STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006597	A. BUILDING: _____ B. WING _____	06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE HALL NURSING & REHAB CENTER	620 WEST BRIDGEPORT WHITE HALL, IL 62092

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S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 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: 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. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow a physician's order to send a resident to the emergency room; and failed to notify a resident's guardian of a change in condition and hospitalization for one of 4 residents (R42) reviewed for change of condition in the sample of 52. This failure resulted in a three day delay of treatment of R42's wound infection and pneumonia. Findings include:	S9999		

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R42's Face Sheet documents V29 is his guardian/responsible party.

R42's "I Care Plan", dated 2/18/21, documents, "I cannot read or write. I do have some difficulty making my needs and wants known clearly. My wife helps me out. I have a guardian (V29) at this time. I cannot make medical decisions for myself. I am a Full Code with Full Treatment and long term medically administered nutrition including feeding tubes."

On 6/8/21 at 11:20 AM, R42 was walking out of the dining using his walker with assist of two staff, V9, Certified Nursing Assistant (CNA) and V2, Director of Nursing (DON). V7, Registered Nurse (RN) stated R42 was usually up walking with his walker and did not need assist. R42 stated he just didn't feel steady. V7 performed a blood glucose monitoring for R42, which resulted in 234. R42 was then assisted back to the dining room for lunch.

A facility fax, dated 6/8/21, untimed, by V7 to V28, R42's MD (Medical Doctor) documents: "Patient (R42) identified. Resident has BP (blood pressure) 160/80, HR (heart rate) 110, SPO2 (oxygen saturation) 94%, RR (respiratory rate) 22, Temp-102.4 F (Fahrenheit). Wife (R44) says that the resident told her he wants to go to the hospital. Tylenol 650 mg (milligram) given po (by mouth). Kindly advise on next steps. Thank you." At the bottom of this fax there is an order, "Send to ER (emergency room) please." This order was signed by V28, R42's medical doctor on 6/8/21 at 2:22 PM.
Another copy of this same facility fax, without V28's response documented on it, has additional information at the bottom of the page which

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documents, " May we obtain labs, CBC (Complete Blood Count), CMP (Comprehensive Metabolic Profile), and U/A (urinalysis) and Chest x-ray first, instead of sending to the hospital at this time?" There is no documentation of V28's acknowledgement or response to this fax by indicating that he received the second fax, or changed his order to send R42 to the ER.

R42's Progress Note, dated 6/8/21 at 1:38 PM, by V7, Registered Nurse (RN), documented, "The wife of (R42) reported to the writer that the husband has told her that he wants to go to the hospital because he is not feeling well. Vital signs taken on the resident: BP 160/80, HR 110, SPO2 94 %, Temp 102.4 F, RR 22. V28 (R42's medical doctor) notified on fax. "

R42's Progress Note, dated 6/8/21 at 7:31 PM, documents: Addendum: We requested (V28) for lab investigations of CBC (Complete Blood Count), CMP (Comprehensive Metabolic Profile) and UA (urinalysis) together with a CXR (chest x-ray), still awaiting replies from V28. Handed over to the incoming nurse." There were no further progress notes documented for R42 until 6/9/21 at 2:51 PM which documented : COVID-19 rapid test done due to signs and symptom- elevated temperature- with negative results.

On 6/9/21 at 9:30 AM, R42's wife/roommate (R44) stated R42 was not feeling good last night and wanted to go to the hospital. R44 stated no one had talked to them about sending R42 to the hospital after she told them he was not feeling good last night, and he did not get sent to the hospital. R44 stated R42 ate his breakfast this morning in the dining room, but couldn't walk to the dining room, and had to ride in the wheelchair instead.

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On 6/9/21 at 1:00 PM, V2, DON, stated R42 had not been tested for COVID-19 the day before, even though he had a temperature of 102.4 She stated the nurse had faxed a report to V28 regarding R42's change of condition, including his wife reporting he did not feel good and wanted to go to the hospital, and his fever. V2 stated, after discussing R42's condition with a supervisor, the nurse sent another fax to the MD requesting labs and x-rays, but the doctor did not respond to that fax, and R42 did not get sent to the hospital. V2 stated R42 should have been tested for COVID due to having a signs of COVID. She stated she could not find any documentation he had been tested for COVID, sent to the ER as ordered, or the MD had responded to the request for labs and x-rays to done. V2 stated when V28 did not respond to the request to get labs and x-rays done in the facility, V7 should have sent R42 to the ER as ordered.

On 6/9/21 at 1:30 PM, V6, Licensed Practical Nurse (LPN), was R42's nurse and she stated she had not received any report from the midnight nurse regarding R42 being sent to the hospital or any labs or x-rays being ordered. She stated she had not had any reports of anything going on with R42 today. She stated he has been out to the dining room for lunch and breakfast. She stated he did not walk to the dining room for lunch like he usually does, and she was not sure if he walked to breakfast or came up in the wheelchair.

R42's Progress Note, dated 6/9/21 at 2:55 PM, by V2, DON, documents: "Called V28's office regarding resident's recent elevated temperature. Left message with receptionist and left message on nurse voicemail. Waiting for orders. Will continue to monitor patient, no elevated temp at

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S9999	Continued From page 5 this time." R42's Progress Note, dated 6/9/21 at 4:08 PM, by V2, DON, documented, "Spoke with (V28) regarding resident recent condition, per (V28) he did receive the notification asking for labs and x-ray and the MD would have been fine to go ahead and order labs to keep resident in house as long as it was okay with the resident. He was under the impression that the resident wanted to go to the hospital, however per conversation with the charge nurse, the wife and resident were agreeable to treat in house. (V28) said to disregard note to send to ER and gave orders to obtain CBC, CMP, Chest X-Ray and UA with C&S (Culture and Sensitivity) in house." R42's Progress Note, dated 6/9/21 at 5:25 PM, documents, "(V29) (R42's state appointed guardian) aware of resident having a fever and Dr's (doctor's) stat orders of CBC, CMP, UA, culture if indicated and a 2 view chest X-ray. " On 6/10/21 at 9:30 AM, R42 was sitting in his recliner watching television with his roommate/spouse (R44). R42 stated he still does not feel good and when asked what part of him did not feel good, he put both hands on his abdomen and stated, "here." R44 (R42' spouse) stated R42 was not eating good and needed help. She stated he was using the wheelchair instead of walking with his walker to go to dinner last night and to breakfast this morning. She stated he had an x-ray done yesterday, but no blood work has been drawn yet. She stated, "He's not right. He needs checked out." R44 stated R42 had still not been sent to the hospital. On 6/10/21 at 10:04 AM, V1, Administrator, stated the facility had called R42's doctor	S9999		

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yesterday (6/9/21) to get orders for labs and x-rays. V1 stated if the nurse did not get a different order on 6/8/21 when the doctor ordered R42 to be sent to the ER, then she would have expected the nurse to send R42 to the emergency room as ordered.

On 6/10/21 at 2:00 PM, V2, Director of Nursing, stated it is the facility's protocol if an order is received to send a resident to the ER, the nurse is to call the supervisor on call and discuss it with her, and if she is ok with transfer to the ER, the resident would be sent, but the supervisor may decide to have the nurse ask the doctor if it is ok to treat the resident in the facility by taking x-rays or getting labs, instead of sending the resident to the emergency room. V2 stated in R42's case, the supervisor told the nurse to check with R42's doctor to see if they could do a chest x-ray and labs in the facility, but that nurse did not get a response from the doctor, so R42 should have been sent to the ER as ordered by the physician on 6/8/21.

On 6/10/21 at 2:40 PM, V2 stated she had just talked to R42's roommate/spouse who informed her she was very worried about R42 because he was not feeling good and had some diarrheal stools 3 times today. V2 stated the nurse was going to call R42's doctor to get an order to send him to the ER, but if they did not get a response from the MD , he was going to be sent out per nursing judgement.

R42's "Resident Transfer Form", dated 6/10/21, but untimed, documents, "Diagnosis at time of transfer: Fever, wife states he has had diarrhea x 1. Events or change in condition leading up to request for ER evaluation/ reason for ER visit or reason for consult: Wife requested." According to

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S9999	Continued From page 7 the transfer form, R42's fever was 99.5 at the time of transfer. On 6/11/21 at 1:10 PM, V29, R42's Guardian, stated she received a call on 6/9/21 in the afternoon informing her R42 had a fever and the doctor had ordered labs and an x-ray to be done. She stated that is the only call she received regarding R42 recently. She stated she did not receive a call on 6/8/21 to report any changes in his condition, and had not been notified he had been sent to the emergency room yesterday, on 6/10/21. V29 stated she had checked the on-call notifications, and nobody had notified OSG (Office of State Guardian) of R42 being sent to or admitted to the hospital. V29 stated if the doctor had ordered for R42 to go to the hospital on 6/8/21 and the facility did not receive a different order right away to do labs in the facility, she would have expected him to be sent to the emergency room as ordered. V29 stated she thought R42's fever had happened on 6/9/21 when she was notified of the new orders. On 6/11/21 at 1:35 PM, V13, Licensed Practical Nurse (LPN), stated on 6/8/21 it was brought to her attention R42 had a fever and the doctor gave an order to send him to the emergency room. V13 stated she discussed this with her supervisor, V2, and they decided to request the doctor order labs, a urinalysis and chest x-ray that could be done in the facility instead. She stated she discussed this with the nurse, V7, who was taking care of R42, and instructed her to notify the doctor and request labs and x-ray. She stated after that she was "out of it"...it was up to the nurse to notify the MD to request labs and x-ray instead of sending R42 to the hospital and to get the order. V13 stated because V7 did not get a different order, she should have followed the	S9999		

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physician's orders and sent R42 to the hospital. V13 stated she gave V7 an education regarding following physician orders yesterday when V7 came to the facility, informing her the need to follow physician's orders.

On 6/11/21 at 2:00 PM, V30, V28's nurse, stated the office closed at 5:00 PM on 6/8/21, so if the nurse sent across another fax requesting labs and X-rays for R42 at 7:00 in the evening, that fax would not have been seen until 8:00 AM the next day. V28 stated the facility should not have faxed the request, but should have called the on-call physician. She stated V28 is out of the office until Tuesday, but she has worked several years with him, and if he gave the order to send a resident to the ER, and the resident and family wanted that person to go, he would have expected the resident to be sent to the ER as ordered.

On 6/11/21 at 3:00 PM, V28, MD, stated he did receive a faxed report on 6/8/21 at 2:22 PM, informing him R42 had a fever and that he wanted to go to the hospital. He stated he ordered for R42 to be sent to the emergency room, because if a resident is not feeling well and requests to be sent to the hospital, it is in the best interest of the patient to go ahead and send them to the hospital to have them assessed. V28 stated he is aware the facility is able to get labs and x-rays in the facility, but to have labs and x-rays in the hospital is more timely, and if a resident is acutely ill, to send him to the ER is the appropriate thing to do. V28 stated he received a phone call from the facility on 6/9/21, in the afternoon, from the facility asking about doing labs and chest x-ray on R42 in the facility. He stated he had been under the impression the resident and family had wanted him sent out to the ER on 6/8/21, but the facility told him the

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resident and family were agreeable to R42 being treated in the facility. V28 stated he did not receive the second fax with the requests for labs and x-rays until after he had already spoken to the nurse from the facility on 6/9/21. He stated he received an update at that time that the resident's vital signs were stable and R42 was acting like his normal self. V28 stated he would have expected the facility to call him, not fax him, after hours if there was something they wanted. He stated he did not receive any further notification until the following day, and had not been aware until then that R42 had not been sent to the ER as ordered. V28 stated the facility knows they are to call the exchange for the physician on call or himself after hours. He stated the facility also has his cell phone and have contacted him on other occasions before this, even when he was not on call, so he knows they are able to reach him. He stated he had words about this with the facility on previous occasions and knows it is convenient to just fax something, but all faxes that come to him are put in a folder in the office, and he may not get the chance to view them until late in the day if the office gets busy. V28 stated he would have expected the facility to follow his orders unless he or another physician on call gave a different order. V28 stated he is aware R42 is in the hospital now, but was not able to determine what his diagnosis was with having only received his chest x-ray results, which were normal.

On 6/11/21 at 3:30 PM, V32, Regional Nurse, stated the facility notifies residents' guardians of any changes in condition.

R42's Hospital Transfer Summary, dated 6/13/21 at 11:48 AM, documents he was admitted to the hospital on 6/10/21 with the diagnosis of diabetic

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S9999	Continued From page 10 foot ulcer and pneumonia. It documents during his hospitalization he was started on IV (intravenous) antibiotics and was discharged on oral antibiotics. On 6/15/21 at 9:42 AM, V2, DON, stated the facility does not have a specific policy regarding following physician orders, other than medication orders. The facility's policy, Notification of a Change in a Resident's Status, dated 11/17, documents, "The attending physician/physician extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations. The policy documents, under "Responsibility": All Licensed Nursing Personnel". Under "Procedure", the policy documents, "1. Guideline for notification of physician/responsible party (not all inclusive): a. Significant change in/or unstable vital signs (temperature, blood pressure, pulse, respiration). b. emesis/diarrhea. e. Symptoms of any infectious process. 2. Document in the Interdisciplinary Team (IDT) notes: a. resident change in condition; b. Physician/physician extender notification; c. Notification of responsible party." (B) 2 of 3 300.1210 b) 300.3240 f) Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 11 b) The facility shall 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 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. Section 300.3240 Abuse and Neglect 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. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision to prevent resident to resident altercations for 4 of 4 residents (R40, R46, R51, R78) reviewed for incidents in the sample of 52. This failure resulted in R46, R51, R78 being fearful and experiencing intimidation related to R40's aggression. Findings include: R46's Care plan, dated 8/21/2020, documents she has diagnosis of Alzheimer's and becomes confused. It also documents that R46 does not like it when other residents come into her room and to please redirect them out.	S9999		

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S9999	Continued From page 12 R51's Care plan, dated 4/29/2021, documents she has diagnosis of Dementia and becomes confused. It also documents R51 has depression and anxiety. R78's Care plan, dated 3/24/2021, documents she has diagnosis of Dementia, is easily confused, and can be verbally aggressive to staff and peers. R40's Care Plan, dated 7/21, documents Mental Wellness/Mood, "I have dementia with behavioral disturbances, anxiety and insomnia. It also documents, "I wander into other's rooms and take things out of their rooms." It continues, "I am verbally aggressive, I may yell at staff or peers. Please track my behaviors and monitor me for side effects from my medication." R40's Care Plan also documents Behavior tracking in place, if interventions do not work please notify the nurse. R40's Minimum Data Set (MDS), dated 4/29/21, documents behavior did not exist for Physical, Verbal, Other Behavior symptoms directed towards others. R40's Departmental Notes, dated 6/8/2021 at 11:57, documents, "Resident has entered R51's room on several occasions. Res (resident) has stood over peer in her bed, and gone through peers belonging. Res yells at peers, takes their personal items and then intimidates peers with threats to hit and hurt them. Peers have voiced concern and fearfulness of resident." R40's Departmental Notes, dated 6/8/2021 1:56 AM, documents "Resident went into (room) and frightened both roommates with standing order (over) their beds, and going through their personal items." It also documents, "Res	S9999		

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S9999	Continued From page 13 attempted to go lay down in male peers room, in same bed with res." R40's Resident Incident Report, dated 6/13/2021, documents "Res (resident) was arguing with female peer & reached out & started hitting her. While staff were separating res, res grabbed cup of water & threw it on peer." R40's Departmental Notes, dated 6/13/2021 12:52 AM , documents, "At beginning of shift, dayroom was busy with a lot of residents were talking back and forth. Res was walking around room and many conversations btwn (between) peers. This stimulus made resident very anxious, res was talking fast and stated that 'I need everyone to stop talking, I can't take all the noise.' Attempted to remove resident from busy day room and escort resident to her own room where it was quiet and calm. Res came back to day room and was redirected back to her room where there was no outside stimulation." R40's Departmental Notes, dated 6/13/2021 2:45 AM, documents "Res found in peers room going through peers drawers and closet." Resident was undressed except for sweater. It also documents "Resident stated that "since the plane crashed tonight, she could not find her clothes." R40's Departmental Notes, dated 6/13/2021 5:34 PM, documents "Late entry @ 3:50 p.m. Res was arguing with female peer & reached out & started hitting her. While staff was separating res, res grabbed cup of water & threw it on peer." R40's Departmental Notes, dated 6/14/2021 11:58 PM, documents "late entry for 135 pm 6/14/21 MUM (Memory Unit Manager) responded to noise from resident room. It continues to	S9999		

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S9999	Continued From page 14	S9999		

document (R40) took a cloth object and intentionally struck another resident. (R40) removed from the hallway and sent to the ER (emergency room) for psych eval."

On 6/14/2021 at 11:59 AM, R40 was sitting in room, on bed, eating meal with staff in room sitting on opposite bed.

On 6/10/2021 at 2:15 PM, V34, Memory Unit Manager (MUM) stated R40 is not appropriate for the memory unit. V34 stated R40 requires more supervision. V34 stated R40 usually sleeps during the day and wakes up later in the day and her behaviors start at that time. V34 stated R40 believes the unit is her home and antagonizes the other residents, yelling at them. V34 stated when R40 had a private room off the unit, she did not have behaviors. V34 stated R40 was better. V34 stated she was not aware of the reason R40 was placed back on the unit. V34 stated there is a lot of stimulation that causes R40's behavior to increase. V34 stated R40 yells and hits other staff and residents on the hall and wanders into others rooms. V34 stated when this occurs, she attempts to redirect resident which at times can be difficult. V34 stated they direct R40 to her room. V34 stated R40 requires more supervision than the unit, and is not appropriate for the memory unit.

On 6/14/2021 at 11:30 AM, V2, Director of Nursing (DON), stated R40 was going out to the Hospital. V2 stated last week she became aware of R40's behaviors. V2 stated she had identified the intimidated resident as her (DON) grandmother. V2 stated once she became aware of R40's behaviors, she attempted to put things in place, but the resident had another altercation. V2 stated at that time, an order was received to

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S9999	Continued From page 15	S9999		

send her to the hospital for psych evaluation, and R40 was placed on supervision. When asked if R40's behaviors of intimidation, sexually inappropriateness and resident to resident altercations would have been less or not happened if R40 would have been placed on supervision prior to today, V2 stated, "Yes, that is why she is going to the hospital." V2 stated "She (R40) is not appropriate for our facility."

On 6/14/2021 at 11:50 AM, V26, Assistant Director of Nursing (ADON), stated she is the person that does the investigations with incidents, and had investigated the R40's incidents. V26 stated R40 was out on the regular floor and had a private room. V26 stated during this time, she did have verbal behaviors with staff. V26 stated R40 was moved to the unit and behaviors increased, and was more physical with staff and other residents. V26 stated on the unit, there is an increase in stimulation, and R40 does not do well with that. V26 stated resident does have behaviors of hitting, yelling, intimidating other residents, and a history of wanting to cuddle with male residents. V26 stated R40 is to be redirected to her room. V26 stated the intervention of coming back later is in place, but is at times not possible. V26 stated R40 requires more supervision than the Memory Unit, and is not appropriate for the unit.

On 6/15/2021 at 2:30 PM, V34 stated R40 had a resident to resident altercation with R78 on 6/14/2021. V34 stated R78 and R51 were the residents in R51's room on 6/8/2021.

(B)

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S9999	Continued From page 16 300.1210 b) 300.1210 d)3) 300.1220 b)3) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 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: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care	S9999		

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plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Based on observation, interview, and record review, the facility failed to provide person centered interventions or care to address dementia related behaviors such as wandering and resident to resident altercations for 1 of 1 residents reviewed for dementia care in the sample of 52. This failure resulted in R40 being sent to the hospital for psychiatric treatment with no psychiatric diagnosis.

Findings include:

R40's Care Plan, dated 7/21, documents Mental Wellness/Mood, "I have dementia with behavioral disturbances, anxiety and insomnia. It also documents, "I wander into other's rooms and take things out of their rooms." It continues, "I am verbally aggressive, I may yell at staff or peers. Please track my behaviors and monitor me for side effects from my medication." R40's Care Plan also documents, "Behavior tracking in place, if interventions do not work please notify the nurse."

R40's Minimum Data Set (MDS), dated 4/29/21, documents behavior did not exist for Physical, Verbal, Other Behavior symptoms directed towards others.

R40's Departmental Notes, dated 6/8/2021 at 1:56 AM, documents, "Resident (resident) went into (room) and frightened both roommates with standing order (over) their beds, and going through their personal items." It also documents,

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S9999	Continued From page 18 "Res attempted to go lay down in male peers room, in same bed with res." R40's Departmental Notes, dated 6/8/2021 11:57, documents, "Resident has entered (R51's) room on several occasions. Res has stood over peer in her bed, and gone through peers belonging. Res yells at peers, takes their personal items and then intimidates peers with threats to hit and hurt them. Peers have voiced concern and fearfulness of resident." R40's Departmental Notes, dated 6/13/2021 at 12:52 AM , documents, "At beginning of shift, dayroom was busy with a lot of residents were talking back and forth. Res was walking around room and many conversations btwn (between) peers. This stimulus made resident very anxious, res was talking fast and stated that 'I need everyone to stop talking, I can't take all the noise.' Attempted to remove resident from busy day room and escort resident to her own room where it was quiet and calm. Res came back to day room and was redirected back to her room where there was no outside stimulation." R40's Departmental Notes, dated 6/13/2021 at 2:45 AM, documents "Res found in peers room going through peers drawers and closet." Resident was undressed except for sweater. It also documents, "Resident stated that "since the plane crashed tonight, she could not find her clothes." R40's Departmental Notes, dated 6/13/2021 at 5:34 PM, documents, "Late entry @ 3:50 p.m. Res was arguing with female peer & reached out & started hitting her. While staff was separating res, res grabbed cup of water & threw it on peer."	S9999		

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S9999	Continued From page 19 R40's Resident Incident Report, dated 6/13/2021, documents Res was arguing with female peer & reached out & started hitting her. While staff were separating res, res grabbed cup of water & threw it on peer. R40's Departmental Notes, dated 6/13/2021 11:47 PM, documents, "Res has been sexually inappropriate with peer." It also documents, "They were first found to be in peers room, both lying on the same bed." It continues to document, "Resident did come to day room with staff for monitoring. Later, peer was sitting in chair in dining room and resident sat on his lap and they started to cuddle." On 6/14/2021 at 11:59 AM, R40 was sitting in her room, on the bed, eating a meal, with staff in the room sitting on the opposite bed. R40's Departmental Notes, dated 6/14/2021 11:58 PM, documents, "late entry for 135 pm 6/14/21 MUM (Memory Unit Manager) responded to noise from resident room." It continues to document, "(R40) took a cloth object and intentionally struck another resident. (R40) removed from the hallway and sent to the ER (emergency room) for psych eval (psychiatric evaluation)." On 6/10/2021 at 2:15 PM, V34, MUM, stated R40 is not appropriate for the memory unit. V34 stated R40 requires more supervision. V34 stated R40 usually sleeps during the day, and wakes up later in the day, and her behaviors start at that time. V34 stated R40 believes the unit is her home, and antagonizes the other residents, yelling at them. V34 stated when R40 had a private room off the unit, she did not have behaviors. V34 stated R40 was better. V34 stated she was not	S9999		

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S9999	Continued From page 20	S9999		

aware of the reason R40 was placed back on the unit. V34 stated there is a lot of stimulation that causes R40's behaviors to increase. V34 stated R40 yells and hits other staff and residents on the hall and wanders in others' rooms. V34 stated when this occurs, she attempts to redirect the resident, which at times can be difficult. V34 stated they direct R40 to her room. V34 stated R40 requires more supervision than the unit, and is not appropriate for the memory unit.

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S9999	Continued From page 21 increase stimulation, and that R40 does not do well with that. V26 stated resident does have behaviors of hitting, yelling, intimidating other residents, and a history of wanting to cuddle with male residents. V26 stated R40 is to be redirected to her room. V26 stated the intervention of coming back later is in place, but is at times not possible. V26 stated R40 requires more supervision than the Memory Unit, and is not appropriate for the unit. On 6/15/2021 at 2:30 PM, V34 stated R40 had a resident to resident altercation with R78 on 6/14/2021. V34 stated R78 and R51 were the residents in R51's room on 6/8/2021. V34 stated R40 had a sexually inappropriate encounter with R29. On 6/15/2021 at 8:50 AM, Behavioral Health Policy was requested. As of 6/15/2021 at 3:00 PM, the facility had not provided the policy. (C)	S9999		