Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6004287 | A. BUILDING: ______ B. WING ______ | C 08/30/2022 |

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| HERITAGE HEALTH-MOUNT STERLING | 435 CAMDEN ROAD MOUNT STERLING, IL 62353 |

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| S 000 | Initial Comments<br><br>Complaint Investigation:<br>2226196/IL149832<br><br>A partial extended survey was conducted. | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br>300.610a)<br>300.610c)1)<br>300.620a)<br>300.1010h)<br>300.1210a)<br>300.1210b)<br>300.1210d)3)6)<br>300.1220b)3)<br>300.3300b)<br>300.3300j)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>c) The written policies shall include, at a minimum the following provisions: | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers;

Section 300.620 Admission, Retention and Discharge Policies

a) All involuntary discharges and transfers shall be in accordance with Sections 3-401 through 3-423 of the Act.

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 of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which

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allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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 that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing

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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 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.

Section 300.3300 Transfer or Discharge

b) Each resident's rights regarding involuntary transfer or discharge from a facility shall be as described in subsections (c) through (y) of this Section.

j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's

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| S9999 | Continued From page 4<br>clinical record. (Section 3-408 of the Act)<br><br>These Regulations are not met as evidenced by:<br><br>Based on record review and interview the facility failed to allow a resident (R1) to return to the facility after being sent to the hospital for an acute behavioral and medical condition, failed to document all measures the facility took to meet R1's needs that could not be met by the facility along with developing and implementing a care plan to meet those needs, failed to involve R1, R1's Power of Attorney (POA), and the Ombudsman to develop a plan to meet R1's needs, failed to notify the resident, resident's representative, and long term care Ombudsman in writing and verbally of R1's discharge, including notification of appeal rights, and failed to establish and follow a written policy on allowing a resident to return to the facility after hospitalization for one of three residents (R1) reviewed for discharge in the sample of three. These failures resulted in R1 remaining in the hospital for 46 additional days after being medically cleared by the hospital physician to return to the facility resulting in R1 being placed in another facility in Norridge, Illinois (approximately 253 miles) from the facility in which was R1's home for two years and seven months. V7 stated R1 would be more confused, scared, and have increased behaviors due to being unaware of his surroundings, staff and not being able to see his friends.<br><br>Findings Include:<br><br>The Facility Assessment Tool revised on 1/27/21, documents the following: Part 1: Our Resident Profile- Indicate if you may accept residents with, or your residents may develop, the following | S9999 | | |

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common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management-diagnosis summary: the facility documented they have residents with diagnoses which include-Heart Circulatory System, Metabolic Disorders, Musculoskeletal Systems, Neurological System, Psychiatric Mood Disorders; Special Treatments: the facility documented they have 10 residents residing in the facility with Mental Health Treatments/Behavioral Health Needs; Care Area Assessment Summary: the facility documents they have 14 residents with a Behavioral Symptoms care area and 62 residents with a Falls Care Area; Part 2: states "Services and Care We Offer Based on or Residents' Needs- General Care- Mobility and fall/fall with injury prevention, Mental Health and Behavior- Manage the medical condition and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/(Post Traumatic Stress Disorder), other psychiatric diagnoses, intellectual or developmental disabilities. Management of Medical Conditions- Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions."

The Facility's New (Federal Regulations) for Involuntary Discharge/Transfer (date unknown), states "Prior to involuntary discharge/transfer, the facility must document steps that were taken to avoid discharge/transfer. This should include a meeting with the resident and, if applicable, the resident's representative. The notice of an

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| S9999 | Continued From page 6<br><br>involuntary discharge/transfer must now be served at least 30 days before the effective date of the discharge/transfer in a language and manner understood by the resident. The following must be included in the notice: The reason for the involuntary discharge/transfer; The effective date of the discharge/transfer; The location where the resident will be discharged/transferred; A hearing request form and a pre-addressed, stamped envelope to mail the form. Note that a request for hearing will stay with the involuntary discharge/transfer; The name, mailing address, and telephone number of the person responsible to supervising the transfer; The name, mailing address, and telephone number of the Office of the State Long Term Care Facility Ombudsman; and if the person has intellectual/developmental disabilities or serious mental illness, the name, mailing address, email address, and telephone number of Equip for Equality. A copy of the notice must be mailed to the Department, and the State Long-Term Care Ombudsman or Equip for Equality. The involuntary discharge or transfer must be documented in the resident's record, including the following: The basis for the discharge/transfer; Needs that cannot be met by the facility, the steps taken to meet those needs, and needs that can be met by the new facility, as documented by the resident's physician; Physician documentation that the resident no longer needs long term care services; and Documentation of the danger that failure to discharge/transfer would pose. At a minimum, the following information must be provided to the receiving facility: Resident's physician and contact information; Resident Representative and contact information; Advance directive, if any; All special instructions or precaution; Care Plan goals; Discharge/transfer summary; and All other necessary information to ensure a safe and | S9999 | | |

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| S9999 | Continued From page 7<br>effective transition of care."<br><br>On 8/24/22 at 12:02PM, V1 (Administrator) verified that the Facility Assessment last revised on 1/27/21, documents the most current assessment data.<br><br>The Facility's Behavior (Serious Behavior) Emergency policy dated 9/2011, states "The facility will ensure that a resident who displays a serious behavior emergency, (that is to say) any suicide attempts or threats, any physical acts which cause injury or potential injury to the resident, employees, visitors, or other residents, and any behavior exhibited which requires constant staff intervention will receive appropriate referral, treatment and services. Guidelines: 1. Any staff member, who suspects a resident is experiencing a serious behavior emergency which threatens the health, safety or welfare of the resident, employees, visitors, or other residents, shall report the problem to the charge nurse immediately. 2. The charge nurse shall promptly examine the resident. If it is determined that a serious behavior emergency has occurred, the charge nurse shall notify the resident's own physician and/or psychiatrist or psychologist. 5. If the resident's own physician, and/or psychiatrist or psychologist cannot be reached, the charge nurse is to call the facility's medical director and notify of the serious behavior emergency. 7. Upon assuring the resident's safety, the nurse will document the sequence of events outlining the serious behavior emergency, the interventions taken and outcome."<br><br>The facility CMS (Centers for Medicare and Medicaid Service) Form 672 dated 8-24-22 and signed by V1 (Administrator) documents 12 residents that reside within the facility have | S9999 | | |

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psychiatric diagnoses and 15 residents who have Dementia type diagnoses. This same form also documents eight residents have behavioral healthcare needs, but only two of these residents have a care plan to support the behavioral healthcare needs.

R1's Pre-Admission Hospital Geriatric Psych (Psychology) Discharge Summary dated 1-22-20 documents, "Admitting Diagnosis: Threatening Neighbors. Discharge Diagnosis: Dementia NOS (Not Otherwise Specified). History and Hospital Course (R1) was brought into (hospital) emergency department after he was seen waiving a loaded revolver at his neighbors. The police were called in. There had been deterioration in his ability to function independently in his ability to complete his basic and advanced activities of daily living. His house was in poor condition, and he had not been bathing. (R1) was unable to recall the incident leading to this admission. The patient was admitted to the inpatient psychiatric unit for safety and stabilization. Provider reviewed current psychotropic medication regimen and made adjustments as clinically indicated. Impulse Control is impaired. Insight is impaired and judgement is impaired. Assessment: Dementia and Depression single episode. (R1) is glad to be going to long term care in Mount Sterling as this is close to his friend who lives in Mount Sterling. Transfer instructions: Risperidone one mg (milligram) and 0.5 mg at bedtime daily. Trazodone 50 mg every night at bedtime."

R1's MDS (Minimum Data Set) Assessment dated 6-8-22 documents R1 is severely cognitively impaired, has verbal and other behaviors, and requires extensive assistance of two staff for bed mobility, dressing, and personal hygiene. This same MDS documents R1

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requires supervision for transfers and locomotion on the unit.

R1's Order Summary Report dated June 1, 2022, documents R1 has the diagnoses of Psychosis not due to a substance or known physiological condition, Delusional Disorders, Vascular Dementia without Behavioral Disturbance, Hypertension, Type II Diabetes Mellitus, Major Depressive Disorder, and Circadian Rhythm Sleep Disorder. This same Order Report documents Trazodone 12.5 mg at bedtime for Insomnia related to Circadian Rhythm Sleep Disorder, Zyprexa 2.5 mg at bedtime for Psychosis, Sertraline 25 mg daily for Major Depressive Disorder, and Medroxyprogesterone Acetate 2.5 mg daily for sexual behaviors.

R1's Physician/Notification Clarification Form dated 6-13-22 documents, "(R1) very disruptive yelling most of day. Cursing at staff. Unable to figure out what (R1) is needing. Kicking at staff when attempting to get vital signs. Roaming in and out of other rooms. Just FYI (For Your Information). (V6/R1's Physician) Comment: Monitor perhaps sitting in the hallway."

R1's Progress Notes dated 6-21-22 at 7:53 AM and signed by V5 (RN/Registered Nurse) documents, "(R1) required encouragement to feed self this morning, (R1) had been given food that was cut up, a spoon, fork, and drinks. (R1) yelled out for another spoon. This nurse brought resident a spoon. (R1) continued to yell out for a spoon, while becoming verbally aggressive and calling people a "f***ing b***h. (R1) threw food across room. Will continue to monitor."

R1's Physician/Notification Clarification Form dated faxed on 6-21-22 at 5:16 PM and signed by

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V5 (RN/Registered Nurse) documents, "(R1) has been having behavioral yelling all day. (R1) won't feed self, or sit up on own, (R1) has a glazed look about eyes, but says he's not in pain, left fist is clenched. (R1) won't feed self and requires being fed, but if not fed in a timely manner throws food across the room. Can't get vitals. Won't cooperate." This same information is not documented in R1's Progress Notes and R1's Medical Record does not contain a follow-up from (R1's) physician.

R1's Progress Note dated 6-22-22 at 7:53 AM and signed by V5 (RN/Registered Nurse) documents, "(R1) was yelling in the north dining room about shooting. (R1) stated he was hungry. Peanut butter sandwich given. (R1) was asked to scoot butt back in wheelchair. (R1) refused and slid out of wheelchair onto the floor. (R1) did not hit his head. Skin tears were acquired on right arm. Two CNA's (Certified Nursing Assistants) and this RN used (mechanical lift) to get (R1) off the floor. (R1) wanted coffee. Coffee given to (R1). (R1) then tried to throw coffee on another resident and run resident over with wheelchair. (R1) removed from environment to another hallway. MD (Medical Doctor/V6) notified, and 5 mg (milligrams) Haloperidol injected into resident's right deltoid per order. (R1) continued to hit staff and yell out because (R1) wanted a cup of coffee and his cart to place his coffee on, (R1) placed in room with cart and coffee. (R1) continues to scream. Will continue to monitor."

R1's Progress Notes do not include any documentation of R1 being sent to the emergency room for evaluation.

R1's Care Plan dated 4/7/22, documents R1 exhibits verbal and physical behaviors due to his

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diagnoses of Dementia, Psychosis, Delusional Disorder and his ineffective coping skills. This same care plan does not include any updated interventions related to R1's behaviors on 6/21/22 and 6/22/22. R1's Care Plan dated 4/7/22, has not had any behavioral interventions updated since 10/19/21.

R1's Ambulance Care Record dated 6/22/22, states "EMS (Emergency Medical Services) called for an 87-year-old male patient (R1) who had fallen. When EMS arrived (R1) was sitting on the edge of bed in care of (facility staff). Staff stated (R1) had fallen twice this morning, not witnessed by staff. (R1) had a small hematoma on forehead. (R1) had a skin tear on left forearm. (R1) alert to normal status per staff. (R1) has a history of Dementia. (R1) can become violent with staff and other residents of facility. (R1) had bruising to his arms from falling. (R1) moved to stretcher by EMS crew. (R1) secured to stretcher with five straps. (R1) rested comfortably enroute to hospital. EMS crew had no difficulty with (R1 having) violent outburst. EMS kept (R1) calm by talking with (R1). (R1's) care turned over to (local hospital Emergency Department)."

R1's Hospital Emergency Department records dated 6/22/22, documents the following: R1 arrived via ambulance with a primary complaint of hitting his head during a fall. R1 received an Ativan (antianxiety medication) 2 milligram injection intramuscularly on 6/22/22 at 11:13AM.

R1's CT (Computed Tomography) dated 6/22/22 at 10:12AM, states "Findings are overall concerning for infarct (Stroke). No acute intracranial hemorrhage."

R1's laboratory (lab) results document the

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| S9999 | Continued From page 12 | S9999 | | |

following: BNP (Brain Natriuretic Peptide/lab used to diagnose heart failure) dated 6/22/22 at 12:10PM, documents R1's BNP was 262 picograms per milliliter with the normal range of 0-99 picograms per milliliter. This same lab result states "Note: 201-400 picograms per milliliter: Likely moderate (Congestive Heart Failure)"; Glucose 170 milligrams (mg)/deciliter (dl) with a normal range of 83-110 mg/dl.

R1's Ultrasound of bilateral carotid arteries dated 6/22/22, states "Indications: Stroke. Cardiovascular Accident (CVA/Stroke) with fall today."
R1's local hospital admission record dated 6/22/22, documents R1 was admitted for a Stroke and worsening mental status and deterioration.

R1's local hospital Inpatient Physician progress note dated 6/22/22 at 11:00PM, states "Staff informed (physician) that (R1's) mental status has deteriorated since admission at 1:30PM (R1) opens his eyes to painful stimulus then falls back asleep. (R1) was given Ativan, Haldol, and Valium (since arriving at the Emergency Department). Plan: Worsening mental status-Overmedication with Ativan, Haldol and Valium versus Worsening CVA. Transferring to a larger hospital for Intensive Care Unit admission."

R1's local hospital Initial Interview form dated 6/23/22, documents R1 was admitted to this local hospital on 6/22/22 at 1:35PM with chief complaint of fall and Admitting diagnosis of CVA/Stroke. R1 was discharged to a larger hospital for intensive care on 6/23/22 at 12:25AM

R1's Progress Notes dated 6-22-22 at 12:22PM and signed by V5 document, "Nurse with (hospital) called with update on (R1). MRI

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| S9999 | Continued From page 13<br>(Magnetic Resonance Imaging) showed possible stroke. (Hospital) is admitting (R1)."<br><br>R1's Hospital Stroke Consult Progress Note dated 6-23-22 at 1:15PM documents, "(R1) is an 87-year-old male with past medical history of Dementia, Hypertension, Type II Diabetes Mellitus admitted for AMS (Altered Mental Status). (R1) was last known well at 6-22-22 (unknown). (R1) went to outside Emergency Room for fall. (R1) was found on the ground with bruises on his arm. Incidentally, non-contrast CT (Computed Tomography) head was done due to the fall and showed wedge shaped right parietal lobe infarct appears subacute to chronic. (R1) showed agitation and received IV (Intravenous) Haldol, IV Ativan in IV Valium. After that, (R1) was found to have an agonal breathing and sonorous respirations, (R1) was transferred to (another hospital) for further evaluation of the stroke and ICU (Intensive Care Unit) level cares. Assessment: Right parietal lobe infarct."<br><br>R1's Hospital Discharge Planning Notes dated 6-30-22 document, "Received message from (facility) stating that patient has been denied due to inability to meet needs. Spoke with (V4/Hospital Liaison) to see how long patient will need to be on good behavior before returning and she states they have denied, aware of the repercussions."<br><br>R1's Hospital Discharge Planning Notes dated 7-6-22 and 7-7-22 document, "7-6-22 at 4:21PM: Received in a basket to send referral to facility and message left with (V4) if need referral re-sent and to call back concerning if (R1) can return to facility after medically ready since (R1) has been there (at the long-term care facility) as a custodial for two to three years. | S9999 | | |

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7-7-22 at 1:53PM: Spoke with (V4). Facility still declined inability to meet (R1's) needs. 7-7-22 at 2:06PM received secure chat from (V11/R1's Hospital Physician) asking if facility would review if behavior improved. Spoke with (V4) who stated at this time the facility stated this is their final decision. (V4) stated if (R1) did improve greatly she would see if facility would review referral again. Team notified by chat."

R1's Hospital Discharge Planning Notes dated 7-26-22 at 11:24AM document, "Reached out to (V4) to look at referral. V4 replied with, 'I just had a chance to review. (R1) needed a bedside sitter yesterday. (R1) is still yelling out, restless, uncooperative, agitated, and combative. We cannot meet (R1's) needs and we will be declining and that regional leadership also replied and approved denial."

R1's Hospital Interdisciplinary Notes dated 8-8-22 document, "Discharge Placement Request-(Facility) denied-unable to meet (R1's) needs. 8-4-22 (R1) more towards baseline, now out of restraints and no longer has sitter. Does continue to yell. Ombudsman called to file complaint by V3 (R1's Hospital Case Manager) for hospital dumping. IDPH (Illinois Department of Public Health) made aware and will open a formal investigation. Hospital and (R1) has not received Discharge notice from (facility).

8-5-22 (R1) now had not been combative since 8-2-22.

8-8-22 Specialist consulted for assistance with placing (R1) at long term care facility. (R1) has not been in restraints or had sitter since 7-22-22. No chemical restraints since 8-2-22. Zyprexa,

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| S9999 | Continued From page 15<br>Zoloft, and Depakote orally."<br><br>R1's Progress Notes dated 8-12-22 and signed by V8 (R1's Hospital Physician) document, "(R1) has remained in hospital due to need for placement. Case Management is following. Psychiatry last saw a couple weeks ago. (R1) has not been combative with staff since 8-2-22 per notes. (R1) has been out of wrist restraints. (R1) appears to be closer to his baseline on the new medications that are being prescribed. (R1) does yell out when he needs something. It is my opinion that (R1) could be easily cared for at a skilled nursing facility at this point."<br><br>R1's Hospital Interdisciplinary Notes dated 8-9-22, 8-10-22, 8-11-22, and 8-13-22 document, "Discharge Placement Request-(Facility) denied-unable to meet (R1's) needs."<br><br>R1's Hospital Discharge Readiness Note dated 8-15-22 documents, "Discharge to Norridge Gardens in Norridge, Illinois."<br><br>R1's Progress Notes/Medical Record does not include any further documentation about R1's discharge, needs that could not be met by the facility preventing the facility from re-admitting R1 from the hospital, or notification to the resident, resident's representative, and long-term care ombudsman in writing or verbally of R1's discharge, including notification of appeal rights.<br><br>On 8-23-22 at 11:20AM V5 stated, "I have worked with (R1) for quite a while as a CNA before I became a nurse. (R1) would refuse cares at times and yell if he wanted coffee. On 6-22-22 in the morning, (R1) started to refuse to sit up in his wheelchair and would not let the staff re-position him. (R1) threw his coffee and almost hit a | S9999 | | |

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resident. (R1) slid to the floor and got skin tears. (R1) would not let me take care of the skin tears and was screaming loudly. I called (V6) and got an order for Haldol. I gave (R1) Haldol 5 mg (milligram) IM (Intramuscularly) into the right arm. (R1) continued to fight us (facility staff) and refused to get off of the floor. We had to use the (mechanical lift) to get him up off of the floor and take him to his room. I was running behind on my medication pass already and (R1) kept screaming loudly from his room. The staff could not get (R1) to quit screaming. I went and got (V2/Director of Nursing) and told her I needed help as I did not have time to do medication pass and deal with (R1). (V2) came to help and was unable to get (R1) calmed down. (V2) had me call (V6) and report that (R1) still would not quit screaming. (V6) gave me an order to give (R1) more Haldol. I told (V2) about the order for more Haldol, and (V2) said we were just going to send (R1) to the emergency room for evaluation because (V2) did not feel comfortable with giving (R1) more Haldol. I did not call 911 or give the hospital or paramedics report. I am not sure who did. I did not document in (R1's) medical record that (R1) was sent to the emergency room, and I did not fill out an occurrence report as I am a new nurse and did not know that I had to. I filled out an occurrence report three days later. I also did not send anything to the hospital about what interventions we had tried with (R1)."

On 8-23-22 at 11:30AM V10 (Geriatric Care Specialist) stated, "(R1) had behavior of just yelling out, 'Come here. Come here.' I never really had any issues with (R1) having physical behaviors. I am not completely sure why the facility could not re-admit him."

On 8-23-22 at 9:00AM V3 (Hospital Case

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| S9999 | Continued From page 17<br><br>Manager) stated, "The facility would not accept (R1) back even after (R1) was stabilized. The facility never did issue the hospital or (R1) a discharge letter. The facility just dumped (R1) on the hospital to find placement. (R1) had to be transferred to a facility up by Chicago, Illinois."<br><br>On 8-23-22 at 9:30AM V4 (Hospital Liaison) stated, "I have nothing to do with whether the facility can re-admit (R1). I was just told by the facility that (R1's) needs could not be met and I would relay that information to the hospital."<br><br>On 8-23-22 at 12:00 PM V1 (Administrator) stated, "The IDT (Inter-Disciplinary Team) met several times about (R1) being re-admitted to the facility. At first, we did not re-admit him because he needed soft wrist restraints and sitter. The last time we denied him was because he still had a few episodes of agitation. (R1's Physician) was not notified about the facility refusing to take him back and we did not document an assessment or reason why the facility could not meet (R1's) needs in (R1's) medical record along with care plan interventions attempted. We did not notify the resident, resident's representative, or long-term care Ombudsman in writing or verbally of the facility's refusal to allow R1 to be re-admitted to the facility. I was not the Administrator at the time (R1) was admitted originally to the facility after being in a psychiatric unit. The facility does not have a policy on re-admitting residents to the facility after a therapeutic leave or transfer to the hospital."<br><br>On 8-23-22 at 12:00 PM V9 (Regional Ombudsman) stated, "I did not receive a notice of discharge from the facility when the facility decided to deny (R1) re-admission after hospitalization. I also was not involved with | S9999 | | |

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developing a plan of care to meet (R1's) needs to return to the facility. It is always in the best interest of the resident to return to the facility."

On 8-23-22 at 1:00 PM V7 (R1's Power of Attorney) stated, "The facility did not notify me that they sent (R1) to the hospital and did not notify me that they were not going to take him back. I never received anything about (R1's) discharge. The Peoria hospital called me and informed me that (R1) was there, and the facility would not take him back. The hospital told me they were going to send (R1) to a facility in Chicago. I do not even know the name of the facility in Chicago, and that facility has not called me about how (R1) is doing, I know (R1) has to be scared, confused, and upset that he does not know anyone in Chicago and would not like living that far away from his home. (R1) will probably have more behaviors. I am not able to visit (R1) that far away. I would like to see the facility re-assess (R1) and take him back. The facility knew when they admitted him that he had mental problems and behaviors."

On 8-24-22 at 8:30AM V2 (Director of Nursing) stated, "I have worked at the facility since December 2020. (R1) has a very 'jarring' voice. (R1) had never been disruptive or have physical behaviors like he had on 6-22-22. (R1) would always repeat himself by saying 'Hey. Hey. Come here.' We could intervene and usually stop (R1's) behavior. I heard loud arguments and went to the unit (Dementia unit) to find out what was going on. (V5) told me that (R1) had fell out of the wheelchair and got skin tears. (V5) had already gave (R1) IM Haldol. I told (V5) to leave (R1) alone in his room since he was not in 'grave condition.' (R1) was in his room and was safe. (R1) kept screaming loudly and most of the

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| S9999 | Continued From page 19<br><br>residents were wondering what was wrong. We had already dealt with (R1's) behaviors for over 45 minutes and did not have time to deal with (R1) any longer. I told (V5) to call (V6) again and let her know that (R1) continued to yell loudly. (V6) wanted (V5) to administer another dose of IM Haldol. I told (V5) that unless (V6) wanted to assess (R1) and give (R1) the Haldol herself, that we were not giving (R1) anymore Haldol. I decided to have (V5) send (R1) to the hospital for evaluation. I did not give the hospital or paramedics report on what interventions had been attempted with (R1). I know the hospital had sent referrals wanting the facility to re-admit (R1) several times and I know the hospital physician had noted (R1) was stable and back to his baseline, but I had noticed (R1's) pulse had dropped to below 34 once and did not feel comfortable with him coming back to the facility. I did call the hospital nurse to see why his pulse had dropped and she reported that on occasion (R1's) pulse does drop. I made the decision that (R1) could not be re-admitted to the facility because our facility is not close enough to a hospital in-case (R1) needed medical help. I did not document anything in (R1's) medical record about the facility refusing to re-admit (R1) or give (R1) or (R1's POA) a discharge letter as to why the facility cannot handle (R1)."<br><br>On 8/24/22 at 1:00PM, V2 stated she is currently responsible for care plan duties. V2 stated R1's care plan was not updated with R1's "worsened behaviors" on 6/21/22 and 6/22/22. V2 stated "I did not add any new interventions to (R1's) care plan. R1 is one of those people that has a loud, jarring voice. It's hard to say whether he was yelling or if it was just his loud voice."<br><br>On 8-24-22 at 1:00 PM V6 (R1's Physician) | S9999 | | |

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| S9999 | Continued From page 20<br>stated, "I was not made aware that the facility refused to re-admit (R1). I never did an assessment, review (R1's) records, or document anything about (R1) or why the facility could not meet (R1's) needs to return to the facility."<br><br>(B) | S9999 | | |