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| S 000 | Initial Comments<br><br>Complaint Investigation:<br><br>2340676/IL155707 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.1220b)3)<br>300.3210t)<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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>resident to meet the total nursing and personal care needs of the resident.<br><br>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:<br><br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>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.<br><br>Section 300.3210 General<br><br>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. | S9999 | | |

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| S9999 | Continued From page 2<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to prevent resident-to-resident physical abuse for 2 of 4 residents (R2, R3) physical altercation involving reviewed for abuse in the sample of 8. This failure resulted in a R3 pushing R2 down to the ground on 1/12/2023. Subsequently, R2 was sent out to the hospital where he was diagnosed with a hip fracture requiring surgery and 15 staples.<br><br>Findings include:<br><br>R3's January 2023 Physician Order Sheets (POS) documents diagnoses of unspecified dementia, unspecified severity without behavioral disturbances, psychotic disturbances, mood disturbances and anxiety, major depression disorder, schizophrenia, diabetes mellitus.<br><br>R3's Minimum Data Set (MDS) dated 12/14/2022 documents R3 is moderately impaired for cognition. R3's MDS documents R3 is independent for activities of daily living, including bed mobility, transfers, walking in room and walking in corridor. R3's MDS documents R3 does not have any impairments and is able to walk without any cane, walker and or wheelchair.<br><br>R3's Nurse's Notes dated 12/15/2022 at 4:42 PM, "This resident (R3) became very agitated when another resident wandered into his room, this resident pushed the resident out of his room and into the hallway causing the other resident to fall and hit his head. This nurse talked to this resident (R3) and explained to him that the other | S9999 | | |

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resident (R2) is confused and doesn't know what he is doing and that the other resident didn't mean this resident any harm. This resident (R3) stated, "I don't believe that. He knows exactly what he's doing and I'm tired of him coming in my room and he better not do it again."

An undated statement from V6, Licensed Practical Nurse (LPN) from 12/15/2022 incident documents, "When passing medication on the 100-hall, I saw (R2) fall backwards out of (R3's) room. He attempted to get himself up from the floor so we helped him up and took him to the dining room and I assessed him for pain and injury. He did not appear to be in any pain, but he did hit his head so EMS was called to send him for a more thorough assessment."

R3's Final Report Facility Incident Report for R3 on 12/15/2023 at 4:45 PM, documents, "Resident (R2) walked into (R3's) room. (R3) then pushed (R2) out of the room, causing him to fall on the floor. (R2) was assisted up by two staff and taken to the dining room. He (R2) was given a full body and pain assessment. Staff interviewed (R3) to determine the circumstances that led to the altercation. (R3) stated only that he was frustrated that (R2) came into his room. (R3) does not have instances of aggression documented in his care. (R2) who is nonverbal, was unable to state his recollection of the events. He (R2) was sent back to (Facility) with no new orders of injuries. Fall protocol was continued for (R2) and (R3) was placed on one-on-one supervision temporarily to prevent any further complications. (R3) did not want to move rooms when asked."

R3's Nurse's Note dated 12/15/2022 at 10:25 PM, "Resident on follow up related to altercation with

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another resident. Resident is on 1:1. Resident was in resident's room for the entire shift. No further behaviors noted. Resident is in bed resting with call light within reach."

R2's and R3's Care Plan was reviewed and does not document any interventions for the altercation on 12/15/2021.

R3's medical records does not document when R3 was removed from one on ones.

On 2/1/2023 at 10:40 AM, V1, Administrator stated, "We should have put in an intervention to prevent (R3) and (R2) from having any incidents or from it happening again. It should have been care planned after the first altercation on 12/15/2022. Off the top of my head, I cannot tell you what was put into place after (R2) entered (R3's) room. It should be documented in the Care Plan."

R3's Nurse's Notes dated 1/12/2023 at 7:41 PM, "Note Text: (R2) resident was bringing his supper tray to the dining room when another resident (R3) walked up to him and he yelled out. This nurse turned to see what was going on. As this nurse yelled out other resident's name, this resident (R3) threw his tray on the table and pushed other resident to the floor (R2)." This occurred 29 days later after the first altercation on 12/15/2022.

R3's Initial Report undated from incident date of 1/12/2023 at 6 PM, documents, "Staff reported to the administrator that she witnessed resident (R3) push second resident (R2) to the floor. The staff attempted to intervene but were unsuccessful. (R2) was assessed for pain and injuries and assisted to his feet. There was no sign of pain or

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| S9999 | Continued From page 5<br>injury from (R2) and both residents were sent to the ED (Emergency Department) for further treatment and evaluation. Investigation to follow."<br><br>R2's Hospital Records dated 1/13/2023 at 7:44 AM, documents, "(R2) is a 63-year-old male that presented to (hospital) after a ground level fall onto their right side. Following fall patient was unable to ambulate. Patient was initially evaluated by the ED (emergency department) physician who obtained plan films documenting a hip fracture. Subsequently Orthopedics has been consulted for further management. Patient reportedly has dementia, history of alcohol abuse and schizophrenia and is living (Facility). He is non-verbal and unable to cooperate with exam due to his condition." R2's x-ray of his right hip document "An acute mildly displaced right greater trochanter fracture extending to the intertrochanteric region." The Hospital Report documents a right proximal femur (hip) open reduction internal fixation with a cephalomedullary nail procedure was completed for R2 on 1/13/2023 at 5:15 PM.<br><br>R3's Care Plan, initiation date 1/12/2023, "Resident to resident altercation. Enhance supervision as needed (date initiated 1/12/2023). Behavior: (R3) exhibits behavior of physical aggression manifested by people coming in his room and asking him questions that he does not like. When people are asking him questions, he will say the cops are coming to arrest everyone. 3/22/22. (R3) physically aggressive towards Social Service Director and smacked her in the face. Resident to resident altercation 12/15/2022, 'Resident to resident altercation.' 1/12/2023. 1:1 Supervision x 72 hours (start dated 1/13/2023 - 1/16/2023). ABUSE: (R3) is at risk for abuse and neglect related to him having a psychiatric history | S9999 | | |

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and a diagnosis of dementia. (R3) displays signs and symptoms of confusion, disorientation, and forgetfulness with poor judgement skills. (R3) at times displays hallucinations and delusions. (Dated 4/13/2022)."

R3's Final Report dated 1/19/2023 from the incident date of 1/12/2023 at 6 PM, documents, "Staff reported to the administrator that she witnessed resident (R3) push second resident (R2) to the floor. The staff attempted to intervene but were unsuccessful. (R2) was assessed for pain and injuries and assisted to his feet. There was no sign of pain or injury from (R2) and both residents were sent to the ED (Emergency Department) for further treatment and evaluation. (R3) returned to the facility with no new orders. Requesting hospice to increase social visits, per (V17, Medical Director) (R2) is safe to resident in the facility. (R2) was admitted to local hospital with diagnosis of right hip fracture where he underwent surgical intervention, returning to the facility with new orders for therapy services and pain control. Resident remains WBAT (Weight bearing as tolerated) status, no active sign/symptoms of pain with ambulation at this time."

On 1/27/2023 at 8:28 AM, V1, Administrator stated, "There was an incident in the facility with a resident injury. (R2) was the victim. He is a little guy, and he likes to wander around the facility. (R3) likes to stay in his room and he keeps to himself mostly. (R2) was taking his lunch tray back and was in the dining room area when (R3) thought he was in his space, so he pushed him, and he broke his hip. Yes, they had been in altercations before back in December, R2 went into (R3's) room and he pushed him."

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| S9999 | Continued From page 7<br><br>On 1/27/2023 at 9:03 AM, R3 was in his room lying on his bed fully dressed staring at the ceiling. When asked if he needed anything he replied, "No". There were no signs on the door and no 'stop signs' in place.<br><br>On 1/27/2023 at 9:28 AM, V4, Certified Nursing Assistant (CNA) stated, "I was here working the day (R3) pushed and hurt (R2). I had just walked (R2) and sat him down at the table close to the nurse's station. I was standing at the nurse's station when (R3) approached (R2) and said, 'go away' then (R2) stood up and (R3) had a tray in his hand and he put the tray down and shoved (R2) really hard. Poor baby, he hit the ground really hard from the push and cracked his femur. (R3) can be aggressive and they did have an altercation about a month ago. (R2) likes to wander and he likes to go back on the 100-hall where (R3's) room is at and I think he is constantly trying to open the door and making noise, and this annoys (R3). (R3) does not like (R2). Before the incident (R2) was walking all over the place he could out walk us all. He is nonverbal and usually keeps his head down and wanders around the building. He is pleasantly confused. Not really able to talk to you or tell you what is going on. He fractured his femur and had to have surgery and has 15 staples now and is in wheelchair. He (R2) used to run marathons."<br><br>On 1/27/2023 at 9:44 AM, V7, CNA stated, "I was not working when (R3) pushed (R2). I heard about it, but I did not see anything. I am agency staff. (R2) was able to walk around in fact he walked really fast walker before the accident. Because of his fracture he is in a wheelchair now. (R2) is not able to talk and or communicate very well. (R3) was a private person and liked to stay in his room most of the day. I think he got upset | S9999 | | |

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because (R2) was in his space and pushed him."

On 1/27/2023 at 1:12 PM, V10, Social Service Director stated, "I have been working here in this position for about four months. Before me (V8) was the Former Social Service Director. (V8) told me (R3) had hit her in the face. She was doing an assessment with him he lost his temper and hit her. (R3) is very paranoid. (R3) does not come out of his room very often. He only comes out to take his food tray out. (R3) is very paranoid. (R2) is harmless and is constantly walking all over the place. He used to run marathons. I was not working the day back in December when (R2) was wandering down the 100 hall and went into (R3's) room and he pushed him out the first time. I heard the second time this happened he pushed (R2) when he was bringing his tray out of his room. (R2) was next to him, and (R3) sees (R2) as a threat and he just shoved him. (R2) went down really hard and he went down and injured his femur. We have to take (R3) to the surgeon on Tuesday. (R3's) neighbor is one of his POA and he says that (R3) was in the military and has paranoid. In (R3's) mind (R2) is a threat to him because of his schizophrenia. When he comes out of his room he talks, and he mostly stays to himself. But in his mind, he does not like (R2). I have not personally had any issues with (R3) personally, but I know he has a history of aggressive behavior."

On 1/31/2023 at 4:11 PM, V2, Director of Nursing stated, "I got a call from (V9, Licensed Practical Nurse) and she told me (R3) came into the dining room to take back his tray and (R2) bumped into him and he (R3) slammed down his tray and pushed (R2). (R2) hit his head and hip and they were both sent out to the hospital. (R2) had a

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hip fracture. Both of the residents were put one on one. (R2) is still on one on one. If a resident is on 1:1 I would expect staff to be always within arms lengths with the resident. They should never ever leave the resident unless there is another person filling in for them. I know there was an incident with (R2) and (R3) back in December when (R2) entered (R3's) room. We put a stop sign on R3's door so (R2) would see it and not enter. I am not aware of (R2) entering (R3's) room after that incident."

On 2/1/2023 at 10:55 AM, V15, CNA stated, "(R3) stays in his room a lot. I am not aware of any altercations or fights with (R2) and (R3) before January when (R2) was pushed by (R3) and broke his hip."

On 2/1/2023 at 11:13 AM, V16, CNA stated, "I have been working here for about four months now. (R3) will come out of his room and talk with the nurses and he takes his own showers. He likes to come out and get tea. (R2) wanders all over this place and he is likes to go to the doors and set the alarms off. I am not aware of any altercations and/or fights with (R2) and (R3) except when (R2) pushed (R3) and broke his hip a few weeks ago."

On 2/1/2023 at 2:11 PM, R3 stated, "There were 8 residents that wandered in my room last night. They tortured me, pulled out my eyes and went up my nose and inside my mouth. I fought them off. I have a right to protect myself."

On 2/1/2023 at 2:28 PM, V18, Family of R3 stated, "(R3) has schizophrenia, and dementia and he doesn't play well with others. Sometimes he feels threatened especially if someone comes into his space or his room. He just recently

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pushed a resident down and hurt them. This is not the first time this has happened. When he feels confronted, he feels threatened and he will act out. (R3) doesn't play well with others. He likes to have his own space."

On 2/1/2023 at 11:12 AM, V9, LPN stated, "I remember working the day (R3) pushed (R2). I was working and it was right after supper. I was standing at the desk and (V4) the Certified Nursing Assistant and I were at the desk. (R3) was walking into the dining room as he was carrying his tray to take it back to the kitchen. Then all of a sudden (R3) started yelling and threw his tray down and it happened so fast he then pushed (R2) to the floor really hard. We separated the residents, and I notified the DON, and the POA. The POA was really rude to me and told me that (R2) was in (R3's) space. I just got moved to working the floor, so I have not really seen any interactions between (R2) and (R3) and I am not aware of any past behaviors or altercations between the two. Not that I am aware of anyway. (R2) was injured and his hip was fractured."

On 2/1/2023 at 2:57 PM, V19, Psychiatric Nurse Practitioner stated, "I would expect staff to keep all residents in the facility safe while they are living there. With a resident with aggressive behaviors, I would expect staff to always keep all residents safe. I have not seen (R3) for quite some time. (R3) was refusing his medication and if I remember correctly. He had some strange delusions he thought he was a native American, just extreme stuff. At that time, he was not harming anyone and he was refusing medication, not answering questions. Because of this (R3) went on hospice. I have not even since him since August 2022. If he does not take his medication

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| S9999 | Continued From page 11<br>or talk with me it is hard for me to help him. This is why he went to hospice."<br><br>The Facility Abuse Policy of 10/2022 documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents." The Policy documents "Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment." The Policy documents "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident." (A) | S9999 | | |