STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING _____ B. WING _____	06/30/2023

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BRIA OF ALTON	3523 WICKENHAUSER ALTON, IL 62002

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S 000	Initial Comments Complaint Investigation: 2345183/IL161250 Investigation of Facility Reported Incident of 06-08-2023/IL160756 Investigation of Facility Reported Incident of 05-09-2023/IL160894	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.610a) 300.1210b) 300.1210d)6) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free from sexual, physical, and verbal abuse for 2 of 3 residents (R2 and R7) reviewed for abuse in the sample of 12. This failure resulted in R9 assaulting R7 when R7 denied R9 sex. R7 received abrasions to her face and has memories which cause her fear and anxiousness related to this incident. Findings include: 1. R7's June 2023 Physician Order Sheet (POS) documents R7 has diagnoses of schizophrenia, heart failure, major depression, insomnia, need for assistance with personal care and chronic pain. R7's Minimum Data Set (MDS) dated 4/7/2023 document R7 as moderately impaired for cognition. R7's MDS documents R7 uses a	S9999		

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S9999	Continued From page 2 wheelchair and is not steady but able to stabilize without staff assistance for moving to seated to standing position, walking, moving on and off toilet. For surface to surface (transfer between bed and chair or wheelchair, and turning around) R7 is not steady, only able to stabilize with staff assistance. R9's June 2023 POS documents R9 has diagnose of schizophrenia, bipolar disorder, and legal blindness. R7's Facility-Reported Incident Form, Initial Report, dated 5/9/23, documented there was an allegation of sexual abuse with R7 being the alleged victim. This form did not document there was an allegation of physical abuse. The Report documented R9 as the alleged perpetrator. There was no description of the incident. The Report documented the incident occurred in R7's room and police were notified. The Report documented "residents separated, placing alleged perpetrator on enhanced supervision, providing psychosocial support to alleged victim." R7's Facility-report Incident Form, Follow-up Investigation Report, with date of Incident as 5/9/2023, documents "Alleged victim (R7) reports she was reclining in her chair, reading a book when the alleged perpetrator (R9) knocked on her door. R9 alleged perpetrator identified himself when she asked who was there. R7 alleged victim states she allowed alleged perpetrator in, he shut the door. She asked him why he shut the door and he stated he wanted to talk to her, she sat back into her recliner, alleged perpetrator approached her stating he wanted sex, she pushed her call light and started yelling for help, at that time, the alleged perpetrator put his hand over her mouth pressing against her glasses.	S9999		

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S9999	Continued From page 3 Staff came in the room and took him out." The Report documented "Resident states she was 'shaken up' and doesn't want to see or speak to the resident again." The Report documented "Witnesses report hearing resident scream, upon staff member entering room from next door, alleged perpetrator was standing over alleged victim with 'his hand over her face, and he struck her a couple times." The Report documents "Upon conclusion of thorough investigation, the facility can not substantiate allegation of sexual abuse. The rapid response of the staff to the call light/resident screaming prevented the alleged perpetrator from carrying out actions related to his stated desire of 'having sex.' R7 alleged victim denies that resident (R9) touched her in any sexual manner." (BIMS/Brief Interview for Mental Status score of 10, good historian) she (R7) denies he (R9) struck her. R9 alleged perpetrator has been discharged from facility, no plan to return to the facility. Based on resident interview, staff interview, record review resident observation no sexual abuse occurred." This Report did not address that R9 struck R7 a couple of times. On 6/13/2023 at 2:02 PM, R7 stated, "(R9) lived here and he was blind, and he has a cane. I heard a knock at my door, and it was (R9). He said, 'I need to talk to you,' and then he closed the door. I said 'hi, why did you close the door?' and he said, 'I want to have sex with you,' and I said, 'oh no you are not!' and he said, 'Oh yes I am,' and he came over and put his hand over my mouth to keep me from yelling and I turned my head and started screaming really loud. He began pushing my glasses into my face and nose and he was really hurting me. He is no longer here but I still get so upset just thinking about it scared me so much! He did hurt me, but he did not get what he wanted. I feel sick to my stomach	S9999		

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S9999	Continued From page 4 just talking about it, it was awful!" R7's Statement dated 5/9/2023 documents, "Resident states that she was in chair, reclined back reading her book. Heard knock and asked who it was (R9) was there, he stated, that he needed to talk with her. He came in and shut the door and (R7) asked why he shut the door and (R9) approached stated he wanted sex. She stated that (R9) put his whole palm across his face and pressing as hard as he could against her face and was pressing as hard as he could against her face and glasses, and she began screaming as loud as she could and then staff came running and separated (R9) away from (R7). (R7) states she is okay but shaken up from it. She does not feel safe around (R9). States doesn't want to see or talk to him again." A statement from V11, Licensed Practical Nurse (LPN) dated 5/9/2023 documented, "I was sitting at the nurse's station when the CNA (Certified Nursing Assistant) came to report that she heard (R7) screaming and when she walked into the room (R9) had his hand over (R7's) mouth and hitting her in her face." A statement from V9, CNA, dated 5/9/2023 documents, "(R9) was standing over (R7) with his hand over her face then he struck her face a couple of times, and I ran in and grabbed him and directed him to his room and told the nurse and supervisor." On 6/14/2023 at 9:12 AM, V9, stated, "I remember that day. I was in another room close to (R7's) room laying a patient down when I heard (R7) screaming. That was not like her to scream so I ran into her room, and I saw (R9) standing over her and (R9) was hitting her in the face and	S9999		

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S9999	Continued From page 5	S9999		

she was covering her face with both of her hands. She was crying and upset, and I immediately separated the two and grabbed (R9) and contacted my supervisor on duty and the nurse. (R9) was not wanting to be redirected and leave and we called the police. I eventually got (R9) back to his room. (R7) told me that (R9) had come into her room and shut the door and (R9) told her he wanted to f*** her and she was very upset and crying and told me 'No' he was not. She said he put his hand over her mouth so he could stop her screams and she was shaking. I know she was upset, and angry afterwards. She has calmed down now but she gets nervous with male staff/visitors and is fearful of males even today when they are entering her room and/or with her door being closed. I know she will always remember it."

On 6/14/2023 at 3:22 PM, V18, Licensed Practical Nurse (LPN) stated, "The CNA (V9) came and got me and told me (R9) had to be pulled off of (R7) because he had went into (R7's) room and he had his hand over her mouth and he was hitting her with his other hand in her face/head area. (R9) had already been removed from (R7's) room and when I went into (R9's) room (R9) was j****** off and had his penis in his hand. When I went to check on (R7) she was hysterical, she was crying and upset. (R7) said (R9) told her he was going to have sex with her, so she started screaming and then he put his hands over her mouth. When the police came and started asking him questions (R9) kept acting like he had not done anything, but he was caught hitting (R7) in the face."

A statement from V10, CNA Supervisor stated, "Was at nursing station going over paperwork. I heard a loud noise and ran towards the sound

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S9999	Continued From page 6 upon entering. Nurse has female resident's statement on file." R7's Questions by the Facility dated 5/10/2023 from (R7) documents, "Have you ever had any negative experiences with another resident in the facility?" R7 replied, "No". "Do you feel safe?" R7 responded, "I don't know, I am scared." "Are you afraid of any Resident in the Facility?" R7 responded "Yes, (R9)." R7's Psychology Diagnostic Assessment dated 5/11/2023. "Case Conceptualization: "Met with resident to review the referral for counseling services. Resident appears anxious, has need for order in her environment and with her clothing. Resident voluntarily recalled the incident with the other resident this week and has some continued anxiety related to being in her room alone." R7's Police Report documents, "On 05/09/2023 at approximately 6:23 PM, hours, I was dispatched to (Facility) in reference to a report of a PATIENT-ON-PATIENT BATTERY. It should be noted that through prior police experiences, I am aware that (Facility) is a living facility for individuals with mental and/or physical disabilities. I arrived on scene and contacted employee, (V18, Licensed Practical Nurse/LPN), who reported a male patient, (R9), battered a female patient, (R7), after she refused to have sexual intercourse with him. (V18) advised a coworker, (V9), had witnessed the battery. I contacted (V9), who stated she had heard (R7) yelling for help from her (R7's) room. (V9) stated the door to (R7's) room was closed and when she opened it, she observed (R9) holding his hand over (R7's) mouth and hitting her in the face. (V9) was unable to describe the strikes, but stated she separated (R7) and (R9) and placed (R9) back in	S9999		

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S9999	Continued From page 7	S9999		

his own room. It should be noted that (R7) does not move well without assistance and mostly sits in a chair or her bed. It should also be noted that (R9) is blind, bi-polar and utilizes a wheelchair. I contacted (R7). (R7) was actively shaking and crying, stating that she was scared. (R7) stated she was sitting in her room with the door open, watching television. (R7) stated (R9) entered the room and immediately shut the door. (R7) stated she asked (R9) what he wanted; at which time he said something similar to "Will you have sex with me?" (R7) stated she told (R9) "No". (R7) stated (R9) then approached her and attempted to grab her. (R7) stated she began to yell for help at which time (R9) placed his hand over her mouth and "hit" her. (R7) was unable to describe the strikes. (R7) stated a nurse then entered her room and removed (R9). I observed (R7) to have a small abrasion, approximately the size of a fingernail, in the center of her left cheek. (R7) refused medical treatment, but repeatedly stated she was very scared and did not want (R9) to come back. I utilized a departmental issued camera to photograph (R7), and the photographs were later downloaded and attached to this case. (R7) was advised on how to obtain an order of protection. (R7) stated she was desirous of criminal charges against (R9). I allowed (R7) to sign a departmental agree to prosecute form. The form was later downloaded and attached to this case." Signed by V19, Officer/Sergeant of Local Police.

The Resident Right Policy with a revision date 11/2018 documents, "You must not be abused, neglected, or exploited by anyone financially, physically, verbally, mentally or sexually."

2. R2's Facility-Reported Incident Form Initial Report, undated document, "(V18), LPN

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S9999	Continued From page 8 (Licensed Practical Nurse) contacted (V1), Administrator, at 8:41 AM on 4/22/2023 that (R2) was in the dining room and requested for more milk for his cereal from Dietary Worker (V21). (V21) asked (R2) to say "please," and (R2) got upset. (V21) made a statement to (R2) that was witnessed by (V18)." R2's "Facility-Reported Incident Form Follow-Up Investigation Report", undated, documents, "(V18), LPN, contacted (V1), Administrator, at 8:41 AM on 4/22/2023 that (R2) was in the dining room and requested for more milk for his cereal from (V21). (V21) asked (R2) to say "please" and (R2) got upset. (V21) was immediately sent home pending the outcome of investigation. MD (Medical Doctor)/POA (Power of Attorney) notified. Police contacted." "Staff noted that (V21) stated to (R2) to say please when asking for milk. (R2) cursed at (V21) and (V21) responded in an unprofessional manner towards (R2)." The Report documented "Staff interviewers conducted and stated that (V21) did react to (R2) in an unprofessional manner." V23's Hand-Written Statement dated 4/22/23 documents, "I was sitting at the desk on when I heard yelling from the dining room. I walked in and (R2) and kitchen worker (V21) was yelling at each other. I immediately told (R2) to go to his room. He stayed and (V21) came back out the kitchen and they started yelling and threatening each other. They both said they was gonna beat each other's a**. While these two continued yelling and threatening each other I ushered (R2) out the dining room and another kitchen worker kept (V21) away. After getting back to the hall (R2) told us this all started over him asking for a glass of milk for his cereal."	S9999		

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R2's Nurse's Note written by V18, dated 4/22/23 at 11:09 AM, documents, "It was reported to this nurse by another resident that this resident asked for a glass of milk and was told to please say please, and this resident got upset and said he didn't have to say pleas [sic] and then he walked off and went to his room, this nurse went to asked this resident what had happened and he stated 'Nothing happened, I asked for another glass of milk to eat my bowl of cereal with and was told I needed to say please, I'm not going to say please when it comes to eating my cereal with and was told I needed to say please, I'm not going to say please when it comes to me eating my food so I got upset and to keep me from going off I got up and left and went back to my room.'"

On 6/14/23 at 3:18 PM, V18, stated, "From what I remember, (R2) wanted extra food and they told him to say "please" to be nicer. One of them said, "Meet me outside," and (R2) said that didn't happen and was told to leave the dining room after he threw his food on the floor. I was not in the room at the time it happened."

On 6/15/23 at 1:46 PM, V23, Certified Nursing Assistant (CNA), stated, "I was working down the hall when I heard yelling coming from the dining room. When I got down there (R2) was yelling at (V21), and (V21) was yelling back. (R2) was calling (V21) names and was upset about milk. (V21) was threatening to "beat his a**" because he was being so rude. (R2) was my patient, so I took him out of the dining room."

R12's Witness Statement dated 4/22/23 documents, "All I know is (R2) wanted some milk, he got up to get it his self and a CNA (Certified Nursing Assistant) told him he couldn't get his own milk. Then (R2) told (V21) he was going to

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S9999	Continued From page 10 beat his a**. Then (V21) said he was going to beat his a** back. I feel safe around the kitchen workers." On 6/14/23 at 3:54 PM, R12 stated, "Both (R2) and (V21) were saying bad words to each other in the dining room. Both were talking about hitting one another and calling each other 'b******'. It was all over a thing of milk." (B) Statement of Licensure Violations 2 of 3: 300.610a) 300.620h) 300.1210a) 300.1210b) 300.1210d)2) 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 300.620 Admission, Retention and Discharge Policies h) If a resident insists on being discharged and is discharged against medical advice, the facts involved in the situation shall be fully	S9999		

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S9999	Continued From page 11 documented in the resident's clinical record. 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 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: 2) All treatments and procedures shall be administered as ordered by the physician.	S9999		

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S9999	Continued From page 12 These Regulations are not met as evidenced by: Based on interview and record review the Facility failed to develop and implement a safe discharge plan to meet resident's needs including identifying the capability of home caregiver and need for resident equipment for 1 of 5 residents (R13) reviewed for discharge planning in the sample of 17. This failure resulted in R13, who had dementia with aggression, being sent home to V26, R13's wife, who did not have the physical capability to care for R13 and meet his needs. This caused V26 fear and stress. Finding include: R13's Hospital Admission Diagnoses with an encounter date of 2/27/2023 at 7:18 PM, document diagnoses of aggressive behavior, dementia, dementia with agitation, dementia with behavioral disturbances. R13's Hospital Records also document a Computerized Tomography was performed on 2/27/2023 at 4:40 PM and document, history, "worsening dementia." R13's Hospital Discharge Records dated 2/27/2023 documents, "Per wife patient's dementia is progressively worsening since past couple of months and becoming more aggressive and agitated. Patient went to primary care physician office who recommended to go to the Emergency Room to have MRI (Medical Imaging Technique) brain and further work up." R13's Face sheet document he was admitted to the facility on 3/7/2023. The Face Sheet documented R2's home as a city being located 84 miles away from the facility.	S9999		

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	IL6002778	A. BUILDING _____ B. WING _____	06/30/2023

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S9999	Continued From page 13 R13's Care Plan Meeting Quarterly Report dated 3/17/2023 documents, "Moderate protein-calorie malnutrition, type 2 diabetes mellitus without complications, and difficulty in walking, not elsewhere classified. Patient and Family Goals: To move to a LTC (Long Term Care) facility closer to family. Alert with confusion. Compliant with care and medications. Skin intact. Needs supervision with cues for ADLs (Activities of daily living)." R13's Care Plan addressing Activity of Daily Living document, "Resident requires assist with daily care needs related to dementia." Date initiated 3/8/2023. Mechanical lift with 2 staff assists for transfers. Discharge Planning: "The resident and guardian express the desire for the resident to continue with long term care placement. Resident and wife express desire for placement in (different town) to be closer to family after his therapy is completed." Date initiated 5/4/2023. R13's Daily Skilled Nursing Note dated 5/8/2023 at 1:24 PM, "Resident alert with confusion, he is independent with his ADL's (Activities of Daily Living). Ambulates with a slow steady gait. Anxious about going home. Cooperative with care. He is able to make needs known. Denies pain when asked." R13's June 2023 Physician Order Sheet documents R13 has diagnoses of difficulty in walking. Type 2 diabetes; cognitive communication deficit; problems related to care; unspecified schizoaffective disorder; and unspecified dementia. R13's Transfer/Discharge Report dated 6/22/2023 at 10:10 AM, "private home/apartment, with no home health services. Home."	S9999		

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S9999	Continued From page 14 R13's Minimum Data Set Discharge Assessment dated 6/22/2023 documents R13 has memory problems and has modified independence for decision making of activities of daily living. R13's Progress Notes dated 6/22/2023 at 10:10 AM, "Note Text: resident discharged home via facility transportation. Resident was sent home with discharged paperwork and medication, no narcotics sent with resident. Resident verbalized understanding of discharged instructions." R13's Social Service Notes dated 6/22/2023 at 12:51 PM, "Resident was discharged home. Called resident's wife to let them know that they are on their way because wife stated she did not have transportation to pick resident up from facility. Resident's wife okay with discharge and stated where to have resident dropped off with belongings. Social Service Director received a call from resident's primary from Springfield and they asked why resident was discharged. Doctor (facility) ordered discharge since resident was adamant about going home." On 6/27/2023 at 12:44 PM, V3, Assistant Director of Nursing stated, "(R13) was discharged home because he wanted to go home, it was his choice." On 6/27/2023 at 2:32 PM, V26, wife of R13 stated, "I got a call from (Facility), and they told me (R13) no longer wanted to be in the facility and they could not hold him against his will. The girl on the phone told me we owed them money and the girl on the phone told me she would lose her job if I didn't accept (R13) back in the house. They did not provide me with any assistance or help or any notice. They just dumped him off with two or three days of his medication. I am 81 years	S9999		

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old, and I have cancer. My doctor (V27, Primary Physician at home for R13) told me he was against (R13) coming home and it was unsafe and said he would call the (Facility). (V27) told me he told them he did not think it was a good idea because I am not able to take care of (R13) and it was not safe. That was back in May, but I don't remember the date. Some days I can barely get out of bed, and I am having issues just taking care of myself. (R13) needs meals and food. It has been such a hardship for me. Plus (R13) is a good Christian man, and before his dementia he would never hurt me, but he is real active at night and he has broken two of my fingers and broke my eardrum. He becomes violent at times and hurts me. I just can't handle him but what am I supposed to do with him as he is my husband, and he does not know what he is doing. I can't take care of him, and they sent him back for me to take care of him."

On 6/27/2023 at 3:24 PM V27, Community Primary Care Physician stated, "(R13) has advanced dementia and he is verbally and physically abusive with his wife. That is one of the main reasons he went into the nursing home to begin with. He was abusive to his wife before he went into the home. (R13) is about five foot six inches and his wife is only four foot eleven inches. It is not a good situation for either of them because she has some health issues and is not able to take care of (R13). (R13) is a mechanical lift and the wife is not able to take care of him. It is a bad situation all over. I sent a letter to the facility recommending that they keep (R13) but they ignored my recommendations and sent (R13) home anyway. I can provide a copy of the letter to you."

Communication letter to facility starting 5/8/2023

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S9999	Continued From page 16 at 12:18 PM, documents, "Caller states they were discussing discharge plan for patient and states that (V27, Primary Home Physician) had placed an order for (R13) to not return home. Caller states that if there is an order that states that, they are needing a copy faxed over to them." Communication dated 5/10/2023 at 12:41 PM, "It is not an order. The patient cannot take care of himself due to dementia and his wife cannot take care of him. It is unsafe for him to return to his home for the same." Communication dated 5/10/2023 at 12:46 PM, "Spoke with (V4, Social Service Director), request for the statement to be faxed to them, as they do not have anything in their chart stating that. Communication dated 5/10/2023 at 12:48 PM, "Faxed as requested." On 6/28/2023 at 1:32 PM, V4, Social Service Director stated, "(R13) had expressed that he wanted to go home. His wife was apprehensive at first, but I told her we could not keep (R13) against his will, and we discharged him home. His primary physician contacted us regarding him discharging but he did not give us an order that we could not discharge him and (V17), our Medical Director gave us the okay." On 6/28/2023 at 1:45 PM, V28, On Call Physician for V17, Medical Director stated, "If a resident has a diagnosis of dementia and has some confusion, we normally do not discharge them back to their home. V17 stated with dementia they have a high risk for self- awareness, safety awareness, elopement risk, just overall lots of risks especially in their moments of confusion. It will all depend on if the resident is able to make safe decisions and their awareness at the time." On 6/30/2023 at 9:01 AM, V4, Social Service Director stated, "I thought because (R13) wanted	S9999		

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S9999	Continued From page 17 to go home and he was somewhat intact then we could send him home. I was aware of his diagnosis of dementia, but I think there was an issue with his wife not wanting to pay the bill, so we sent him home." On 6/30/2023 at 9:05 AM, V29, Business Office Manager stated, "I wanted to talk to you about (R13). I think we are getting a tag but see I talked with the wife, and she did not want to pay us, and she owed us money, so we discharged him. I did not know what else to do and she did not want to lose her income, so we discharged him. I did not document anything in his chart and no we did not issue him or start an involuntary discharge." The Discharge Policy dated June 2015 documents, "Discharge potential is assessed by Social Services on admission. When the IDT, (interdisciplinary team) in conjunction with the resident/patient and family determine that a resident/patient is ready to be discharged, the physician is contacted for an order. Social Services will meet with the resident/patient and/or family to set up outside services and equipment. A Discharge Instruction Form is initiated by Social Services or Discharge Planner and finished by the IDT." The Facility Contract dated 3/14/2023 documents, "Facility reserves the authority to determine and make all arrangements regarding residency, including admission and discharge of the Resident and other Residents and adjustments in rates and accommodations consistent with law and Facility's policies. The right to a minimum of 30-day notice of an involuntary residency termination, except where the resident poses a threat to himself or others, or in other emergency situations, and the right to	S9999		

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S9999	Continued From page 18 appeal such termination." (B) Statement of Licensure Violations 3 of 3: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 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 allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999		

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S9999	Continued From page 19 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: 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 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.	S9999		

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S9999	Continued From page 20 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. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to provide person-centered behavioral health services for residents with substance use disorders for 3 of 4 residents (R1, R2, and R4) reviewed for behavior services in the sample of 12. This failure resulted in R2 using drugs and alcohol, found unresponsive and emergency services called. Findings include: 1. R2's Face Sheet, undated, provided by the facility document he was admitted to the facility on 11/22/2022. R2's Hospital History and Physical, dated 4/11/22, documented R2 has Polysubstance Abuse but stated he had been sober for 3 years. The Hospital record continued to document R2 urine toxicity screen was positive for amphetamines and opioids. R2's June 2023 Physician's Order Sheet (POS) document R2 has diagnoses of bipolar disorder, unspecified psychosis not due to a substance or known physiological condition, current episode manic severe with psychotic features, generalized anxiety and depression, asymptomatic human	S9999		

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S9999	Continued From page 21 immunodeficiency virus (HIV infection status), and other psychoactive substance abuse, uncomplicated, and chronic viral hepatitis c. On 6/13/2023 at 10:02 AM, V7, Regional Vice President stated, "We admitted (R2) for enteritis (inflammation of the small intestine). R2's Minimum Data Set dated 4/2/2023 document he is cognitively intact for decision making and needs staff assistance of one staff with bed mobility and walking in the room. R2's Care Plan last reviewed 4/19/23 documents, "Smoking: Resident uses tobacco products and is at risk for complications." The Care Plan documented "The resident has a history of substance abuse/chemical dependency." R2's care plan did not contain a resident centered SUD (substance abuse disorder), goals and or interventions or how the facility would address R2's substance abuse issues. The Care Plan documented "Resident demands to go to ER (Emergency Room) due to various reasons in order to receive narcotic pain medications." R2's Behavior Tracking, dated 4/6/23 at 11:40 AM, document, "cursing, entering rooms, rummaging, agitated, worse with redirection, better with re-approach. R2 accusing, cursing, screaming, agitated, worse with redirection. Physical aggression, cursing at others, entering rooms, throwing/smearing food, agitated, worse with redirection. 5/31/23: elopement, exit seeking, no intervention documented. R2's Progress Notes dated 5/12/2023 at 11:11 AM, "Writer called to dining room by staff to assess resident related to resident head bobbing slurred speech and diaphoresis. Resident upon	S9999		

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initial assessment slow to respond to verbal and tactile stimuli. Resident pale and sweating profusely. Writer questioned resident if he ingested any medications or substances related to resident's presentation. Resident states he only took prescribed medications. Staff and writer concerned that resident may have taken something causing his presentation, so writer gave resident Narcan x(times) 2 via nasal inhalation with little effect noted. Resident attempted to drink nasal Narcan and had to be redirected. 911 dispatched by other staff prior to nasal administration. Resident informed of 911 being called and providers on way and resident became verbally abusive towards staff and other residents and wheeled himself to outdoor smoking area with other nursing staff following to maintain resident safety. Writer followed resident outside to smoking area where resident continued to be verbally abusive toward staff. Resident states he will not go to ER (Emergency Room). First responders arrived and after assessing resident and resident's refusal to go to emergency room responders attempted to have resident sign AMA (Against Medical Advice) which resident refused to sign. Resident more alert and speaking in full sentences. Vs WNL (Vital Signs within normal limits) and resident remains angry with staff for giving Narcan and calling 911."

R2's Progress Notes dated 5/26/2023 at 9:00 AM, documents, "Resident took morning medications as ordered as well as PRN (as needed) pain medication per request. Resident informed this nurse that he would be signing out for the day and going to (Superstore) with his roommate and friend. Resident declined to take medications with him. Education provided on the importance of timely medication administration without success. Resident stated he would be fine. Resident

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signed both LOA (Leave of Absence Book) books and left facility with personal cane."

R2's Progress Notes dated 5/26/2023 at 7:14 PM, documented "Received call from ADON (Assistant Director of Nursing) who reported that resident was seen at (Nearby Superstore) and was not acting his usual self, he seemed off per report. Resident had not arrived back to facility as of this time. Call placed to non-emergent police and spoke with dispatcher for a welfare check.

5:14 PM call placed to (V24, Physician) with update on resident situation. 5:22 PM this writer received a call from (V25, Officer) with reports that he had seen resident earlier this afternoon because resident had been accused of stealing money from his roommate's friend who he left the building with. The lady involved did not press charges at this time.

5:30 PM. This writer was leaving work and noticed a male laying on the grass at the school. Upon closer inspection it was (R2). He was unresponsive to this nurse. I called his name and nudged his legs multiple times with no reaction. 911 was called. Upon EMS (Emergency Medical Assistant) arrival resident was starting to become alert. He refused to go to hospital for evaluation. He stated he smoked some weed and a couple hits of the hard stuff. Resident returned to the facility per staff car. (V24) notified and no new orders received."

R2's Progress Notes dated 5/31/2023 at 12:12 PM, documents, "Resident noted to have vomit on floor next to bed. When this writer asked resident if he got sick resident stated, 'No I spilled something.' Resident noted to have empty alcohol container next to bed called 'Death Punch'. This

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S9999	Continued From page 24 writer discarded container and educated resident against drinking with current medications. Resident denies can being his and states he does not drink. Attempted to notify MD (Medical Doctor) awaiting response." R2's Progress Notes dated 6/1/2023 at 11:05 AM, document, "Call placed to (V24, Physician) who is on call for (V27, Medical Director). Update given on meeting with Ombudsman and decision to issue a 30-day involuntary discharge. (V24) is in agreement that resident does not belong in skilled nursing facility." R2's Social Service Note dated 6/1/2023 at 11:01 AM, documents, "(R2) was issued an emergency involuntary discharge with the bed hold policy. Resident is currently here in facility. Facility will assist with finding alternative placement if needed. IDPH and Ombudsman was notified." R2's Social Service Note dated 6/1/2023 at 11:05 AM, documents, "Held a care plan meeting for resident with ombudsman SSD (Social Service Director), Administrator, and stated to resident that there have been multiple verbal altercations, physical aggression with both staff and other residents, non-compliance with care and regulations and policy procedures of facility. There have also been multiple incidents related to possible drug/illegal substance abuse. Care plan held to review multiple and continuous behaviors, he is no longer safe at this facility, and will require alternate placement." R2's Progress Note, dated 6/5/23, documented R2 requested to go to ER due to shortness of breath. The Note documented that at that time, R2 stated that he was going to the hospital, and he would not be returning to the facility.	S9999		

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S9999	Continued From page 25 R2's Progress note, dated 6/5/23 at 9:00 AM documented that local hospital was called and staff at hospital said R2 got into a cab. On 6/9/2023 at 8:05 AM, V3, Assistant Director of Nursing stated, "(R2) would go out on pass and when he returned it was suspected that he was high or intoxicated. He was alert and oriented. Staff had to give him Narcan because he was 'out of it', his VS (vital signs) were low, and he was diaphoretic- staff attempted to send him to the hospital but he refused to go. He was served with involuntary discharge papers, but he left AMA (Against Medical Advice)." V3 also stated R2 was the only resident who received Narcan in the facility. On 6/14/2023 at 2:32 PM, V8, Ombudsman stated, "I am really not sure what to do because I am really concerned that residents with addictions are being admitted to the facility, but the facility is not putting anything in place and are not addressing the addictions. The resident is not getting better, the addictions are not being addressed and then the resident displays things related to the addiction and then they are discharged. I am just scared that we might find someone dead soon if they do not address what is going on with resident's addiction. If they are not going to try and help them then they just stop admitting residents with addictions." On 6/15/2023 at 12:23 PM, V4, Social Service Director stated, "Any resident who is alert and orientated can sign out and leave the facility. The resident just has to document how long they are going to be out and when they are planning on going out. (R2) would go out on pass and when he returned it was suspected at times that he was	S9999		

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	IL6002778	A. BUILDING: _____ B. WING _____	06/30/2023

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high or intoxicated. He was alert and oriented. (R2) overdosed in the front yard and they had to give him Narcan because he overdosed. I had never seen anyone overdose before. I was not aware (R2) had any history or struggles with drugs. (R2) was here before I was here. I do not have any contracts or any interventions addressing his drug addictions or anything in place to assist him with his drug issues. I do not make contracts or have any contracts for any resident, but we do have behavior tracking in place. We allowed (R2) to come and go because that was his right as a resident."

On 6/28/2023 at 4:01 PM, V8 stated, "I know the facility does Bingo programs, but I am here almost 5 days a week and I have never seen any Behavior Programs going on in the facility or any facility efforts to help residents with mental disorders, group counseling or anything targeted at resident's mental disorder or drug/alcohol addictions. For these residents they need more than Bingo."

R2's Behavior Tracking does not document anything related to substance abuse disorders.

2. R1's Medical Records does not document a history of drug use only smoking.

R1's Care Plan does not document any interventions or goals for drug/alcohol abuse.

R1's MDS dated 5/5/23 documents R1 was alert and oriented x (times) 4; he required extensive assist with bed mobility, dressing, and toileting; he required limited assist with transfers and supervision with walking, eating; he was continent of bowel and bladder

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S9999	Continued From page 27 R1's Social Service Notes dated 5/31/2023 at 12:58 document "(R1) was issued an emergency involuntary discharge with the bed hold policy. Resident is currently at (Local Hospital). Facility will assist hospital with finding alternative placement if needed. IDPH and Ombudsman was notified. Family picked up resident's belongings per his request." R1's Nurse's Notes dated 5/26/2023 at 5:56 PM, documents, "This nurse called to resident room to help reposition in bed. Resident was unresponsive, resident assessed. Vitals abnormal. Unable to arouse resident with sternum rub. 911 called. Resident sent to hospital for evaluation." On 6/9/2023 at 8:05 AM, V3 stated, "(R1) was alert and oriented and was in the facility for heart problems. She stated he was sent to the hospital when he became unresponsive, and staff suspected heart issues, but he tested positive for cocaine when in the hospital." V3 stated he was discharged with an involuntary discharge while he was in the hospital. (R1) was a very nice man but he had started hanging around with (R2) and (R3) who were suspected to return from outings under the influence." R1's Hospital Records dated 5/26/2023 documents, "Found unresponsive in nursing home, unknown downtime, history of opioid abuse." On 6/15/2023 at 12:23 PM, V4, Social Service Director stated "I was not aware (R1) had any history of drug abuse and he never left the facility. We had to give him an involuntary discharge because he tested positive at the hospital for drugs."	S9999		

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S9999	Continued From page 28 R1's Hospital Records dated 5/26/2023 document "64-year-old nursing home resident with a history of chronic a flutter, bullous pemphigoid, chronic pain fentanyl patch was brought from nursing home with altered mental status patient was found to be unresponsive at 10:30 AM, this morning last known normal was 5:00 AM. There was no trauma, patient was given Narcan at the scene no response. Upon arrival to the ER, he still is unresponsive." R1's "Emergence Department to Hospital-Admission" dated 5/26/2023 at 11:27 AM documents, "EMS (Emergency Medical Service) from (Facility). (R1) found unresponsive in room with low blood pressure and SpO2 (Saturation of Peripheral Oxygen). Per EMS (Emergency Medical Service), patient responds to painful stimuli with groans. Narcan given without change in condition. Last known well at approximately 0200 (2:00 AM) when he was given a pain pill per NH (Nursing Home)."Cannabinoids, Cocaine, Fentanyl, and Oxycodone were detected in the urine. R1's medical records did not contain a resident centered SUD (substance abuse disorder), goals and or interventions or how the facility would address their substance abuse issues. R1's medical record does not document any drug screens or orders from the physician for a drug screen test. On 6/16/2023 at 12:02 PM, V26, Nurse Practitioner stated, "A lot of it depends on if the resident is short term or long-term care. If a resident is alert and orientated x 3 and going out and if staff would suspect the resident to be	S9999		

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drinking or taking drugs, I would expect the staff to notify us so we could be made aware. Normally, in case like this we would order a drug screen to determine if that is an issue so we could adjust their medications. I am not sure if we were ever contacted regarding any issues with drugs use at the facility."

3. R4's POS dated June 2023 document a diagnosis of anxiety disorder, other psychoactive substance abuse, schizoaffective disorder, and bipolar type.

R4's POS document he is taking ziprasidone HCL oral capsule 40 milligrams (MG) two times a day for bipolar disorder related to schizoaffective disorder, bipolar type.

R4's MDS dated 6/21/2023 document R4 is cognitively intact for decision making.

On 6/29/2023 at 4:33 PM, R4 stated, "No they do not provided counseling to me. I do not attend any type of group meeting or counseling session here at the facility. I know I can get upset easy and I do have a temper. I have not attended any meetings. Last week they had me sign a paper saying that I would not hit anybody or lose my temper."

R4's Care Plan dated 12/27/2022, "Resident is at high risk for elopement related history of poly-substance abuse. 2/26/2023 Resident exited facility again without notifying staff or signing out. Smoking: Observed smoking in his bathroom, became aggressive and belligerent with staff. 3/17/2023 Resident let himself out of the building to smoke, became belligerent and threatening staff with violence." Intervention listed was "3/13/-3/14/23 one on one with Social Service as

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needed. When behavior occurs inform resident that behavior is inappropriate. 3/17/203 Police Department notified and responded. Resident has symptoms such as mood swings, impulsive behavior and attention seeking behavior related to a diagnosis of Schizoaffective and bipolar type Disorder, He has a history of aggressive inappropriate, attention seeking and/or maladaptive behaviors. This history includes cursing, yelling, following direction, destructive behavior and safety concerns with staff and residents. On 2/5/2023 R4 became verbally aggressive due to wanting a wheelchair that belonged to another resident. On 2/5/23 Resident overhead resident speaking on his cell phone saying that "he had Norco's for sale and do you want to buy them." Intervention: Staff to monitor resident taking his medication. SS to meet 1:1 as needed.

On 3/18/2023 threatening violence and aggression towards staff. The resident expresses maladaptive behavioral symptoms related to being observed and on occasion possibly being under the influence of unknown substances.

R4's Progress Notes dated 6/22/2023 at 6:27 PM, documents, "Resident brother called this resident and got this resident update. Resident noted to be yelling and cursing on phone at his brother resident was redirected and calmed down easily no further agitation noted. Resident requested that brother does not call him anymore."

A Behavior Contract was requested for R4 and on 6/29/2023 at 4:49 PM, V4 stated, "I do not have any Behavior Contracts." When R4's Care Plan was shown to V4 she stated she would look into it.

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S9999	Continued From page 31 On 6/29/2023 at 5:01 PM, V4 provided a Behavior Contract with a name scribbled on it documents, the name was not legible and was not dated. The contract documents, "Resident was made known that this behavior is not tolerated. No assaulting any of the staff and residents or raising voices. For the safety of the staff, residents, and himself. He was told to try to talk to any of the supervisors or managers about a certain issue to help with outbursts. Resident has to wait for staff to put in passcode for the door to go outside. If a grievance is not available for him, he agreed to have staff write it out for him." No other contract or details was provided to the surveyor. The contract does not address anything related to drug addiction. The Resident Right Policy with a revision date of 11/18 documents, "Your rights to participate in your own care. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do." (A)	S9999		