STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004907	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Complaint Investigation 2343283/IL158914	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)3) 300.3210 t) 300.3240 b) 300.3240 e) 300.3240 g) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

Section 300.3240 Abuse and Neglect
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator.
e) 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)
g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to investigate a resident-to-resident altercation, failed to assess a resident after a resident-to-resident altercation, and failed to keep a resident safe from resident-to-resident altercations for 3 of 3 residents (R1, R2 and R4) in a sample of 5. This failure resulted in R2 pulling R4's hair, and R2 pulling R1 halfway out of bed. R1 sustained a bruise on her left lower extremity. Findings include: 1. R2's Undated Face Sheet documents, she was admitted to the facility on 5/6/2022 with diagnoses including depression, dementia with mood disturbance, and anxiety. R2's Minimum Data Set, (MDS), dated 2/20/2023, documents moderately cognitively impaired, behavioral symptom presence & frequency: physical and verbal behavioral symptoms (hitting, kicking, pushing, scratching, grabbing, threatening others, screaming at others and cursing at others) directed toward others occurred daily other behavioral symptoms (physical symptoms such as hitting or scratching self, pacing, rummaging, verbal/vocal symptoms like screaming/disruptive sounds) not directed toward other occurred daily. Behavioral symptoms: no impact on resident or others. Change in behavior or other symptoms resident's current behavior status was documented: worse. R2's Care Plan, dated 3/30/2023, documents, behavioral symptoms: resident exhibiting problems as seen by wandering, verbally abusive,	S9999		

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S9999	Continued From page 3 screaming, making disruptive sounds, grabbing and cursing. Goal: Resident will have behavior improve as seen by decreased episodes of. Approaches: encourage family support and/or involvement, encourage resident to keep involvement in activities of choice, encourage resident to vent feelings/fears/frustrations PRN, (when needed), notify MD, (Physician), as needed, observe involvement in activity, provide meds as ordered and monitor effectiveness, psychiatric consult as needed, 1:1 visits as needed for reassurance, call light within reach while in room, check for pain, observe for changes in appetite/signs of withdrawal/ crying and tearfulness decreases in social interactions and changes in routine. R2's Behavioral Analysis Report, dated 4/6/2023 at 10:43 PM, by V9, Certified Nurse Assistant, (CNA), documented scratched a CNA, pulled R4's hair, and tried to pull R1 out of bed. R2's Resident Progress Notes, dated 4/2023, no resident-to-resident altercations documented. On 4/20/2023 at 11:37 AM, R2 lay in bed with the bed lowest to the floor. R2 was awake and calm at the time of the interview. R2 stated she gets mad at staff and residents from time-to-time because, she's "just crazy in that way." R2 recalled pulling R4's hair while in the dining room one day because R4 "wouldn't shut up." R2 recalled she didn't pull any of R1's hair out, but, she did pull R4's hair, so she would stop talking. R2 denied pulling her roommate, R1, out of bed. Review of the Facility's Resident Room Roster, dated 4/20/2023, documents R1 and R2 are roommates.	S9999		

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S9999	Continued From page 4	S9999		

2. R1's Undated Face Sheet, documents she was admitted to the facility on 7/9/2022, diagnoses include Alzheimer's disease, cognitive communication deficit, need for assistance with personal care and psychosis.

R1's MDS, dated 4/14/2023, documents she is severely cognitively impaired. Delirium symptoms of inattention, disorganized thinking and altered level of consciousness behavior present, fluctuates. No behaviors impact resident or others.

R1's Undated Care Plan doesn't address she is at risk for abuse.

R1's Resident Progress Note, dated 4/6/2023, no progress notes documented regarding R2 pulling R1 out of bed, or if R1 was assessed by a nurse for injury after staff observed R2 pulling on R1's lower extremities, pulling her out of bed.

R1's Resident Progress Noted, dated 4/7/2023 at 2:51 AM, by V21, LPN (Licensed Practical Nurse), documents, "Noted a 4.5 x 2 hematoma to L, (left), calf. No c/o, (complaint of), pain or facial grimacing during assessment. Resting in bed in lowest position. Call light within reach. Will continue to monitor. NP, (Nurse Practitioner), and ADON, (Assistant Director of Nurses), notified. Will have day shift notified POA, (Power of Attorney.)"

On 4/20/2023 at 3:00 PM, R1 was observed sitting in her wheelchair near the dining room. R1 didn't respond to IDPH (Illinois Department of Public Health) surveyor's questions. R1 was not interviewable.

On 4/21/2023 at 11:16 AM, V8, LPN, pulled up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 5	S9999		

R1's left pant leg and measured a bruise on R1's left lower calf 5 centimeters, (cm), by 1.3 cm. V8 stated the bruise was purple and black in color.

3. R4's Undated Face Sheet, documents she was admitted to the facility on 2/15/2022, with diagnoses including dementia, psychotic/mood disturbance and anxiety.

R4's Undated Care Plan documents psychosocial well-being resident at risk of abuse, related to diagnosis of dementia. Goal: resident will remain abuse free until next review. Approaches: all staff to monitor resident for signs and symptoms of abuse.

R4's Resident Progress Note, dated 4/6/2023, no progress notes documented regarding R2 pulling R4's hair.

R4's MDS, dated 2/21/2023, documents she is moderately cognitively impaired and has verbal behavioral symptoms, (hitting, kicking, pushing, scratching and grabbing), directed towards others 1 to 3 days. Behavioral symptoms: no impact on resident or others. Change in behavior or other symptoms: same.

On 4/20/2023 at 3:30 PM, R4 was observed sitting in her wheelchair near the dining room. R4 didn't respond to IDPH surveyor's questions. R4 was not interviewable.

On 4/20/2023 at 10:30 AM, V1, Administrator, stated they had two residents get into an altercation over Bingo card a few weeks ago, but there hadn't been any other resident-to-resident altercations in April 2023 that she was aware of.

On 4/20/2023 at 12:06 PM, V2, Director of

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S9999	Continued From page 6 Nursing (DON), stated, "2 residents had an altercation in the activity room over a card game a few weeks ago, but there hasn't been any other resident to resident altercations other than that incident. No residents have a history of being physically aggressive with other residents at the facility." The Facility's Daily Staffing Sheet, dated 4/6/2023, documented V10, CNA (Certified Nursing Assistant), was assigned to 200 hall evening shift which included R1, R2 and R4. On 4/20/2023 at 3:02 PM, V10, CNA, stated she works evening shift from 2:30 PM to 10:30 PM at the facility, and is often assigned to R2. R2 has behaviors and yells at her roommate, R1, often and makes her cry. One evening a few weeks ago, V10 recalled she was assigned to R2 and R2 was "out of sorts." "R2 always yells at staff and residents, especially her roommate (R1) but, this evening R2 was really agitated." V10 attempted to sit with R2 that shift, but she had to take care of other residents as well. At one point, she went to check on R2, and found her pulling R4's hair while R4 lay in bed. V10 redirected R2 at that time, and recalled R4 stated, "I think she thought I wore a wig!" V10 propelled R2 to the 200-hall nurse's station and went to assist other residents. A few minutes later, she witnessed R2 pulling her roommate, (R1), halfway out of bed. R1 was yelling, "Stop! Stop! Stop!" V10 ran into the room and redirected R2 from pulling on R1's lower extremities. V10 stated, she reported R2's behaviors to V14, LPN, but she didn't see her go down and check the residents. V10 stated after she redirected R2, she noted a large dark purple bruise on R1's left lower extremity, calf area. V10 stated for some reason she couldn't document resident behaviors in the computer that night, so	S9999		

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S9999	Continued From page 7	S9999		

when midnight shift got there, she asked another CNA, (name unknown), to document the incident in CNA charting. V10 stated she was upset this incident occurred because no one did anything about R2 yelling at R1 prior to the incident, and R1 has dementia and can't speak up for herself, but she doesn't serve to be yelled at and hurt by R2.

On 4/20/2023 at 1:46 PM, V9, CNA, stated she works midnight shift at the facility from 10:30 PM to 7:00 AM. V9 stated about a week ago, she received CNA report from V10, CNA, and V10 told her R2 thought R4 was wearing a wig and pulled R4's hair. The same evening R2 pulled her roommate, (R1), out of bed, causing a bruise to R1's left lower leg. V9 stated R2 has aggressive behaviors and yells at residents all the time. V9 stated she reported R2's behavior to an agency nurse, (name unknown), but didn't think anything was done about it because, R1 and R2 are still roommates. V9 stated she documented the incident in the CNA charting for V10 because she is an agency CNA and doesn't have computer access. Although she didn't witness the incident, she documented it for V10.

The Facility's Daily Staffing Sheet, dated 4/6/2023, V14, LPN, was assigned to 200 hall evening shift, which included R1, R2 and R4.

On 4/20/2023 at 3:30 PM, V14, LPN, stated she works evening shift from 2:00 PM to 11:00 PM at the facility, and is often assigned to R2. R2 has a lot of behaviors including yelling at staff and residents. V14 witnessed R2 yelling and degrading R1 often and stated, they "bicker a lot." No staff reported R2 pulled R4's hair, or that R2 pulled R1 out of bed. "If staff reported that incident, I would have assessed all resident

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S9999	Continued From page 8	S9999		

involved and documented the incident in the nurse's notes." V14 never witnessed R2 be physical with other residents.

The Facility's Daily Staffing Sheet, dated 4/6/2023, documents V3, Assistant Director of Nursing, (ADON), was clinical on-call.

On 4/21/2023 at 11:00 AM V3, ADON stated no one reported R2 pulled R4's hair or R2 pulled R1 out of bed. It was V3's understanding the bruise on R2's left lower extremity was identified on 4/7/2023, and it was from her wheelchair. "When there is a resident-to-resident altercation staff are expected to call the clinical on-call to let them know what occurred to ensure an investigation is started immediately if needed."

On 4/21/2023 at 11:25 AM, V2, DON stated, "When a new bruise was assessed, I expect staff who initially see the bruise to report it to a nurse. When staff observe a resident-to-resident altercation, staff should immediately separate the residents and ensure they are safe, then notify the charge nurse. The charge nurse is responsible for opening an event and documenting what occurred. The charge nurse should assess all residents involved in the altercation for injuries immediately, so they know the residents are ok. The charge nurse is expected to document the incident in all involved residents' medical records what exactly occurred and if any injuries were sustained. The charge nurse should call (V1, Administrator) and (V3, ADON), and if there is an injury the charge nurse should notify the provider of the resident that got injured. CNAs document resident behavior in the computer but, it is all check off, CNAs can't type free text notes in the computer." V2 read R2's Behavior Analysis Report, dated 4/6/2023, and

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S9999	Continued From page 9	S9999		

stated she wasn't aware R2 pulled R4's hair or that R2 pulled R1 out of bed. It was V2's understanding the bruise on R1's left lower extremity came from her footrest, but it could have been from R2 pulling on her, that is why she expects the charge nurse to assess residents after an altercation, to ensure there are no injuries sustained. V2 expected the charge nurse to obtain written statements from staff regarding what occurred because, resident to resident incidents is considered abuse and she wants to ensure staff are protecting the residents. V2 stated, she expects staff to follow the facility's abuse policy and procedure.

On 4/21/2023 at 12:00 PM, V1 stated no one reported R2 pulled R4's hair, or that R2 pulled R1 out of bed. V1 stated staff should have notified the charge nurse and the charge nurse should have assessed all residents involved for injury and notified herself, V2, and V3, and an investigation should have been started immediately.

On 4/21/2023 at 2:10 PM, V22, Family Nurse Practitioner, stated, "(R2) has physical and verbal behaviors, and she is followed by a psychiatrist. (R2) has advanced dementia and grabs, hit and yells at staff and residents. Approximately 2 weeks ago a nurse, (name unknown), reported to her that (R2) grabbed (R1's) leg and (R1) sustained a bruise." V22 stated, "The facility staff knew about it because a nurse told me about it; I assumed it was investigated. " V22 stated she wasn't told R2 attempted to pull R1 out of bed, or R2 pulled R4's hair; she would have notified R2's psychiatrist because she can't do anything else for R2 other than to drug her, and that could cause R2 to fall. V22 expected facility staff to follow the abuse policy and investigate the

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S9999	Continued From page 10	S9999		

resident-to-resident altercation when it occurred. The CNA should have reported the incident to the charge nurse, who should have assessed all residents immediately and documented in each resident's medical record what occurred and if any injuries were sustained.

The Facility's Abuse Prevention Program, revised 9/29/2022, documents employees are required to report any incident, allegation or suspicion of potential abuse they observe, hear about or suspect immediately to the administrator. Upon learning of the report, the administrator shall initiate an incident investigation. The nursing staff is additionally responsible for reporting on facility incident report the appearance of suspicious bruises. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing documentation, and reporting to the administrator. If the resident complains of physical injuries, or if resident harm is suspected, the resident's physician will be contacted for further instructions. The facility will take steps to prevent further potential abuse while the investigation is in progress and will immediately take appropriate steps to remediate the non-compliance and protect residents from additional abuse. Residents who allegedly mistreated another resident will be removed from the situation and will have limited contact with the targeted individual during the course of investigation. The accused resident's condition shall be immediately evaluated to determine most suitable therapy, care approaches and placement, considering his/her safety, as well as the safety of other residents and employees of the facility. Any willful action that results in physical injury, mental anguish or pain must be reported. Internal investigation of abuse: all incidents will be documented, whether or not

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S9999	Continued From page 11 abuse occurred, was alleged or suspected. Any incidents or allegation involving abuse will result in an abuse investigation. Any other incident or pattern involving "reasonable cause to suspect abuse," will result in an abuse investigation. The facility shall immediately contact local law enforcement authorities in the following situations: physical abuse involving physical injury inflicted on a resident by another resident. (B)	S9999		