| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6007025 | A. BUILDING: _____ B. WING _____ | 04/13/2023 |

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| EASTSIDE HEALTH & REHAB CENTER | 1400 EAST WASHINGTON STREET PITTSFIELD, IL 62363 |

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| S 000 | Initial Comments<br><br>Annual Licensure and Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>State Licensure Violation 1 of 3<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)2)5)<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>300.1210 Section 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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<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>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.<br><br>These Regulations were not met as evidenced by:<br><br>Based on interview, observation and record review, the facility failed to appropriately reposition to prevent shearing and pressure, ensure pressure ulcer treatment performed as ordered and dressing intact for 1 of 2 resident (R26) reviewed for pressure ulcers in the sample of 32. This failure resulted in R26's sustaining a shear / pressure ulcer of the right buttocks and coccyx. | S9999 | | |

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| S9999 | Continued From page 2<br><br>Finding include:<br><br>R26's Profile Face Sheet, undated, documents that R26 was admitted on 2/13/23 with diagnoses of Heart Failure, Type 2 diabetes and morbid obesity.<br><br>R26's Nursing Admission Assessment, dated 2/13/23, documents that R26 had no open areas on her buttocks.<br><br>R26's Minimum Data Set (MDS), dated 2/23/23, documents that R26 is moderately cognitively impaired, is totally dependent on 2 staff members for bed mobility and is at risk for pressure ulcers and does not have a pressure ulcer at this time.<br><br>R26's Monthly weight documents that in April 2023, R26 weighed 253.4 pounds.<br><br>R26's Skin Assessment, dated 3/25/23, documents, "Skin to buttocks sheared r/t (related to) to small (mechanical lift) pad.<br><br>R26's A. I. M. (Assessment Intercommunication Management) for Wellness, dated 3/27/23, documents, "This change of condition, symptoms, or signs observed and evaluated are new skin areas on R (right) lower extremity and R hip. Nursing note; Resident noted to have several scattered opened areas not pressure related. Cleansed and creamed at this time. No infection noted. Skin Displaced. Can we have an order to cleanse and cover with cream TID (three times a day) and prn (as needed)."<br><br>R26's Treatment Administration Record (TAR), dated 3/28/23, documents, "Apply triad cream to areas and R leg and hip every shift and prn." | S9999 | | |

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| S9999 | Continued From page 3<br><br>R26's Wound Doctor Notes, dated 3/30/23, documents that R26 has a Stage 3 Pressure Ulcer to the right buttock with full thickness. This Pressure Ulcer measures 8.5 x 13 x 0.1 cm (centimeter). Primary Dressing: Collagen powder apply once daily for 30 days; Alginate calcium with silver apply once daily for 30 days, Santyl apply once daily for 30 days. Gauze island with border apply daily for 30 days.<br><br>R26's Wound Doctor Notes, dated 3/30/23, documents that R26 has a Stage 1 Pressure Ulcer of the right inferior medial hip with partial thickness measuring 3 x 13 x 0.1 cm. Dressing: Collagen Powder apply once daily for 30 days; Alginate calcium with silver apply once daily for 30 days. Dressing Gauze island dressing with border apply once. daily for 30 days.<br><br>R26's Wound Doctor Notes, dated 3/30/23, documents that R26 has a unstageable Pressure ulcer of the medial coccyx full thickness measuring 1.5 x 1.5 cm x 0.1 cm. Dressing: Collagen powder apply once daily for 30 days; alginate calcium with silver apply once daily for 30 days; Santyl apply once daily for 30 days Dressing: Gauze island with border apply once daily for 30 days."<br><br>The NPUAP (National Pressure Ulcer Advisory Panel) at https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf documents the definition, "Unstageable Pressure Injury: Obscured full- thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If eschar is removed, a Stage 3 | S9999 | | |

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| S9999 | Continued From page 4<br>or Stage 4 pressure injury will be revealed."<br><br>R26's Wound Doctor Notes, dated 3/30/23, documents that R26 has a Stage 1 Pressure Ulcer of the right inferior medial hip with partial thickness measuring 2.4 x 13.5 x 0.1 cm. Dressing: Skin prep once daily for 30 days."<br><br>R26's Physician Orders, dated 3/30/23, documents, "Cleanse area to rt (right) buttock apply Santyl, calcium alginate collagen powder change daily x (times) 30 days. Cleanse area to rt inferior medial hip apply collagen powder calcium alginate with silver change daily x 30 days. Cleanse area to coccyx apply collagen, calcium alginate with silver and santyl change daily x 30 days."<br><br>R26's Wound Doctor Notes, dated 4/7/23, documents that R26 has a Stage 3 Pressure Ulcer to the right buttock with full thickness. This Pressure Ulcer measures 9.2 x 12.5 x 0.1 cm (centimeter). Primary Dressing: Collagen powder apply once daily for 22 days; Alginate calcium with silver apply once daily for 22 days. Gauze island with border apply daily for 30 days.<br><br>R26's Wound Doctor Notes, dated 4/7/23, documents that R26 has a unstageable Pressure ulcer of the medial coccyx full thickness measuring 1.0 x 1.9 cm x 0.1 cm. Dressing: Collagen powder apply once daily for 22 days; alginate calcium with silver apply once daily for 22 days; Santyl apply once daily for 22 days Dressing: Gauze island with border apply once daily for 30 days."<br><br>R26's Physician Orders, dated 4/7/23, documents, "R buttock - DC (discontinue) santyl to area apply collagen powder calcium alginate | S9999 | | |

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| S9999 | Continued From page 5<br>cover with dry dressing change daily and PRN (as needed)."<br><br>R26's Skin Assessment, dated 4/7/23, documents, "R buttocks: Stage 3 Pressure Ulcer 9.2 cm (centimeter) x 12.5 cm x 0.1 cm. Irregular Shape. Red and yellow in color with moderate drainage."<br><br>R26's Skin Assessment, dated 4/7/23, documents, "Medial Hip: Stage 1 pressure Ulcer 2.4 cm x 13.5 cm x 0.1 cm Irregular shape. Red and yellow in color with no drainage.<br><br>On 4/13/23 at 11:03 AM, V15, Certified Nurses Aide (CNA), and V14, CNA, provided pericare for R26. R26 did not have a dressing on the right medial coccyx. At the end of care V14 and V15 pulled R26 up to the head of the bed. R26 was not lifted during this. R26 was drug along the mattress by a bed pad.<br><br>On 4/13/23 at 11:26 AM, V17, Licensed Practical Nurse (LPN), provided dressing changes for R26. V17 covered the right inferior medial hip with tape. V17 failed to apply skin prep as ordered.<br><br>On 4/12/23 at 2:15 PM, V1, Administrator, and V16, LPN, both stated that R26's right buttock wound "just appeared one day." V1 further stated that she was getting R26 a low air-loss mattress and that it will be delivered tomorrow.<br><br>On 4/13/23 at 12:20 PM, V24, Wound Doctor, stated that R26's right buttocks wound very well could have started as a shear but now it is a pressure ulcer from not repositioning. V24 stated that today the wound is 6.6 x 12.5 centimeters. V24 stated that it will more than likely take 2 months for the wound to heal and that it is very | S9999 | | |

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| S9999 | Continued From page 6<br>important to offload and reposition for wound healing. V24 also stated that tape should have not been put over the right inferior medial hip because she ordered skin prep for that area.<br><br>On 4/13/23 at 1:45 PM, V1, Administrator, stated that R26 should be positioned in bed using a draw sheet and that 2 staff members are not enough for R26 to be turned and repositioned.<br><br>The facility policy Preventative Skin Care dated revised 1/18, documents it is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep the clean, comfortable, well groomed, and free from pressure ulcers.<br>The policy documents:<br>#11 Practice care in moving and lifting residents.<br>a) Prevent shearing forces during moving and transfers.<br>b) Prevent pulling resident across the sheets.<br>c) Avoid scratches, bruises, and skin irritation.<br>This policy does not address treatments.<br>(B)<br><br>State Licensure Violation 2 of 3<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.1210a)<br>300.1210b)5)<br>300.1210d)6)<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 | S9999 | | |

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| S9999 | Continued From page 7<br>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>300.1210 Section General Requirements for Nursing and Personal Care<br><br>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 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)<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 | | |

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| S9999 | Continued From page 8<br>resident to meet the total nursing and personal care needs of the resident.<br><br>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.<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>These Regulations were not met as evidenced by:<br><br>1. Based on interview, observation and record review, the facility failed to provide supervision, investigate falls, develop a root cause analysis and implement progressive interventions to prevent further falls for 1 of 3 residents (R30) reviewed for falls in the sample of 32. This failure resulted in R30 sustaining a head laceration which required 6 staples.<br><br>Findings include:<br><br>R30's Profile Face Sheet, undated, documents that R30 was admitted on 12/15/22 and has diagnoses of Fx (fracture) of neck of right femur, Parkinson's disease and Dementia. | S9999 | | |

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| S9999 | Continued From page 9<br><br>R30's Minimum Data Set (MDS), dated 12/24/23, documents that R30 is cognitively intact and requires extensive assistance of 2 for transfers, ambulation and toileting. This MDS also documents that R30 is only able to stabilize with staff assist and uses a walker and a wheelchair.<br><br>R30's MDS, dated 3/12/23, documents that R30 is mildly cognitively impaired, requires extensive assistance of 2 for transfers and ambulation, extensive assistance of 1 for toileting. This MDS also documents that R30 is only able to stabilize with staff assist and uses a walker and a wheelchair.<br><br>R30's Fall Risk Assessment, dated 12/15/22 and 3/10/23, both document that R30 is a high fall risk.<br><br>R30's Care Plan, dated 12/26/22, documents, "Resident has risk factors that require monitoring and interventions to reduce potential for self injury. She has weakness, unsteady gait, hx (history) of falls with recent fall with LROM (limited range of motion) rt (right) hip d/t (due to) fx and takes psy (psychiatric) meds. Medications. She is alert and follows directions and is in therapy. Review quarterly and as needed during daily care and services of Resident's plan for safety, giving verbal cues as needed to gain Resident participation in minimizing risk factors and injury. Insure adaptive devices are kept out of sight. Encourage and assist placement of proper footwear. Remind resident to lock wheelchair brakes. Observe for unsteady / unsafe transfer or ambulation and provide stand by or balance support as needed. Assist resident to clean and place prescribed eyewear when awake. Use 1 assist with ww (wheeled walker) and gait belt for all transfers. Use additional assist as needed | S9999 | | |

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| S9999 | Continued From page 10<br>when Resident is not feeling well, feeling dizzy or weak. Observe for and educate on proper technique and use of device. Use 1 assist with ww (wheeled walker) and gait belt for all ambulation. Use additional assist as needed when Resident is not feeling well, feeling dizzy or weak. Observe for and educate on proper technique and use of device. 1/30/23 body alarm x 24 hours. 1/31/23 poor safety awareness d/t (due to) acute condition. 3/1/23 Thirty minute checks x 24 hours. 4/6/23 30 min (minute) safety checks x 24 hours."<br><br>R30's A.I.M. (Assess Intercommunicate Management) for wellness, dated 1/30/23 at 12:00 AM, documents, "Res. (resident) cont (continues) to be confused @x (at times). Attempted to walk self to BR (bedroom)/ generally requiring, 2 assist, and fell to buttocks. ROM WNL (range of motion within normal limits). No injury noted (speaking about kids behind chair, etc.) c/o (complaint of) mild low back disc. Assisted to bed."<br><br>R30's QA (quality assurance) Progress Note, dated 1/31/23 at 9:30 AM, documents, "QA committee met and reviewed fall from 1/30/23. Res had gotten up by self and lost balance and fell. Tabs alarm applied for 24 hours. Care Plan updated."<br><br>R30's Nurses Note, dated 1/31/23 at 1:15 AM, documents, "Res cont to be confused has attempted to get up without assist several times. Res seeing a little boy in her room. Continue Macrobid for UTI. No adverse effects noted r/t (related to) previous fall."<br><br>R30's Nurses Note, dated 1/31/23 at 10:30 AM, Res alert wit occ (occasional) confusion. Res | S9999 | | |

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| S9999 | Continued From page 11<br>cont to have hallucinations She is seeing children in her room Continue on Macrobid for UTI (urinary tract infection).<br><br>R30's A.I.M. for wellness, dated 1/31/23 at 4:40 PM, documents, "Heard a noise from restroom res was laying on back on floor. Blood was coming from back of head. States back of head hurts a little. able to move upper and lower extremities by self. Res had been sitting in recliner with alarm in place. She took alarm off and got up by herself lost balance and fell on floor. Intervention. Res sent to ER (Emergency Room) for eval."<br><br>R30's Nurses Note, dated 1/31/23 at 10:00 PM, documents, "Called for report re (in reference to): res status. ER nurse state res was admitted with possible UTI and observation from fall."<br><br>R30's QA Progress Notes, dated 2/1/23 at 9:30 AM, documents, "QA committee met and reviewed fall from yesterday afternoon. Res up without assist after removing tab alarm confused and attempting to "wake son up". Res has poor safety awareness d/t (due to) acute illness. Cont ABT (antibiotics) and monitoring. CP (care plan) updated.<br><br>R30's Nurses Note, dated 2/1/23, documents, Res arrived back to facility by facility van. transferred 2 assist. Res has 6 staples in the back L (left) side."<br><br>R30's Nurses Note, dated 2/28/23 at 3:50 PM, documents, "Resident left facility at this time by ambulance."<br><br>R30's Nurses Not, dated 3/1/23 at 12:00 AM, documents, No adverse effects noted r/t previous | S9999 | | |

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| EASTSIDE HEALTH & REHAB CENTER | 1400 EAST WASHINGTON STREET PITTSFIELD, IL 62363 |

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| S9999 | Continued From page 12<br>fall."<br><br>R30's QA Progress Note, dated 3/1/23, documents, QA committee met to review fall from 2/28/23. Resident attempted to transfer self without assist causing fall. Resident sent to ER for eval. Care Plan updated. Resident placed on thirty minute checks x 24 hours once back in facility from ER. Care Plan updated."<br><br>R30's A. I. M. S for wellness, dated 4/6/23 at 6:15 AM, documents, "Res was observed laying on her Rt (right) side on the floor. She slid off the end of her recliner. Res c/o (complaint of) tenderness right knee. Small red area noted to R knee. No difficulties with transfer to wheelchair. Res got up with assist r/t poor safety awareness. 30 minute safety checks initiated x 24 hours."<br><br>R30's QA Committee Note, dated 4/6/23 at 10:00 AM, documents, "QA committee met with therapy to review status addressing neck posturing and feeding."<br><br>On 4/12/23 at 3:15 PM, V1, Administrator, stated that R30 fell the first 2 times because she was acutely ill. V1 stated that R30's son does not like R30 to be out by the nurses station so she could be watched more closely so that is why she was not put out there when she was confused with her UTI. V1 also agreed that there is not a full investigation done on each fall, a root cause analysis completed or progressive interventions put into place."<br><br>The Fall Prevention policy, dated 11/10/18, documents, "To provide for resident safety and to minimize injuries related to falls: decrease falls and still honor each resident's wishes / desires for maximum independence and mobility. Procedure: | S9999 | | |

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| S9999 | Continued From page 13<br>5. Immediately after any resident fall the unit nurse will assess the resident and provide and care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of the fall in the nurse notes or on an AIM for Wellness form along with any new interventions deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nurse Assessment) assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the morning Quality Assurance meeting and any new interventions will be written on the care plan."<br><br>(B)<br><br>State Licensure Violation 3 of 3<br><br>300.1210b)<br>300.1210d)3<br>300.1220b)3)<br>300.3240a)<br>300.3240f)<br><br>300.1210 Section 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 | S9999 | | |

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| S9999 | Continued From page 14<br>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.<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>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.<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. The plan shall be reviewed at least every three months. | S9999 | | |

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| S9999 | Continued From page 15<br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>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. (Section 3-612 of the Act)<br><br>These Regulation were not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to provide supervision to prevent resident to resident aggression, damage of resident property, and invasion of resident rooms for 9 of 9 residents (R9, R19, R32, R40, R41, R43, R44, R47, R55) reviewed for supervision in the sample of 28. This failure resulted in R41 and R44 being fearful of R55 because of his repeated aggressive behaviors and invasion of other residents' rooms.<br><br>Findings include:<br><br>R55's April 2023 Physician Order Sheet documents Vascular Dementia.<br><br>R55's Quarterly Psychosocial Assessment, dated 1/9/23 and 4/5/23, both document a diagnosis of Dementia, his Cognition as severe Impairment/Problem and Behavior to monitor: | S9999 | | |

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| S9999 | Continued From page 16<br>R55 toilets in inappropriate locations, wanders, enters bedrooms uninvited.<br><br>R55's Social Service Progress notes, dated 4/5/23, documents R55 often wanders, goes in and out of other resident rooms, which agitates/upsets residents. He urinates in inappropriate places, on beds, chairs, walls, on floor. He becomes verbally/physically abusive and resistive. At times is not easily redirected. Often sits in recliner at nursing station.<br><br>R55's Nurse Notes, documented the following dates of behaviors:<br>On 1/9/23, R55 is restless, wanders, goes into other resident's rooms, urinates in inappropriate places, will go wherever he wants, wanders most of the night.<br>On 1/16/23, R55 exit seeking, pushing on exit doors.<br>On 2/8/23, R55 continues to frequently be up at night, goes into other resident's rooms which upsets the residents. Has been known to urinate on beds, recliners.<br>On 2/20/23, 2/21/23, 2/22/23, documents wandering around in and out of resident's rooms, one episode, of flushing snacks down the toilet, combative with staff. Another episode, wandering, in and out of resident's rooms, and laying in their beds and eating their snacks, not easily redirected.<br>Another episode on 2/25/23, R55 aggressively hitting staff and aggressive with a visitor.<br>On 3/2/23, R55 "this morning, wondering the halls as usual for this resident, has had aggressive behavior. This evening R55 wandering the facility and in and out of other resident's rooms."<br><br>R55's Care Plan, current review dated 4/6/23, documents, R55 "wanders, goes in and out of | S9999 | | |

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| S9999 | Continued From page 17<br>other residents rooms, goes in and out of bath/shower rooms when others are in there. often urinates inappropriate places, out in the hallway, in trash cans, was noted in another residents room and sat in their recliner voided (urinated), voided on another residents bed." Also documents undated hand written interventions to "seat @ (at) ns (nursing) station, offer snack/drink."<br>Current interventions, dated 2/23/23, for Trazadone (an antidepressant and sedative classification).<br><br>R55's Facility Reported Incident form, dated 2/23/23, documented, on 2/23/23 at 6:21AM, V23, Certified Nurse Aide (CNA), witnessed R55 was standing at the nursing station and R32 was sitting in a recliner at the nursing station when R55 walked over and struck R32 in the side of the head.<br><br>R55's Behavior Tracking Record, dated April 2023, documents diagnosis of Dementia with Targeted Behavior of: Combative, hitting, punching, slapping, pushing. The Goal: Will Cause no harm to self or others. The Interventions: 1:1, remove from area, divert attention, offer drink/snack.<br>It documented this behavior occurrence 10 times on 4/12/23, however, no intervention and outcomes were documented.<br>R55's Second Behavior Tracking log documents Wandering-goes into other residents room, attempts to exit and Third Behavior Tracking, documents, Toilets in inappropriate places, on carpet, on walls, trash cans, in recliners, on beds.<br><br>On 4/11/23 at 1:10PM, V6 and V7, both CNAs, stated when R55 starts going into residents rooms, they redirect back to the recliner at the | S9999 | | |

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| S9999 | Continued From page 18<br>nursing station.<br><br>On 4/12/23 at 9:10AM, V12 and V18, both CNA's, stated they were showering R55 in the shower room, when R55 hit V12 in the chest and V18 in the stomach. They both stated, R55 then calmed down and his shower was completed. They also stated they reported this incident to V22, Licensed Practical Nurse (LPN).<br><br>On 4/12/23 at 2:00PM, V1, Administrator, stated she was not aware of this incident.<br><br>On 4/13/23 at 8:51AM, V22, LPN, stated V12 and V18 reported to her the physical altercation that occurred on 4/12/23 of R55 hitting both CNAs while R55 was getting a shower. V22 stated, "I got side tracked and did not report the incident to (V1, Administrator)."<br><br>On 4/12/23 from 8:45AM through 2:00PM, based on 15 minutes or less observation intervals, R55 was asleep in recliner in front of the nursing station no resident centered activities were provided. At 2:20PM, R55 got up out of the recliner located at nursing station. R55 walked down the hallway towards the dining area. R55 stopped and opened a resident's closed door, stepped in the room, and walked out of the room. There were no staff present in the area during this time.<br><br>On 4/11/23 at 2:05PM, V6, CNA, stated that earlier today, R55 went into R9 and R40's room, which they were not in their rooms at the time, and was witnessed and reported by R44. V6 stated that R55 "peed," in their trash can that is between the two resident's beds. | S9999 | | |

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| S9999 | Continued From page 19<br><br>On 4/12/23 at 1:40PM, R19 stated she saw R55 enter R9's and R40's room, as she can see the room from her recliner. R19 stated R55 was in that room for a while, she activated her call light to alert the nursing staff that R55 was in R9's and R40's room. R19 stated she heard the nurse state that R55 had urinated in their trash can in their room. R19 states, "Please stop him from going into our rooms." R19 stated she was asleep in her recliner, when she woke up from her chair and saw R55 laying in her bed, she yelled for help and now she keeps her door shut to keep R55 from coming into her room.<br><br>On 4/12/23 at 9:15AM, R41 stated R55 came into her room urinated in her dresser drawer that was opened and splattered on her purse that was on the floor in front of the dresser. R41 stated she now shuts her door to keep R55 out from entering her room. R41 states, "I feel scared because he has hit nurses."<br><br>On 4/12/23 at 9:20AM, R44 stated R55 has come in the room and urinated in the trash can that is located at the bedside. R44 also stated R55 has been known to hit staff, so they are scared to agitate him.<br><br>On 4/12/23 at 9:25AM, R43 stated R55 comes in the room, and now R43 has the curtain pulled, which sometimes seems to help with R55 coming into room.<br><br>On 4/12/23 at 8:56AM, R47 states, "he peed in my chair and wall, I keep door shut now because of R55. When I sleep at night in bed, I keep my shoes at the head of my bed, because I have had to throw them at him to get him out of my room, I don't know why we have to put up with his issues." R47 also stated, " I shut my door when I | S9999 | | |

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| S9999 | Continued From page 20<br>go to the dining room to eat, and I sit at a dining room table to where I have clear view of my room."<br><br>On 4/13/23 at 9:10AM, V1, Administrator, stated that 1 on 1 is considered, as needed with R55 and she would expect an intervention to be specific to his behaviors.<br><br>(B) | S9999 | | |