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S 000	Initial Comments Complaint Investigations: 2345568/IL161730 2345659/IL161835 Investigation of Facility Reported Incident of May 22, 2023; June 17, 2023; June 22, 2023; and June 27, 2023/IL161438 Investigation of Facility Reported Incident of May 5, 2023; June 13, 2023; June 25, 2023; and June 29, 2023/IL161442	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.3210t) 300.3240e) 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	S9999		

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S9999	Continued From page 1 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: 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.	S9999		

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S9999	Continued From page 2 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 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) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent resident-to-resident physical and sexual abuse for 8 of 12 residents (R2, R8, R9, R12, R13, R14, R15 and R16) reviewed for abuse in the sample of 30. R15 struck R12 in the head with an unknown object causing a lump to R12's head. On a later date, R15 stabbed R16 in the left chest with a paring knife causing R16 to require emergency medical services and R15 was arrested and remains police custody; and R13 hit R14 on the head with an object and on a later date, R13 stabbed R14 in the head with a pen causing R14 to require emergency medical services and R13 was sent out for psychiatric evaluation.	S9999		

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S9999	Continued From page 3 Findings include: 1.R15's Face Sheet documents his diagnoses to include Asthma, Difficulty in Walking, Low Back Pain, Chronic Obstructive Pulmonary Disease (COPD), Non-Displaced Longitudinal Fracture of Left Patella, Alcohol Abuse, Anemia and Gastroesophageal Reflux Disease (GERD). R15's Minimum Data Set (MDS) dated 3/31/23 documents he is alert and oriented and independent with his Activities of Daily Living (ADLs). R15's Facility Incident Report documented R15 had a resident-to-resident altercation with R12 on 5/5/23 at 1:15 PM. The Facility's Incident Report, dated 5/5/23, documented "Two male residents involved in an altercation. Immediately separated and assessed. Full investigation to follow. During the course of the investigation, the following facts were determined: (R12) was noted ambulating in the day area with a lump noted to his forehead. When (R12) was asked about what happened, he stated another male resident, (R15), had hit him in the head with something hard. (R12) was assessed and was noted with no other injuries or impairments. (R15) stated that (R12) had been coming into his room and threatening to take his phone and other items out of his room. (R15) admitted he struck another resident but would not admit to the item that was used during the altercation. Room searches were performed on both men's' rooms and all items of concern were removed. (R15) was placed in a group for anger management and for 15-minute checks. The two men have had no further incidents or altercations since the date of this altercation, and both have maintained their prior level of functioning." There was no	S9999		

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documentation of what items of concern were removed from R12's and R15's rooms.

R15's Care Plan, date initiated 5/30/22, document "Abuse: Resident is at risk for abuse and neglect related to Chronic Obstructive Pulmonary Disease, Unspecified, and Alcohol Abuse. Resident is an Identified Offender. He has a history of peer-to-peer altercations. 6/25/23: resident to resident altercation." R15's peer to peer altercation that occurred on 5/5/23 with R12 was not documented on R15's Care Plan. There were no updated interventions after R15's resident to resident altercation with R12 on 5/5/23 until 5/30/23. These interventions include Assess resident for abuse and neglect upon admission and quarterly. Assure resident that he/she is in a safe and secure environment with caring professionals. Explain that psychosocial adjustment is often facilitated by developing a trusting relationship with another person (for example, social worker, nurse, CNA, peer) and by verbalizing thoughts, needs and feelings. Assure the resident that staff members are available to help, and department heads maintain an "open door" policy. Continue to monitor medication, ADLs, status, and behaviors. Establish a counseling schedule with resident. Encourage the resident to verbalize/share thoughts, anxieties, fears, concerns, and general feelings. Identify areas that put resident at risk. Immediately report any episodes of unknown injury, abuse, or changes in resident's behaviors to Administrator for immediate intervention and review."

R15's Care Plan Focus, dated 3/30/22, documents "The resident has a history of criminal behavior. The resident has demonstrated stability during the admission screening process

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and does not appear to present an unusual risk at this time. The Illinois Department of Public Health performed a Criminal History Analysis and made a determination regarding his level of risk. He was deemed a moderate risk. According to the resident's history he has been charged with unlawful possession of a weapon by a felon, Theft/Control/Firearm, Car Theft, and Aggravated Assault. The resident has a diagnosis of Alcohol Abuse, Uncomplicated. Interventions for this care plan include Evaluate the resident's ability to control impulses, document accordingly. Teach impulse control strategies. Follow facility protocol addressing substance abuse. If substance abuse is suspected utilize appropriate blood/urine testing, limit setting, counseling, and consequences. Review the IDPH Criminal History Analysis (CHA). Implement suggestions, if reasonable and appropriate. Moderate risk interventions include appropriate supervision and observation, regular monitoring, attention to behavior changes, visual monitoring if warranted and periodic reassessment."

The facility's document, "Facility-Reported Incident Form Initial Report" dated 6/25/23 documents, "On 6/25/23 at 8:25 PM Staff reported that they responded to loud voices, upon responding they observed (R15) and (R16) in verbal exchange. (R15) then was observed with small paring knife in his hand making contact with (R16's) left side rib area. The incident occurred in the doorway of Room (room number listed). (R16) sustained a small puncture wound to lower left rib area. Physician notified; new orders received to send to ER (Emergency Room). Type of injury: puncture wound."

The facility's Follow-up Investigation Report, dated 6/30/23, documents, under Conclusion,

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"Staff reported that (R15) had just returned from LOA (Leave of Absence) with family, he was requesting snacks from staff at which time (R16) made a statement towards him resulting in (R16) placing hands on (R15) and giving a light push, staff saw something in (R15's) hand while swinging arm towards (R16) making contact. Residents were immediately separated, staff remained with (R15) until police, EMS (Emergency Medical Services) arrived with (R15) escorted from facility by police. Licensed nurse provided pressure to left lower rib area with pressure applied until EMS arrived. (R16) transferred to ER (Emergency Room) for evaluation with no significant injury and/or treatment required, all diagnostic testing negative. (R15) medical record review reveals he has a history of Alcohol Abuse, history of homelessness, strained family relationships and BUE (Bilateral Upper Extremity) ROM (Range of Motion) loss related to weakness. (R16's) medical record review: he has poor social skills, limited coping skills which at times leads to conflict with others. History of Alcohol Abuse, inappropriate attention seeking behaviors along with maladaptive behaviors. He has a history of using loud tone when expressing frustration. (R16) has maintained his usual routine with no signs of mental anguish noted and no psychosocial distress noted. He continues to be visualized throughout facility interacting with peers, attending activities of his choice. When asked, he states, "I'm fine." Police investigation ongoing, once investigation completed, addendum will be sent."

R16's Hospital Records dated 6/25/23 at 9:00 PM document, "Description of Mechanism: Stabbing to left chest. Review of systems: Respiratory: cough, hemoptysis, sputum, dyspnea on exertion,

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dyspnea at rest, wheezing. Cardiovascular: chest pain from stab; Gastrointestinal: abdominal pain left upper quadrant. Chest x-ray: Impression: Sequelae of penetrating injury in the lateral chest wall without extension into the thoracic and peritoneal cavity. Injuries: puncture wound to left chest. Plan: wound washed out and dressed. Follow up with trauma clinic as needed."

R16's Face Sheet documents his diagnoses to include Major Depressive Disorder, Cutaneous Abscess of Right Hand, Osteoarthritis, Hypertension and Alcohol Abuse.

R16's MDS dated 5/3/23 documents R16 is alert and oriented and independent with his ADLs.

R16's Care Plan documents "Abuse: (R16) is at risk of abuse and neglect related to history of assault leading to rib fractures and other injury prior to admission. (R16) is noted to have a history of peer-to-peer altercations. 4/4/23: peer to peer incident; 6/25/23: resident to resident altercation.

On 6/29/23 at 3:15 PM R16 was lying on his bed in his room with a clean, dry, intact white gauze bandage on his left side of torso. He stated he and (R15) usually got along good and would play dominos out in the dining room with a couple of other residents. R16 stated sometimes they would have words during a game but all in fun, nothing serious. R16 stated the agency nurse was passing medications and had called his name so he went to the door to get his meds and R15 kept walking past his door, saying things about R16 arguing with the new guy and R15 was being disrespectful. R16 stated R15 came between the nurse and her cart, and the nurse yelled, "He's got a knife!" and then R15 stabbed

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him. R16 stated he went in his room and slammed the door closed. R16 stated R15 walked up the hall to the front after he stabbed him. R16 stated, "He (R15) was drunk. He just came back from being out with his family."

On 7/5/23 at 3:09 PM, V16 (Licensed Practical Nurse/LPN) stated, "I was standing right by the double doors at the nurse's station, and I heard arguing between (R15) and (R16). Their voices were getting louder so I started walking towards them to see what was going on and try to diffuse the situation, and when I was within about two feet from them, (R15) pulled out the knife and jabbed him (R16) with it. (R16) put his hand over it and went into his room and closed the door. (R15) had the knife at his side, not trying to hide it, and started walking fast up the hall. I yelled out, "He's got a knife. Call 911. He just stabbed him (R16). The other staff said, "No, he's armed. We don't get involved with that." I went in to check on (R16) and he was lying on his bed with his hand over his left side, with his shirt over it, lying in the fetal position. He (R16) said, "I'm fine." but he let me look at the wound. It was about 1-2 centimeters with a little bit of flesh coming out of it. It wasn't bleeding a lot by then, but there was blood on his shirt and on the floor. I put some gauze over it and held pressure on the wound until EMS arrived. I work for agency, and this was the first and last time I worked at this facility. From what some of the other staff told me, and I cannot recall their names, (R15) went out with his family and had just got back and he was drunk. Another staff told me (R15) made the statement to her, "It wasn't my knife. There's no blood on it and my prints aren't on it." V16 stated the other staff told her this was unusual behavior for (R15) and that he was usually a very nice gentleman. The staff had called the police and

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S9999	Continued From page 9 the Administrator, and the Director of Nursing (DON) came in and did the report." 2. R13's Face Sheet documents his diagnoses to include: COPD, Diabetes Mellitus with Hyperglycemia, CVA (stroke) with Hemiparesis and Hemiplegia Affecting the Right Non-Dominant Side; Auditory Hallucinations and Schizoaffective Disorder. R13's MDS dated 4/18/23 documents he is alert and oriented. R13's Care Plan dated 3/13/17 documents: Abuse: At risk for abuse and neglect related to Schizoaffective Disorder, Depression, Auditory Hallucinations, history of behaviors and requires some assistance with care. He is noted to have a history of peer-to-peer altercations. 3/12/23 peer to peer altercation. 6/13/23 Peer to peer altercation. The Facility's Initial Report, dated 7/10/23 at 1:45 AM documents, under Allegation Details, "Staff reported responding to loud voices, upon approaching, (R14) stated (R13) made physical contact with him." The report further documents R14 was transferred to ER for evaluation and there is no serious bodily injury or sign of mental anguish identified. Injuries described in report are as follows: Scratches, small open area. The report documents there is no known witness at this time. R13's Progress Note, dated 7/10/23, at 4:54 AM documents, "Resident initiated resident to resident altercation. Residents immediately separated; local police notified. Physician notified with new orders received to send to ER for psychiatric evaluation related to physically	S9999		

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aggressive behaviors towards peer. Behavior was not easily redirected. Staff provided 1:1 to ensure safety of patient and peers until EMS/police arrived. MD/Guardian notified. Resident going to local regional hospital. Emergency transfer discharge provided at local ER, copy provided and explained to supervisor in ER department, copy provided and explained to resident. Copy provided to resident. IDPH and ombudsman notified via email. Call placed to resident daughter/guardian with no answer, left message to return call as soon as she received message, will attempt until contact made."

On 7/10/23 at 7:01 PM, V20 (Emergency Room/ER Nurse) stated R14 was brought to the emergency room by ambulance on 7/10/23 around 3:00 AM. V20 stated R14 told her another resident named (R13) had come into his room and punched him in the face several times and then stabbed him in the head with a pen. V20 stated R14 never really answered her as to whether R13 was his roommate or if he lived on the same hall as R14. V20 stated R14 had what appeared to be fresh injuries to his face and head including a black eye, a laceration to his left cheek over his cheekbone area and three puncture wounds to his scalp, two in front and one in the back of his head, and the puncture wounds had hematomas around them. V20 stated R14 had told this same resident (R13) has assaulted him multiple times in the past. V20 stated R14 received facial x-rays and a head Computed Tomography Scan (CT scan) to rule out facial fractures and she stated they were negative for fractures and showed the puncture wounds were superficial and did not penetrate his skull. V20 stated R14 had other injuries that appeared older, including bruises to the right side of his face, including eyebrow and cheek, upper

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left arm bruising, and scratches on his mid-lower back that looked like fingernails. V20 stated she attempted to call the facility to verify R14's report that he was assaulted by R13 before this. V20 stated she called the facility at least a dozen times and someone would pick up the phone and hang it back up without answering. V20 stated at about 6:00 AM a nurse (V14) answered the phone, but refused to answer any questions, and informed V20 she would have to talk to the Administrator. V20 stated (V1 Administrator) returned her call within a few minutes and she (V1) did confirm that this was not the first time R13 had assaulted R14. V20 stated V1 informed her that she had been at another hospital with R13 on that night and stated V1 informed her R13 would not be returning to the facility. V20 stated V1 informed her R13 had been on special monitoring, and she did not know why he assaulted R14 or how this protection plan failed. V20 stated R14 did not want to return to the facility, but his brother was his Power of Attorney, and they were unable to reach him by phone. V20 stated R14 was having visual hallucinations while in the emergency room, responding to "his wife" in the room when there was no one else in the room. V20 stated R14 was discharged back to the facility that same morning.

On 7/12/23 at 9:16 PM, during phone interview, V14 (Licensed Practical Nurse/LPN) stated she was not R14's nurse on 7/10/23 but she was the first staff to respond when she heard R14 yelling out. She stated she could not understand what R14 was saying, but she ran to his room and when she entered, R14 was sitting in his wheelchair with R13 standing over him, and R13 was stabbing R14 in his head with a pen. V14 stated she yelled at R13 to stop, and he did not immediately stop but finally did without her having

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to lay hands on him. V14 stated she did not know how many times R13 stabbed R14 with the pen, but stated he was "going at it." R14 stated other staff responded and entered R14's room and redirected R13 out of the room and he was taken to his room and kept on 1 on 1 until the ambulance arrived. V14 stated R13 did not say why he was assaulting R14, but when the EMTs (Emergency Medical Technicians), one of them reported to her that R13 stated he had assaulted R14 because R14 had thrown urine on him a month ago. V14 stated she assessed R14, and he had two puncture wounds on his head, one in front and one in back, and he also had several scratches on his face. V14 stated both R13 and R14 were sent to the hospital. She stated the incident happened around 1:40 AM. She stated there were no more behaviors between R13 and R14 before they left the facility. V14 stated she had not seen R13 have any aggression towards R14 prior to R13 attacking R14. She stated this type of behavior was "over the top" for R13.

According to facility documents, there were two incidents when R13 physically assaulted R14 prior to the incident on 7/10/23 and are as follows:
The Facility's Follow-up Investigation Report, dated 6/14/23, documents, under "Conclusion": On June 13, 2023, staff responded to loud voices, upon entering room (R13) stated, "He thought the back scratcher was his and when I told him it wasn't, he picked up his urinal and threw his urine at me so when he did, I reached over and made contact with his head. I didn't mean it, I just reacted to the urine being thrown this way." (R14) stated, "Yeah, I threw it at him, then he got me on top of the head." Skin assessment completed on both residents with (R14) observed to have small scratch on top of head. (R14) denied pain. (R13)

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was immediately relocated to another room with enhanced monitoring provided. Based on complete, comprehensive investigation, facility cannot substantiate intention abuse and facility believes situation occurred, however based on interviews with both residents the situation was without any intent as (R13) reacted to situation, both residents agree that situation was a disagreement over who the back scratcher belonged to."

The Facility's Facility Reported Incident Form, Initial Report dated 6/29/23 at 8:30 AM documents, "Staff reported (R13) approached (R14) making physical contact. Staff witnesses stated that (R13) was sitting in the dining room waiting for meal tray, he moved away from table and approached (R14) making contact with face. Residents immediately separated; physician notified with new orders to send (R13) to ER (Emergency Room) for psych evaluation."

The facility's Final Report for this incident, dated 7/7/23 documents, "On 6/29/23 R13 was sitting in the dining room at table during breakfast meal; R13 removed self from table and approached R14 making contact. R13 was placed on enhanced monitoring. "

On 7/11/23 at 9:10 AM R14 was sitting in his wheelchair in his room. R14 had small purplish-black bruises under both eyes. R14 was wearing a hat with headphones over it and declined to let his head/scalp be observed, stating, "No, you don't need to look at that. I'm fine. I'm not having any pain. I don't know what happened. He's (R13) just some crazy guy who came in and beat me up in the middle of the night." R14 stated, "I feel fine. I feel safe. You can go now."

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S9999	Continued From page 14 R14's Face Sheet documents his diagnoses to include Type 2 Diabetes Mellitus with Diabetic Retinopathy and Macular Edema; Acute Kidney Failure; Bipolar Disorder; HTN; History of Falls; and Schizophrenia. R14's MDS dated 3/24/23 documents he is alert and oriented. R14's Care Plan dated 4/20/22 documents: Abuse: (R14) is at risk for abuse and neglect related to impaired cognition secondary to psychiatric diagnosis. He is noted to have a court appointed guardian at this time, his brother. 6/13/23 peer to peer altercation. 3. R12's Face Sheet documents his diagnoses to include Paranoid Schizophrenia, Drug Induced Subacute Dyskinesia, Other Sexual Dysfunction Not Due to Substance or Known Physiological Condition, Anxiety Disorder, Cognitive Communication Deficit and Borderline Intellectual Functioning. R12's MDS dated 3/23/23 documents he is alert and oriented and requires supervision with his ADLs. R12's Care Plan dated 3/31/22 documents "Abuse: At risk for abuse and neglect related to his diagnosis of Depression, Schizophrenia, and Borderline Intellectual Functioning. He has been noted to ask for items of others in a way that is not appropriate such as "give me some of that". Has a history of peer-to-peer altercations. 6/22/23 Resident reported to stop resident who was independently propelling self down hall and ask her to suck his d***, while masturbating." R12's peer to peer altercation with R15 was not	S9999		

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S9999	Continued From page 15 documented on his care plan. The Facility's Follow-up Investigation Report, dated 6/29/23, documents, under Conclusion documents "On June 22, 2023, (R2) reported as she was independently propelling her electric wheelchair down the hall upon approaching (R12's) room he asked her to stop and once she did, he asked her to suck his d*** while masturbating. (R2) immediately removed herself from the situation and reported to staff. Local police were immediately notified. Physician notified with new orders to send (R12) to ER for evaluation. Complete comprehensive investigation has been completed with facility unable to substantiate abuse. Medical record review and interviews reveal (R12) has no previous behaviors of this nature. (R2) has shown no signs of mental anguish, psychosocial distress and has maintained her usual routine with her being observed in common areas interacting with peers, attending activities of her choice. (R12) remains hospitalized." R2's MDS dated 4/19/23 documents she is alert and oriented. R2's Care Plan dated 5/28/23 documents "Abuse: (R2) is at risk for abuse and neglect related to her diagnoses of CHF (Congestive Heart Failure), history of multiple Myocardial Infarctions (MI) and multiple CVAs, Hypertension, COPD, decreased ability to complete all her care tasks on her own and requires assistance. Resident shared during assessment that she has been a victim of domestic violence, addiction in the past and diagnosis of depression. History of altercations with peers. 3/27/23 peer to peer altercation. 5/28/23 peer to peer occurrence."	S9999		

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On 6/27/23 at 10:45 AM R2 stated R12 called her over to his room and asked her to suck his p**** while he was masturbating. R2 stated one other time he had called her over to his doorway while he was masturbating, and she was disgusted, and she turned around and left immediately. R2 stated she got angry the second time and immediately reported the incident to the Director of Nursing, who called the Administrator and R12 was sent out of the facility right away. R2 stated if they hadn't sent (R12) out of the facility, she would not have felt safe taking a shower, and would have been afraid he might come into her room at night. R2 stated she never went into R12's room and he never came into her room.

R12's Progress Notes dated 6/22/23 at 11:01 PM documents, "Resident 1 (R12) verbally sexually assaulted another resident. Resident 2 that was assaulted stated, "I was coming down the hallway and when I got to his door, he started patting his bare private area and ask me to suck his d***." Resident 2 (R2) was extremely uncomfortable and stated that she was afraid to lay down because she was afraid that he would assault her. Resident 1 (R12) was escorted to room; staff did 1 on 1 with resident until EMS present. DON notified, EMS called and said they would be a few hours until pick up report called into (hospital) for psych evaluation, will continue to monitor."

R12's Progress Notes for April, May and June 2023 were reviewed and documented four other times R12 was noted to be sexually inappropriate towards staff prior to resident-to-resident sexual abuse with R2 on 6/22/23.

4. The Facility's Follow-up Investigation Report, dated 6/23/23 documents, under, Conclusion

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S9999	Continued From page 17 documented "On June 17, 2023 (R9) was standing next to (R8's) chair and was noted to have his hand resting under her shirt. Residents were immediately separated with (R9) being place on enhanced monitoring." R8's Face Sheet documents her diagnoses to include Adult Failure to Thrive, Weakness, Need for Assistance with Personal Care, Schizophrenia, Unspecified Psychosis Not Due to A Substance or Known Physiological Condition, and Alzheimer's Disease with Late Onset. R8's MDS dated 6/7/23 documents she is severely cognitively impaired. R8's Care Plan dated 10/16/19 documents, "(R8) is at risk for abuse and neglect related to her impaired cognition related to diagnosis of psychosis and past TBI (traumatic brain injury) with cognitive and safety awareness deficits. 6/12/20 Involved in an altercation with a peer." R9' Face Sheet documents his diagnoses to include Alzheimer's Disease with Early Onset; Weakness; Schizoaffective Disorder, Bipolar Type; Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Major Depressive Disorder; and Alcohol Dependence with Alcohol Induced Persisting Dementia. R9's MDS dated 5/31/23 documents he is severely impaired cognitively. R9's Care Plan dated 12/12/14 documents, "(R9) is at risk for abuse and neglect related to Psychosis, Cerebral vascular Accident (CVA), Severe neuro-cognitive disorder, Affective Mood	S9999		

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S9999	Continued From page 18 Disorder, Depression, Dementia, and GERD (Gastroesophageal Reflux Disease. He expresses resistance with care needs such as changing clothing and personal hygiene. Has a history of getting physical with others over cigarettes. Has a history of peer-to-peer altercations. 6/17/23 resident observed with his hand resting under another resident's shirt." On 7/14/23, at 10:02 AM, V1, Administrator, stated "With (R9) I did not feel the intent was there as he just had his hand resting under her shirt and they had a relationship before and were both confused so I did not substantiate it." The facility's policy, "Abuse Policy and Prevention Program 2022" dated 10/2022, documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; and implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation,	S9999		

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S9999	Continued From page 19 misappropriation of property and mistreatment, and making necessary changes to prevent future occurrences. Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update, as necessary. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of residents." "A"	S9999		

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F 000	INITIAL COMMENTS Complaint Investigations: 2345068/IL161113-No Deficiency 2345160/IL161266-F684 2345305/IL161401-No Deficiency 2345427/IL161562-No Deficiency 2345568/IL161730-F600 and F610 cited 2345625/IL161802-No Deficiency 2345659/IL161835-F600 and F610 cited Investigation of Facility Reported Incident of May 22, 2023; June 17, 2023; June 22, 2023; and June 27, 2023/IL161438-F600 and F610 Investigation of Facility Reported Incident of May 5, 2023; June 13, 2023; June 25, 2023; and June 29, 2023/IL161442- F600 and F610 A Partial Extended Survey was conducted.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		7/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/26/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Based on observation, interview, and record review, the facility failed to prevent resident-to-resident physical and sexual abuse for 8 of 12 residents (R2, R8, R9, R12, R13, R14, R15 and R16) reviewed for abuse in the sample of 30. This failure resulted in an Immediate Jeopardy when the following resident-to-resident physical abuses occurred: R15 struck R12 in the head with an unknown object causing a lump to R12's head. On a later date, R15 stabbed R16 in the left chest with a paring knife causing R16 to require emergency medical services and R15 was arrested and remains police custody; and R13 hit R14 on the head with an object and on a later date, R13 stabbed R14 in the head with a pen causing R14 to require emergency medical services and R13 was sent out for psychiatric evaluation.

The Immediate Jeopardy began on 5/5/23 when R15 physically abused R12 by striking him in the head with an object causing a lump. On 6/25/23, R15 and R16 got into a verbal and physical altercation and R15 stabbed R16 with a paring knife in R16's chest.

V1 (Administrator), V2 (Director of Nursing), V5 (Regional Director of Operations), and V22 (Vice President of Regulatory Compliance and Clinical Operations) were notified of the Immediate Jeopardy on 7/7/23 at 1:50 PM. The surveyor confirmed by observation, interview, and record that the Immediate Jeopardy was removed on 7/12/23, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the facility's policies and procedures and in-service training.

Findings include:

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1.R15's Face Sheet documents his diagnoses to include Asthma, Difficulty in Walking, Low Back Pain, Chronic Obstructive Pulmonary Disease (COPD), Non-Displaced Longitudinal Fracture of Left Patella, Alcohol Abuse, Anemia and Gastroesophageal Reflux Disease (GERD).

R15's Minimum Data Set (MDS) dated 3/31/23 documents he is alert and oriented and independent with his Activities of Daily Living (ADLs).

R15's Facility Incident Report documented R15 had a resident-to-resident altercation with R12 on 5/5/23 at 1:15 PM. The Facility's Incident Report, dated 5/5/23, documented "Two male residents involved in an altercation. Immediately separated and assessed. Full investigation to follow. During the course of the investigation, the following facts were determined: (R12) was noted ambulating in the day area with a lump noted to his forehead. When (R12) was asked about what happened, he stated another male resident, (R15), had hit him in the head with something hard. (R12) was assessed and was noted with no other injuries or impairments. (R15) stated that (R12) had been coming into his room and threatening to take his phone and other items out of his room. (R15) admitted he struck another resident but would not admit to the item that was used during the altercation. Room searches were performed on both men's' rooms and all items of concern were removed. (R15) was placed in a group for anger management and for 15-minute checks. The two men have had no further incidents or altercations since the date of this altercation, and both have maintained their prior level of functioning." There was no

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documentation of what items of concern were removed from R12's and R15's rooms.

R15's Care Plan, date initiated 5/30/22, document "Abuse: Resident is at risk for abuse and neglect related to Chronic Obstructive Pulmonary Disease, Unspecified, and Alcohol Abuse. Resident is an Identified Offender. He has a history of peer-to-peer altercations. 6/25/23: resident to resident altercation." R15's peer to peer altercation that occurred on 5/5/23 with R12 was not documented on R15's Care Plan. There were no updated interventions after R15's resident to resident altercation with R12 on 5/5/23 until 5/30/23. These interventions include Assess resident for abuse and neglect upon admission and quarterly. Assure resident that he/she is in a safe and secure environment with caring professionals. Explain that psychosocial adjustment is often facilitated by developing a trusting relationship with another person (for example, social worker, nurse, CNA, peer) and by verbalizing thoughts, needs and feelings. Assure the resident that staff members are available to help, and department heads maintain an "open door" policy. Continue to monitor medication, ADLs, status, and behaviors. Establish a counseling schedule with resident. Encourage the resident to verbalize/share thoughts, anxieties, fears, concerns, and general feelings. Identify areas that put resident at risk. Immediately report any episodes of unknown injury, abuse, or changes in resident's behaviors to Administrator for immediate intervention and review."

R15's Care Plan Focus, dated 3/30/22, documents "The resident has a history of criminal behavior. The resident has demonstrated

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F 600	Continued From page 4 stability during the admission screening process and does not appear to present an unusual risk at this time. The Illinois Department of Public Health performed a Criminal History Analysis and made a determination regarding his level of risk. He was deemed a moderate risk. According to the resident's history he has been charged with unlawful possession of a weapon by a felon, Theft/Control/Firearm, Car Theft, and Aggravated Assault. The resident has a diagnosis of Alcohol Abuse, Uncomplicated. Interventions for this care plan include Evaluate the resident's ability to control impulses, document accordingly. Teach impulse control strategies. Follow facility protocol addressing substance abuse. If substance abuse is suspected utilize appropriate blood/urine testing, limit setting, counseling, and consequences. Review the IDPH Criminal History Analysis (CHA). Implement suggestions, if reasonable and appropriate. Moderate risk interventions include appropriate supervision and observation, regular monitoring, attention to behavior changes, visual monitoring if warranted and periodic reassessment." The facility's document, "Facility-Reported Incident Form Initial Report" dated 6/25/23 documents, "On 6/25/23 at 8:25 PM Staff reported that they responded to loud voices, upon responding they observed (R15) and (R16) in verbal exchange. (R15) then was observed with small paring knife in his hand making contact with (R16's) left side rib area. The incident occurred in the doorway of Room (room number listed). (R16) sustained a small puncture wound to lower left rib area. Physician notified; new orders received to send to ER (Emergency Room). Type of injury: puncture wound."	F 600		

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F 600	Continued From page 5 The facility's Follow-up Investigation Report, dated 6/30/23, documents, under Conclusion, "Staff reported that (R15) had just returned from LOA (Leave of Absence) with family, he was requesting snacks from staff at which time (R16) made a statement towards him resulting in (R16) placing hands on (R15) and giving a light push, staff saw something in (R15's) hand while swinging arm towards (R16) making contact. Residents were immediately separated, staff remained with (R15) until police, EMS (Emergency Medical Services) arrived with (R15) escorted from facility by police. Licensed nurse provided pressure to left lower rib area with pressure applied until EMS arrived. (R16) transferred to ER (Emergency Room) for evaluation with no significant injury and/or treatment required, all diagnostic testing negative. (R15) medical record review reveals he has a history of Alcohol Abuse, history of homelessness, strained family relationships and BUE (Bilateral Upper Extremity) ROM (Range of Motion) loss related to weakness. (R16's) medical record review: he has poor social skills, limited coping skills which at times leads to conflict with others. History of Alcohol Abuse, inappropriate attention seeking behaviors along with maladaptive behaviors. He has a history of using loud tone when expressing frustration. (R16) has maintained his usual routine with no signs of mental anguish noted and no psychosocial distress noted. He continues to be visualized throughout facility interacting with peers, attending activities of his choice. When asked, he states, "I'm fine." Police investigation ongoing, once investigation completed, addendum will be sent." R16's Hospital Records dated 6/25/23 at 9:00 PM	F 600		

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F 600	Continued From page 6 document, "Description of Mechanism: Stabbing to left chest. Review of systems: Respiratory: cough, hemoptysis, sputum, dyspnea on exertion, dyspnea at rest, wheezing. Cardiovascular: chest pain from stab; Gastrointestinal: abdominal pain left upper quadrant. Chest x-ray: Impression: Sequelae of penetrating injury in the lateral chest wall without extension into the thoracic and peritoneal cavity. Injuries: puncture wound to left chest. Plan: wound washed out and dressed. Follow up with trauma clinic as needed." R16's Face Sheet documents his diagnoses to include Major Depressive Disorder, Cutaneous Abscess of Right Hand, Osteoarthritis, Hypertension and Alcohol Abuse. R16's MDS dated 5/3/23 documents R16 is alert and oriented and independent with his ADLs. R16's Care Plan documents "Abuse: (R16) is at risk of abuse and neglect related to history of assault leading to rib fractures and other injury prior to admission. (R16) is noted to have a history of peer-to-peer altercations. 4/4/23: peer to peer incident; 6/25/23: resident to resident altercation. On 6/29/23 at 3:15 PM R16 was lying on his bed in his room with a clean, dry, intact white gauze bandage on his left side of torso. He stated he and (R15) usually got along good and would play dominos out in the dining room with a couple of other residents. R16 stated sometimes they would have words during a game but all in fun, nothing serious. R16 stated the agency nurse was passing medications and had called his name so he went to the door to get his meds and R15 kept walking past his door, saying things	F 600		

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about R16 arguing with the new guy and R15 was being disrespectful. R16 stated R15 came between the nurse and her cart, and the nurse yelled, "He's got a knife!" and then R15 stabbed him. R16 stated he went in his room and slammed the door closed. R16 stated R15 walked up the hall to the front after he stabbed him. R16 stated, "He (R15) was drunk. He just came back from being out with his family."

On 7/5/23 at 3:09 PM, V16 (Licensed Practical Nurse/LPN) stated, "I was standing right by the double doors at the nurse's station, and I heard arguing between (R15) and (R16). Their voices were getting louder so I started walking towards them to see what was going on and try to diffuse the situation, and when I was within about two feet from them, (R15) pulled out the knife and jabbed him (R16) with it. (R16) put his hand over it and went into his room and closed the door. (R15) had the knife at his side, not trying to hide it, and started walking fast up the hall. I yelled out, "He's got a knife. Call 911. He just stabbed him (R16). The other staff said, "No, he's armed. We don't get involved with that." I went in to check on (R16) and he was lying on his bed with his hand over his left side, with his shirt over it, lying in the fetal position. He (R16) said, "I'm fine." but he let me look at the wound. It was about 1-2 centimeters with a little bit of flesh coming out of it. It wasn't bleeding a lot by then, but there was blood on his shirt and on the floor. I put some gauze over it and held pressure on the wound until EMS arrived. I work for agency, and this was the first and last time I worked at this facility. From what some of the other staff told me, and I cannot recall their names, (R15) went out with his family and had just got back and he was drunk. Another staff told me (R15) made the

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statement to her, "It wasn't my knife. There's no blood on it and my prints aren't on it." V16 stated the other staff told her this was unusual behavior for (R15) and that he was usually a very nice gentleman. The staff had called the police and the Administrator, and the Director of Nursing (DON) came in and did the report."

2. R13's Face Sheet documents his diagnoses to include: COPD, Diabetes Mellitus with Hyperglycemia, CVA (stroke) with Hemiparesis and Hemiplegia Affecting the Right Non-Dominant Side; Auditory Hallucinations and Schizoaffective Disorder.

R13's MDS dated 4/18/23 documents he is alert and oriented.

R13's Care Plan dated 3/13/17 documents: Abuse: At risk for abuse and neglect related to Schizoaffective Disorder, Depression, Auditory Hallucinations, history of behaviors and requires some assistance with care. He is noted to have a history of peer-to-peer altercations. 3/12/23 peer to peer altercation. 6/13/23 Peer to peer altercation.

The Facility's Initial Report, dated 7/10/23 at 1:45 AM documents, under Allegation Details, "Staff reported responding to loud voices, upon approaching, (R14) stated (R13) made physical contact with him." The report further documents R14 was transferred to ER for evaluation and there is no serious bodily injury or sign of mental anguish identified. Injuries described in report are as follows: Scratches, small open area. The report documents there is no known witness at this time.

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R13's Progress Note, dated 7/10/23, at 4:54 AM documents, "Resident initiated resident to resident altercation. Residents immediately separated; local police notified. Physician notified with new orders received to send to ER for psychiatric evaluation related to physically aggressive behaviors towards peer. Behavior was not easily redirected. Staff provided 1:1 to ensure safety of patient and peers until EMS/police arrived. MD/Guardian notified. Resident going to local regional hospital. Emergency transfer discharge provided at local ER, copy provided and explained to supervisor in ER department, copy provided and explained to resident. Copy provided to resident. IDPH and ombudsman notified via email. Call placed to resident daughter/guardian with no answer, left message to return call as soon as she received message, will attempt until contact made."

On 7/10/23 at 7:01 PM, V20 (Emergency Room/ER Nurse) stated R14 was brought to the emergency room by ambulance on 7/10/23 around 3:00 AM. V20 stated R14 told her another resident named (R13) had come into his room and punched him in the face several times and then stabbed him in the head with a pen. V20 stated R14 never really answered her as to whether R13 was his roommate or if he lived on the same hall as R14. V20 stated R14 had what appeared to be fresh injuries to his face and head including a black eye, a laceration to his left cheek over his cheekbone area and three puncture wounds to his scalp, two in front and one in the back of his head, and the puncture wounds had hematomas around them. V20 stated R14 had told this same resident (R13) has assaulted him multiple times in the past. V20 stated R14 received facial x-rays and a head

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Computed Tomography Scan (CT scan) to rule out facial fractures and she stated they were negative for fractures and showed the puncture wounds were superficial and did not penetrate his skull. V20 stated R14 had other injuries that appeared older, including bruises to the right side of his face, including eyebrow and cheek, upper left arm bruising, and scratches on his mid-lower back that looked like fingernails. V20 stated she attempted to call the facility to verify R14's report that he was assaulted by R13 before this. V20 stated she called the facility at least a dozen times and someone would pick up the phone and hang it back up without answering. V20 stated at about 6:00 AM a nurse (V14) answered the phone, but refused to answer any questions, and informed V20 she would have to talk to the Administrator. V20 stated (V1 Administrator) returned her call within a few minutes and she (V1) did confirm that this was not the first time R13 had assaulted R14. V20 stated V1 informed her that she had been at another hospital with R13 on that night and stated V1 informed her R13 would not be returning to the facility. V20 stated V1 informed her R13 had been on special monitoring, and she did not know why he assaulted R14 or how this protection plan failed. V20 stated R14 did not want to return to the facility, but his brother was his Power of Attorney, and they were unable to reach him by phone. V20 stated R14 was having visual hallucinations while in the emergency room, responding to "his wife" in the room when there was no one else in the room. V20 stated R14 was discharged back to the facility that same morning.

On 7/12/23 at 9:16 PM, during phone interview, V14 (Licensed Practical Nurse/LPN) stated she was not R14's nurse on 7/10/23 but she was the

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first staff to respond when she heard R14 yelling out. She stated she could not understand what R14 was saying, but she ran to his room and when she entered, R14 was sitting in his wheelchair with R13 standing over him, and R13 was stabbing R14 in his head with a pen. V14 stated she yelled at R13 to stop, and he did not immediately stop but finally did without her having to lay hands on him. V14 stated she did not know how many times R13 stabbed R14 with the pen, but stated he was "going at it." R14 stated other staff responded and entered R14's room and redirected R13 out of the room and he was taken to his room and kept on 1 on 1 until the ambulance arrived. V14 stated R13 did not say why he was assaulting R14, but when the EMTs (Emergency Medical Technicians), one of them reported to her that R13 stated he had assaulted R14 because R14 had thrown urine on him a month ago. V14 stated she assessed R14, and he had two puncture wounds on his head, one in front and one in back, and he also had several scratches on his face. V14 stated both R13 and R14 were sent to the hospital. She stated the incident happened around 1:40 AM. She stated there were no more behaviors between R13 and R14 before they left the facility. V14 stated she had not seen R13 have any aggression towards R14 prior to R13 attacking R14. She stated this type of behavior was "over the top" for R13.

According to facility documents, there were two incidents when R13 physically assaulted R14 prior to the incident on 7/10/23 and are as follows:
The Facility's Follow-up Investigation Report, dated 6/14/23, documents, under "Conclusion": On June 13, 2023, staff responded to loud voices, upon entering room (R13) stated, "He thought the

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back scratcher was his and when I told him it wasn't, he picked up his urinal and threw his urine at me so when he did, I reached over and made contact with his head. I didn't mean it, I just reacted to the urine being thrown this way." (R14) stated, "Yeah, I threw it at him, then he got me on top of the head." Skin assessment completed on both residents with (R14) observed to have small scratch on top of head. (R14) denied pain. (R13) was immediately relocated to another room with enhanced monitoring provided. Based on complete, comprehensive investigation, facility cannot substantiate intention abuse and facility believes situation occurred, however based on interviews with both residents the situation was without any intent as (R13) reacted to situation, both residents agree that situation was a disagreement over who the back scratcher belonged to."

The Facility's Facility Reported Incident Form, Initial Report dated 6/29/23 at 8:30 AM documents, "Staff reported (R13) approached (R14) making physical contact. Staff witnesses stated that (R13) was sitting in the dining room waiting for meal tray, he moved away from table and approached (R14) making contact with face. Residents immediately separated; physician notified with new orders to send (R13) to ER (Emergency Room) for psych evaluation."

The facility's Final Report for this incident, dated 7/7/23 documents, "On 6/29/23 R13 was sitting in the dining room at table during breakfast meal; R13 removed self from table and approached R14 making contact. R13 was placed on enhanced monitoring. "

On 7/11/23 at 9:10 AM R14 was sitting in his

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wheelchair in his room. R14 had small purplish-black bruises under both eyes. R14 was wearing a hat with headphones over it and declined to let his head/scalp be observed, stating, "No, you don't need to look at that. I'm fine. I'm not having any pain. I don't know what happened. He's (R13) just some crazy guy who came in and beat me up in the middle of the night." R14 stated, "I feel fine. I feel safe. You can go now."

R14's Face Sheet documents his diagnoses to include Type 2 Diabetes Mellitus with Diabetic Retinopathy and Macular Edema; Acute Kidney Failure; Bipolar Disorder; HTN; History of Falls; and Schizophrenia.

R14's MDS dated 3/24/23 documents he is alert and oriented.

R14's Care Plan dated 4/20/22 documents: Abuse: (R14) is at risk for abuse and neglect related to impaired cognition secondary to psychiatric diagnosis. He is noted to have a court appointed guardian at this time, his brother. 6/13/23 peer to peer altercation.

3. R12's Face Sheet documents his diagnoses to include Paranoid Schizophrenia, Drug Induced Subacute Dyskinesia, Other Sexual Dysfunction Not Due to Substance or Known Physiological Condition, Anxiety Disorder, Cognitive Communication Deficit and Borderline Intellectual Functioning.

R12's MDS dated 3/23/23 documents he is alert and oriented and requires supervision with his ADLs.

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R12's Care Plan dated 3/31/22 documents "Abuse: At risk for abuse and neglect related to his diagnosis of Depression, Schizophrenia, and Borderline Intellectual Functioning. He has been noted to ask for items of others in a way that is not appropriate such as "give me some of that". Has a history of peer-to-peer altercations. 6/22/23 Resident reported to stop resident who was independently propelling self down hall and ask her to suck his d***, while masturbating." R12's peer to peer altercation with R15 was not documented on his care plan.

The Facility's Follow-up Investigation Report, dated 6/29/23, documents, under Conclusion documents "On June 22, 2023, (R2) reported as she was independently propelling her electric wheelchair down the hall upon approaching (R12's) room he asked her to stop and once she did, he asked her to suck his d*** while masturbating. (R2) immediately removed herself from the situation and reported to staff. Local police were immediately notified. Physician notified with new orders to send (R12) to ER for evaluation. Complete comprehensive investigation has been completed with facility unable to substantiate abuse. Medical record review and interviews reveal (R12) has no previous behaviors of this nature. (R2) has shown no signs of mental anguish, psychosocial distress and has maintained her usual routine with her being observed in common areas interacting with peers, attending activities of her choice. (R12) remains hospitalized."

R2's MDS dated 4/19/23 documents she is alert and oriented.

R2's Care Plan dated 5/28/23 documents "Abuse:

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F 600	Continued From page 15 (R2) is at risk for abuse and neglect related to her diagnoses of CHF (Congestive Heart Failure), history of multiple Myocardial Infarctions (MI) and multiple CVAs, Hypertension, COPD, decreased ability to complete all her care tasks on her own and requires assistance. Resident shared during assessment that she has been a victim of domestic violence, addiction in the past and diagnosis of depression. History of altercations with peers. 3/27/23 peer to peer altercation. 5/28/23 peer to peer occurrence." On 6/27/23 at 10:45 AM R2 stated R12 called her over to his room and asked her to suck his p**** while he was masturbating. R2 stated one other time he had called her over to his doorway while he was masturbating, and she was disgusted, and she turned around and left immediately. R2 stated she got angry the second time and immediately reported the incident to the Director of Nursing, who called the Administrator and R12 was sent out of the facility right away. R2 stated if they hadn't sent (R12) out of the facility, she would not have felt safe taking a shower, and would have been afraid he might come into her room at night. R2 stated she never went into R12's room and he never came into her room. R12's Progress Notes dated 6/22/23 at 11:01 PM documents, "Resident 1 (R12) verbally sexually assaulted another resident. Resident 2 that was assaulted stated, "I was coming down the hallway and when I got to his door, he started patting his bare private area and ask me to suck his d***." Resident 2 (R2) was extremely uncomfortable and stated that she was afraid to lay down because she was afraid that he would assault her. Resident 1 (R12) was escorted to room; staff did 1 on 1 with resident until EMS present.	F 600		

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F 600	Continued From page 16 DON notified, EMS called and said they would be a few hours until pick up report called into (hospital) for psych evaluation, will continue to monitor." R12's Progress Notes for April, May and June 2023 were reviewed and documented four other times R12 was noted to be sexually inappropriate towards staff prior to resident-to-resident sexual abuse with R2 on 6/22/23. 4. The Facility's Follow-up Investigation Report, dated 6/23/23 documents, under, Conclusion documented "On June 17, 2023 (R9) was standing next to (R8's) chair and was noted to have his hand resting under her shirt. Residents were immediately separated with (R9) being place on enhanced monitoring." R8's Face Sheet documents her diagnoses to include Adult Failure to Thrive, Weakness, Need for Assistance with Personal Care, Schizophrenia, Unspecified Psychosis Not Due to A Substance or Known Physiological Condition, and Alzheimer's Disease with Late Onset. R8's MDS dated 6/7/23 documents she is severely cognitively impaired. R8's Care Plan dated 10/16/19 documents, "(R8) is at risk for abuse and neglect related to her impaired cognition related to diagnosis of psychosis and past TBI (traumatic brain injury) with cognitive and safety awareness deficits. 6/12/20 Involved in an altercation with a peer." R9' Face Sheet documents his diagnoses to include Alzheimer's Disease with Early Onset; Weakness; Schizoaffective Disorder, Bipolar	F 600		

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F 600	Continued From page 17 Type; Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Major Depressive Disorder; and Alcohol Dependence with Alcohol Induced Persisting Dementia. R9's MDS dated 5/31/23 documents he is severely impaired cognitively. R9's Care Plan dated 12/12/14 documents, "(R9) is at risk for abuse and neglect related to Psychosis, Cerebral vascular Accident (CVA), Severe neuro-cognitive disorder, Affective Mood Disorder, Depression, Dementia, and GERD (Gastroesophageal Reflux Disease. He expresses resistance with care needs such as changing clothing and personal hygiene. Has a history of getting physical with others over cigarettes. Has a history of peer-to-peer altercations. 6/17/23 resident observed with his hand resting under another resident's shirt." On 7/14/23, at 10:02 AM, V1, Administrator, stated "With (R9) I did not feel the intent was there as he just had his hand resting under her shirt and they had a relationship before and were both confused so I did not substantiate it." The facility's policy, "Abuse Policy and Prevention Program 2022" dated 10/2022, documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident	F 600		

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sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; and implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making necessary changes to prevent future occurrences. Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update, as necessary. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents

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and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of residents."

The Immediate Jeopardy that began on 5/5/23 was removed on 7/12/23 when the facility took the following actions to remove the immediacy:

A. Identification of Residents Affected or Likely to be Affected:
1.R15 no longer resides in the facility, discharged into police custody on 6/25/2023.

2.R12 no longer resides in the facility, discharged facility on 6/23/2023.

3.R16 was assessed for trauma related events on 6/26/2023 by V5 (Region Director of Operations). Care planned interventions relating to being a victim of abuse were entered on 6/25/2023 by V5.

4.R13 no longer resides in the facility, discharged on 7/10/2023.

5.R14 refused assessment for trauma related events, ad hoc care plan with R14 and POA held on 7/10/2023, R14 feels safe in the facility, care plan reviewed and updated by V22 (Vice President of Regulatory Compliance and Clinical Operations), V5, and V1 on 7/10/2023.

6.All residents will be assessed for aggressive behaviors by V1, V17 (Social Service Director), to be completed on 7/7/2023, 7/10/2023 and ongoing as needed to include new residents and newly identified behaviors.

7.Through the RAP rounds (customer service

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F 600	Continued From page 20 interviews) with all residents, no new allegations of abuse have been identified. Rap rounds to be completed Monday through Friday by V37 (Restorative Nurse), V38 (Infection Control Nurse), V36 (Medical Records), V35 (Admission Coordinator), V55 (Business Office Manager), and V17 to be initiated on 7/12/23 and ongoing. 8.Potential admissions/referrals will be reviewed for appropriateness of admission by V35 (Admissions Coordinator) or V2 (Director of Nursing). Patients with a documented history of aggressive behaviors and any background check that identifies any potential risk factors for aggressive behaviors will not be accepted for admission completed 7/12/2023 and ongoing. 9.Care plans to be reviewed and revised as needed with implemented interventions to address resident specific behavioral needs and newly identified behaviors by V17, V36 and V37 to be ongoing. Any investigation of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property occurred shall be reviewed by the facility Quality Management committee for possible changes in facility practices to ensure that similar events do not occur again. At this time, the resident specific care planned interventions will be verified in place. The investigation shall be reviewed at the next quarterly Quality Management committee meeting, or sooner, if possible, completed on 7/10/23 and ongoing. 10.Ad hoc QAPI was held on 7/10/23 with V5, V22, and V1 updating plan of care for R14 with interventions added to address being a victim of abuse and discharge plans for R13.	F 600		

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F 600	Continued From page 21 B. Actions to Prevent Occurrence/Recurrence: 1.The corporate and leadership team V34 (Chief Compliance Officer), V22, V33 (Vice President of Policy and Procedure), V1, and V5 reviewed policies and procedures regarding abuse (pp 1-10) on 7/7/2023, 7/11/2023, and 7/12/2023, emergency behavior management- code silver on 7/11/2023, and enhanced supervision on 7/12/2023. 2.Revision of abuse policy to include the announcement of code silver for aggressive behavior on 7/11/2023, pre-admission screening of potential residents, quality management review to include verification of resident specific care planned interventions, and protection of residents by V22 on 7/12/2023. 3.V1 (Facility Administrator) will assign a hall monitor to be on duty 24/7 for 7 days to observe for customer service, residents' rights, and retention of staff education regarding abuse. 1 hall monitor assigned each shift, initiated on 7/11/2023. 4.CPI trained staff will be assigned as hall monitors. Any staff assigned as a hall monitor has previously completed CPI certification by V1 and V56 (Previous Facility Administrator) completed on 7/11/2023 and ongoing. 5.V1, V17 (Social Service Director), and V8 (Psychosocial Director) will facilitate an environmental survey to determine if an immediate room move is necessary for residents exhibiting physically aggressive behavior to determine if a room move is appropriate on 7/11/2023 and ongoing.	F 600		

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F 600	Continued From page 22 6.The interdisciplinary team including V1, V2, V17, V37, V38, V39 (Housekeeping Supervisor), and V40 (Dietary Manager), will provide training to all staff related to the above-mentioned policies to be completed on 7/12/2023 and ongoing. 7.The training will also include residents identified at risk for potential abusive behaviors and how to manage behavior emergency- code silver by V1, V2, V17, V37, V38, V39, and V40 on 7/11/2023, 7/12/2023 to be ongoing. 8.All agency staff, new hires, and facility not available in person or via phone will be educated on the above policies to prevent potential abusive behaviors prior to beginning their next shift by V2 and V41, Human Resources on 7/12/2023 to be ongoing. 9.In the event care planned interventions and behavior management ineffective, staff will facilitate face to face emergency visit with psychiatric services via in person visit, telehealth, or emergency transfer to local hospital. Enhanced supervision 1:1 will be provided upon return to the facility if the aggressor is not admitted for psychiatric evaluation on 7/12/2023 and ongoing. 10.An Ad-Hoc QAPI meeting will be held weekly for four (4) weeks by the QAPI team to discuss this removal plan and identify if additional interventions are necessary to be ongoing. 11.Monitoring/auditing of ongoing education of staff for abuse policy and procedures identifying staff ability to prevent potential abusive behaviors will be completed 5 times weekly by V1 and V2 will continue for a minimum of three months to be	F 600		

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F 600	Continued From page 23 ongoing and will part of the QAPI process. 12.Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 7/12/2023.	F 600		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to substantiate abuse through investigation when abuse occurred for 4 of 12 residents (R9, R12, R13, and R15) reviewed for abuse investigations in the sample of 30. Findings include: 1. R15's Minimum Data Set, MDS, dated 3/31/23, documents he is alert and oriented and independent with his Activities of Daily Living	F 610		7/23/23

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(ADLs).

R15's Care Plan, date initiated 5/30/22, documents "Abuse: Resident is at risk for abuse and neglect related to Chronic Obstructive Pulmonary Disease, Unspecified, and Alcohol Abuse. Resident is an Identified Offender. He has a history of peer-to-peer altercations. 6/25/23: resident to resident altercation."

The facility's document, "Facility-Reported Incident Form Initial Report" dated 6/25/23 documents, "On 6/25/23 at 8:25 PM Staff reported that they responded to loud voices, upon responding they observed (R15) and (R16) in verbal exchange. (R15) then was observed with small paring knife in his hand making contact with (R16's) left side rib area. The incident occurred in the doorway of Room (number listed). (R16) sustained a small puncture wound to lower left rib area. Physician notified; new orders received to send to ER (Emergency Room). Type of injury: puncture wound."

On 7/5/23 at 3:09 PM V16 (Licensed Practical Nurse/LPN) stated, "I was standing right by the double doors at the nurses' station, and I heard arguing between (R15) and (R16). Their voices were getting louder so I started walking towards them to see what was going on and try to diffuse the situation, and when I was within about two feet from them, (R15) pulled out the knife and jabbed him (R16) with it. (R16) put his hand over it and went into his room and closed the door. (R15) had the knife at his side, not trying to hide it, and started walking fast up the hall. I yelled out, "He's got a knife. Call 911. He just stabbed him (R16). The other staff said, "No, he's armed. We don't get involved with that." I went in to

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F 610	Continued From page 25 check on (R16) and he was lying on his bed with his hand over his left side, with his shirt over it, lying in the fetal position. He (R16) said, 'I'm fine.' but he let me look at the wound. It was about 1-2 centimeters with a little bit of flesh coming out of it. It wasn't bleeding a lot by then, but there was blood on his shirt and on the floor. I put some gauze over it and held pressure on the wound until EMS arrived. I work for agency, and this was the first and last time I worked at this facility. From what some of the other staff told me, and I cannot recall their names, (R15) went out with his family and had just got back and he was drunk. Another staff told me (R15) made the statement to her, "It wasn't my knife. There's no blood on it and my prints aren't on it." V16 stated the other staff told her this was unusual behavior for (R15) and that he was usually a very nice gentleman. The staff had called the police and the Administrator, and the Director of Nursing (DON) came in and did the report." The facility's Follow-up Investigation Report, dated 6/30/23, documents, under Conclusion, "Staff reported that (R15) had just returned from LOA (Leave of Absence) with family, he was requesting snacks from staff at which time (R16) made a statement towards him resulting in (R16) placing hands on (R15) and giving a light push, staff saw something in (R15's) hand while swinging arm towards (R16) making contact. Residents were immediately separated, staff remained with (R15) until police, EMS (Emergency Medical Services) arrived with (R15) escorted from facility by police. Licensed nurse provided pressure to left lower rib area with pressure applied until EMS arrived. (R16) transferred to ER (Emergency Room) for evaluation with no significant injury and/or	F 610		

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F 610	Continued From page 26 treatment required, all diagnostic testing negative. (R15) medical record review reveals he has a history of Alcohol Abuse, history of homelessness, strained family relationships and BUE (Bilateral Upper Extremity) ROM (Range of Motion) loss related to weakness. (R16's) medical record review: he has poor social skills, limited coping skills which at times leads to conflict with others. History of Alcohol Abuse, inappropriate attention seeking behaviors along with maladaptive behaviors. He has a history of using loud tone when expressing frustration. (R16) has maintained his usual routine with no signs of mental anguish noted and no psychosocial distress noted. He continues to be visualized throughout facility interacting with peers, attending activities of his choice. When asked, he states, "I'm fine." Police investigation ongoing, once investigation completed, addendum will be sent." On 7/13/2023 at 1:03 PM, V43 (Certified Nursing Assistant) stated, "I remember that night, (R15) had just came back from a family visit and he was asking for snacks. (R15) wanted some peanut butter to put on his graham crackers. When he turned the corner, he saw (R16) and there was an exchange in words and (R16) grabbed (R15) and then (R15) stabbed (R16). (R15) is no longer here I think he is still in jail. They gave him an involuntary discharge." R15's Follow Up Investigation report for 6/25/2023 documents, "Conclusion: This area was left unmarked, and the choices were verified/ Substantiated, not verified /Unsubstantiated and inconclusive. R15's Conclusion area was blank. In the Report it documents, "Describe the plan for oversight or implementation of corrective action if	F 610		

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F 610	Continued From page 27 the allegation is verified and it documents, "Not applicable Abuse or neglect did not occur per investigation." 2. R13's June 2023 POS documents R13 has diagnoses of schizoaffective disorder, auditory hallucinations, and other impulse disorders; nicotine dependence. R13's MDS, dated 4/18/2023, documents R13 is alert and oriented and independent with his Activities of Daily Living (ADLs). R13's Care Plan, 3/13/17, documents, R13 is at risk for abuse and neglect related to schizoaffective disorder, depression, auditory hallucinations, history of behaviors and requires assistance with care. R13's Care Plan documents R13 had a history of peer-to-peer altercations on 3/12/23 and 6/13/23. R13's Facility Incident Report, documents, "On 6/13/2023 staff responded to loud voices, upon entering room (R13) stated, (R14) thought the back scratcher was his and when I told him it wasn't he picked up his urinal and threw his urine at me so when he did, I reached over and made contact with his head. I didn't mean it, I just reacted to the urine being thrown this way. (R14) stated, 'Yeah, I threw it at him, then he got me on top of the head.' Skin assessment completed on both residents with the following noted. (R13) experiences auditory hallucinations, mood swings and has attention seeking behavior; resident also had communication deficit related to being edentulous, per his preferences, resulting in slurred speech. Medical record for (R14) reveals he experiences delusional thoughts, auditory hallucination and has attention seeking	F 610		

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behaviors. Resident also has disorganized thought process. Physician was notified of situation and of small scratch to (R14's) head. Area has healed without complications; resident voiced no complaint of pain and or discomfort. Based on complete, comprehensive investigation facility cannot substantiate intention abuse and facility believes situation occurred however, based on interviews with both resident the situation was without any intent as (R13) reacted to situation, both residents agree that situation was over who the back scratcher belonged to. Both residents have maintained their usual routine with neither showing any signs of mental anguish or psychosocial distress."

R13's Progress Notes does not document any type of abuse occurring to R14 on 6/13/2023.

R13's Facility Incident Report dated 6/29/2023 at 8:30 AM, documents, "Staff reported that (R13) approached (R14) making physical contact. Staff witnesses stated that (R13) was sitting in the dining room waiting for meal tray, he moved away from table and approached (R14) making contact with face. Residents immediately separated; physician notified with new orders to send (R13) to the ER (Emergency Room) for psych evaluation. In the investigation there were no statements from the witnesses. (V17 Social Service Director and V35 Admission Coordinator) were documented as being the witness to this event.

On 7/13/2023 at 12:54 PM, V17 (Social Service Director) stated, "Breakfast time is chaotic, and I really do not remember much that day. I know (R14) did not do anything to provoke (R13) and (R13) did hit (R14) and make physical contact but

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 29 there was no injury. I really do not remember much else." R13's Abuse Investigation Facility Incident Report from 6/29/2023, undated, was documented as not verified and not substantiated. 3. R12's June 2023 POS documents R12 has diagnoses of Schizophrenia, Drug induced subacute dyskinesia, other sexual dysfunction not due to a substance or known physiological condition, anxiety disorder, and cognitive communication deficit borderline intellectual functioning. R12's MDS, dated 3/23/2023 document R12 is alert and oriented and independent with his Activities of Daily Living (ADLs). R12's Care Plan, with initiation date of 3/31/22, documents "PSYCH-SOCIAL: The resident displays socially inappropriate and maladaptive behaviors. This includes begging staff, residents and visitors for food, cigarettes, or money; stealing from others; making sexual remarks or attempting to masturbate in front of women (4/1/2022). Resident exhibited inappropriate behaviors towards staff member. 4/22/23." On 6/27/23 at 10:45 AM R2 stated R12 called her over to his room and asked her to suck his p**** while he was masturbating. R2 stated one other time he had called her over to his doorway while he was masturbating, and she was disgusted, and she turned around and left immediately. R2 stated she got angry the second time and immediately reported the incident to the Director of Nursing, who called the Administrator and R12 was sent out of the facility right away. R2 stated	F 610		

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if they hadn't sent R12 out of the facility, she would not have felt safe taking a shower, and would have been afraid he might come into her room at night.

R12's Progress Note, dated 6/22/2023 at 11:01 PM, documents, "Resident 1 (R12) verbally sexually assaulted another resident. Resident 2 (R2) that was assaulted stated 'I was coming down the hallway and when I got to his door, he started patting his bare private area and ask me to suck his d***'. Resident 2 (R2) was extremely uncomfortable and stated that she was afraid to lay down because she was afraid that he would assault her. Resident 1 (R12) was escorted to room, staff did 1 on 1 with resident until EMS (emergency medical services) present. DON (Director of Nursing) notified, EMS called and said they would be a few hours until pick up, report called into (hospital) for psych evaluation, will continue to monitor."

R12's Investigation Report documents, "On 6/22/2023 (R2) reported as she was independently propelling her electric wheelchair down the hall upon approaching (R12's) room he asked her to stop and once she did her asked to suck his d*** while masturbating. (R2) immediately removed herself from the situation and reported to staff. (Local) police were immediately notified. Physician notified with new orders to send (R12) to ER (Emergency Room)." R12's Investigation also documents it was not verified and was unsubstantiated.

R12's June 2023 Behavior Tracking Record documented that R12 was sexually inappropriate towards staff. The only day that was marked was 6/22/23 and that was the day that R12 asked R2

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F 610	Continued From page 31 to perform an oral sexually act on him. On 7/5/2023 at 2:00 PM, V1 (Administrator) stated, "(R12) was sexually inappropriate towards staff. The resident-to-resident altercation with (R2) and (R12) was not substantiated because it was a he said, she said situation and there were no witnesses so I could not prove anything. (R12) was served an involuntary discharge because he was sexually inappropriate with staff." R12's Medical Records document he was served Involuntary Discharge papers with the date of notice on 6/23/2023, for "the safety of individuals in the facility is endangered." 4. R9's Face Sheet documents his diagnoses to include: Alzheimer's disease with Early Onset; Weakness; Schizoaffective Disorder, Bipolar Type; Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Major Depressive Disorder; and Alcohol Dependence with Alcohol Induced Persisting Dementia. R9's MDS dated 5/31/23 documents he is severely impaired cognitively. R9's Care Plan dated 12/12/14 documents, "(R9) is at risk for abuse and neglect related to Psychosis, Cerebrovascular Accident (CVA), Severe neuro-cognitive disorder, Affective Mood Disorder, Depression, Dementia, and GERD (Gastroesophageal Reflux Disease. He expresses resistance with care needs such as changing clothing and personal hygiene. Has a history of getting physical with others over cigarettes. Has a history of peer-to-peer	F 610		

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F 610	Continued From page 32 altercations. 6/17/23 resident observed with his hand resting under another resident's shirt." The Facility Initial Report document on 6/17/2023 documents, "Resident with diagnosis of dementia and with Brief Interview for Mental Status score or 5 was noted to have hand under shirt of resident with diagnosis of Dementia. Police notified." Conclusion of the Report incident 6/17/2023 documents, "the common area, on 6/17/2023 (R9) was standing next to (R8's) chair and was noted to have his hand resting under her shirt. Residents were immediately separated with (R9) being placed on enhanced monitoring." The facility's document, Follow-up Investigation Report, dated 6/23/23 documents, "On June 17, 2023 (R9) was standing next to (R8's) chair and was noted to have his hand resting under her shirt. Residents were immediately separated with (R9) being place on enhanced monitoring. Interview of witness; "(R9) had his hand resting under her shirt. I immediately separated them and redirected him back to the room where he stayed." This investigation was marked as not verified/unsubstantiated. Describe the plan for oversight or implementation of corrective action if the allegation is verified and it documents "Not applicable. Abuse or neglect did not occur, per investigation." On 7/14/2023 at 10:02 AM, V1 (Administrator) stated, "With (R9) I did not feel the intent was there as he just had his hand resting under her shirt and they had a relationship before and were both confused so I did not substantiate it. For (R12) and (R2) there were no witnesses so I could not substantiate that the abuse occurred,	F 610		

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F 610	Continued From page 33 and I did give him involuntary discharge papers because of it. (R13) is still pending police report. If you are referring to the June incident in the dining room, I am not sure. I believe (R9's) is still pending as well." The Abuse Policy dated October 2022 documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriate of property, deprecation of goods and services by staff and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault including non-consensual or non-competent to consent sexual activity."	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		7/23/23

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practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to provide treatments to wounds as ordered by the physician for 3 of 4 residents (R1, R3, and R4) reviewed for treatments in the sample of 30.

Findings include:

1. R1's Face Sheet documents her diagnoses as Blister (non-thermal) Left Great Toe and Other Acute Osteomyelitis, Left Ankle and Foot.

On 6/27/23 at 10:30 AM V3 (Licensed Practical Nurse/LPN) cleansed R1's left great toe with wound cleanser then applied Bacitracin-Zinc Ointment to her peeling wound on her left great toe. V3 did not apply Povidone-Iodine 10% solution to R1's toe as ordered by physician. R1 stated, "They clean my toe and put ointment on it most days."

R1's Wound Specialist Progress Note, dated 5/29/23, documents R1's wound as: Diabetic Wound of the Left First Toe, Partial Thickness. This progress note documented the Dressing Treatment Plan as: Calcium Alginate once daily and Betadine once daily. R1 was not seen by the wound specialist on her next routine visit one week later due to being hospitalized.

R1's Hospital Records document she was hospitalized 6/3/23 to 6/14/23 for change in condition. Her hospital discharge orders dated 6/14/23 include the order: Povidone-Iodine 10% solution commonly known as Betadine: apply 100

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F 684	Continued From page 35 ml (10-gram total) topically to left heel. There was no clarification noted in the progress notes regarding the wound being on R1's left great toe and not her heel. R1's Treatment Administration Record (TAR) dated June 2023 documents the order for Povidone-Iodine Solution 10% to left great toe daily was discontinued after 6/4/23, but there was no order to resume this treatment order after that date. There was no order for betadine to be applied to R1's left great toe or to her left heel. This TAR also documented R1 did not receive her treatment of Bacitracin-Zinc Ointment to her left great toe on the evening of 6/17/23. There was no order for R1 to received treatment with Povidone-Iodine to her left great toe on her TAR dated July 2023 as of 7/5/23. R1's Wound Specialist Progress Note dated 7/3/23 documents R1's wound as: Diabetic Wound of the Left First Toe, Partial Thickness. The Note documented R1's Dressing Treatment Plan as: Continue Betadine twice daily; discontinue Calcium Alginate. R1's Order Summary Report dated 7/5/23 documents the Physician Order dated 6/15/23 documents the order: Bacitracin-Zinc Ointment 500 units/gram-apply to left toe topically two times a day for healing. R1's Order Summary Report dated 7/5/23 also documents the Physician Order dated 6/15/23 also documents the order: Povidone-Iodine Solution 10%: Apply 100 milliliters (mls.) to left great toe topically one time a day for wound healing. R1's physician orders were not updated with the new physician orders by the wound specialist on 7/5/23.	F 684		

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2. R3's Face Sheet documents his diagnoses to include Type 2 Diabetes with Diabetic Neuropathy, Cellulitis of Right Lower Limb, Encounter for Orthopedic Aftercare Following Surgical Amputation, Peripheral Vascular Disease, Superficial Frostbite of Unspecified Sites, and Gangrene. It documents he was admitted to the facility on 1/12/23. R3's Progress Notes dated 2/21/23 document he went on a home visit on that date, and he did not return to the facility.

R3's Wound Specialist Progress Note dated 2/14/23 documents, "He has a post-surgical wound of the right foot for at least 35 days. There is moderate serosanguinous exudate." The wound measurements documented on this progress note are as follows: 4 centimeters (cm) by 12 cm by 0.6 cm.

R3's Order Summary Report dated 6/27/23 documents the order dated 1/31/23 and discontinued 3/1/23 after R3 was discharged: Dakin's (full strength) Apply to right foot topically every day shift for to promote wound healing for 30 days. Clean wound with Dakin's, apply Santyl and cover with dry dressing.

R3's Minimum Data Set (MDS) dated 1/19/23 documents he is alert and oriented times 3 and required limited assist with Activities of Daily Living (ADLs). It also documented he had a surgical wound when he was admitted to the facility.

R3's Care Plan dated 2/1/23 documents, "(R3) requires assist with daily care needs related to bilateral amputation of all toes secondary to gangrene from frostbite. He is noted to have

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F 684	Continued From page 37 cognitive deficits and requires verbal cues as well. Wheelchair for mobility. (R3) is non-compliant at times with his partial weight bearing status and will ambulate around facility not using his wheelchair. R3's Care Plan dated 2/1/23 documents, "(R3) is at risk for pain/alteration in comfort related to recent amputation of toes to bilateral feet, diagnosis of diabetes and coronary artery disease, and history of peripheral neuropathy and back pain. Interventions for this care plan include, "Administer pain medication and treatments as ordered." R3's TAR dated 1/1/23 to 1/31/23 documents the order: Betadine Solution 10% -apply topically every day shift to promote wound healing. Apply Betadine soaked 4x4s to bilateral feet and apply (absorbent dressing) and then wrap them with (gauze wrap). There was no documentation of this treatment being done as ordered on 1/21/23 (Saturday), 1/22/23 (Sunday), or 1/28/23 (Saturday). There was no documentation in R3's progress notes or on his TAR that he refused these treatments. R3's TAR dated 2/1/23 to 2/28/23 documents the order with start date of 1/31/23: Dakin's (full strength) External Solution: Apply to right foot topically every day shift to promote wound healing for 30 days. Clean wound with Dakin's, apply Santyl and cover with dry dressing. There was no documentation of this treatment being done on 2/5/23 (Sunday), or 2/7/23 (Tuesday). 3. R4's Face Sheet documents her diagnoses to include Abnormal Albumin, Protein-Calorie Malnutrition, Type 2 Diabetes Mellitus.	F 684		

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F 684	Continued From page 38 On 7/5/23 at 10:32 AM V3 (LPN) went into R4's room to provide pressure ulcer and diabetic wound treatments. When V3 removed the dressing from R4's right foot diabetic ulcer, the soiled dressing was dated 7/3/23, indicating it had not been changed the day before as ordered. V3 hand sanitized and donned gloves and removed the soiled dressing. R4 had two elongated diabetic wounds, one on her lateral right foot just below the ankle, and another on her outer lateral right foot, just above the sole of her foot. Both had necrotic tissue covering the wound bases. V3 stated she has had to remove her own dressings before, after returning from having a day off. She stated the staff must have been busy and missed R4's dressing to her right foot yesterday. R4's Physician Order Summary dated 7/5/23 documents an order dated 7/1/23, "Cleanse diabetic wound of the right lower lateral foot, then apply betadine, cover with calcium alginate and wrap with (brand name gauze). Change daily for 16 days. The order previous to this order was dated 6/8/23 to 6/30/23: Cleanse wound to right heel with wound cleanser. Apply (brand name dressing) and (brand name gauze) every 2 days and prn (as needed). (Brand name) boots on for 2 hours and off for 2 hours." R4's TAR dated 7/1/23 to 7/30/23 documents her treatment to her right lateral foot was not done as ordered on 7/2/23 (Sunday) or 7/3/23 (Monday). R4's Progress note dated 7/5/23 at 12:19 PM, back dated to 7/4/23 documents, "Nurse and CNA entered room and attempted to change dressing. Resident refused stating she did not want to turn over. All parties notified."	F 684		

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F 684	Continued From page 39 On 7/5/23 at 2:00 PM, after it was brought to V1's (Administrator) attention that dressing removed today from R4's right lateral diabetic wound was dated 2 days ago, indicating it had not been changed yesterday as ordered. V1 stated, "(V10 LPN) said R4 refused her treatment yesterday. I told her to put a back dated note in R4's chart regarding this." There was no explanation documented for R4's treatment to her diabetic wound to her right lateral foot not being done as ordered on 7/2/23. V1 stated she would expect treatments to be done as ordered by the physician. She stated the nurse should document if a resident refuses the treatment. The facility's policy, Wound Cleansing and Dressings, dated 1/2023, documents, "It is the policy of this facility to cleanse all wounds and clear exudates, bacterial contamination, and debris from the wound bed. Optimal wound healing cannot proceed until inflammation-producing substances are removed from the wound bed. Wound cleansing is completed as indicated in the provider's order by the licensed nurse. It is the policy of this facility to perform wound dressing changes as ordered by the provider using clean technique on all chronic or contaminated wounds."	F 684		