that she would have to stay late and do the charting."

V4's (Licensed Practical Nurse) written statement (dated 05/30/18) documents the following: "When I went to (R15's) room this morning, she was still upset about the incident last night. She voiced to me that (V11) told her that she needed to quit pulling the bath light, and she was told to pull the light so the nurse could look at her bowel movement. I agreed with her that I did tell her to pull the light when she had a bowel movement because I wanted to monitor her. I had told her this last week when she was having all the loose stools. She also told me that the other girl who was working (V12) came and locked her out of the bathroom."

V19's (Registered Nurse) written statement (dated 05/30/18) documents the following: "When I came in (05/29/18) at 06:00 PM, (V11) and (V12) told me that (R15) was being belligerent, severely agitated and paranoid. That (R15) was always pulling the call light even if it was unnecessary. That she messed up her couch with feces and that's why they had to remove it from her room. According to (V11 and V12) they locked her bathroom because she kept pulling the call light and from now on, she had to go to the central bathroom." I (V19) talked to (R15) and she said that they gave her a shot. I explained to her what the Ativan was for. Per (R15) 'I need to know what they are giving me, it is my basic right to know why they gave me a shot. (R15) slept through the night with no

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	IL6006076	A. BUILDING: _____ B. WING _____	11/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

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episode of loose stools.'"

V1's (Administrator) written statement (dated 05/31/18) documents the following: "Spoke with (V17, R15's physician), he states (V11) called and said (R15) extremely agitated, complete change from normal behavior, out of control. (V11) requested Ativan injection. (V17) advised to redirect, (V11) stated they had tried and unable to do at this time. (V17) asked about oral medication, (V11) stated (R15) is refusing oral and would not be possible. (V17) stated he trusts our nurses' judgement and if at this point, Ativan order given times one and Haldol times one if Ativan ineffective."

V12's written statement (dated 05/30/18) verified that V12 locked R15's bathroom door on 05/29/18 after being instructed to, "as a redirection for pulling the emergency cord every time (R15) went to the bathroom."

On 10/31/18 at 09:30 AM, R15 was sitting at the table in the dining room. R15 was able to recall the incident on 05/29/18 with V11 and V12. R15's facial expression became visibly upset, and R15 stated, "They were high and mighty. I didn't feel safe. I was very upset. They locked me out of my bathroom and then they gave me a shot. That made me mad, really mad. It hurt. I didn't think I needed something like that. I didn't want it. She (V11) told me that I needed to be in a mental institute. I still don't understand why they did all of this to me. They didn't ask me if I wanted a shot, they just told me they were giving me a shot. It upset me a lot, it really bothered me, and it still does."

R15's May 2018 Physician's Orders did not have any type of PRN (as needed) psychotropic

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medication ordered for R15, except the one-time intramuscular injections of Ativan and Haldol ordered on 05/29/18.

R15's Medication Administration Record documents R15 was administered the following medications on 05/29/18 at the following times: Tylenol 650 milligrams by mouth at 03:32 PM, Seroquel 25 milligrams by mouth at 04:00 PM, Ativan 2 milligrams intramuscularly one time only at 06:15 PM, and Immodium 2 milligrams by mouth at 06:16 PM.

R15's Progress Notes dated 05/29/18 - 05/30/18 did not document that R15 was offered or refused any type of PRN (as needed) oral medication for behavior management after V11 and V12 locked and secluded R15 from her personal bathroom.

On 10/31/18 at 09:40 AM, V4 (Licensed Practical Nurse) stated that R15, "Has a strict routine. Is very OCD (obsessive compulsive disorder). If you do anything to her room- like change the arrangement, or if anyone unfamiliar enters her room, she would freak out."

On 10/31/18 at 10:35 AM, V1 (Administrator) verified that R15 was given an intramuscular injection for displaying behaviors after V11 and V12 locked and secluded R15 from her personal restroom. V1 would not confirm or deny whether he considered R15's intramuscular injection a chemical restraint, but then stated, "If they would have had to give the Haldol after the Ativan, that would have been a chemical restraint."

On 11/01/18 at 10:00 AM, V1 (Administrator) verified that V11 and V12 locked R15 out of her personal bathroom on 05/29/18, which caused emotional distress to R15. V1 would neither

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S9999	Continued From page 12 confirm nor deny if he considered the 05/29/18 incident of locking R15 out of her personal bathroom involuntary seclusion. V1 (Administrator) verified the facility's abuse policy was not implemented due to V1 not being immediately notified of R15's allegation of abuse that occurred on 05/29/18, because facility staff working on 05/29/18 (V7 and V19, Registered Nurses), who were aware of the incident, did not identify V11 and V12 locking R15's bathroom door as potential abuse. V1 stated that V1 did not substantiate abuse after conducting R15's abuse investigation, because involuntary seclusion was not identified by the facility team that conducted the abuse investigation. On 11/01/18 at 10:05 AM, V2 (Director of Nursing) confirmed that the 05/29/18 incident caused R15 mental anguish. (A)	S9999		