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S 000	Initial Comments Complaint Survey: 2492252/IL171081, 2492737/IL171667, & FRI of 3/17/2024/IL171560	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210b) 300.1210d)6 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Requirements were NOT MET as evidenced: Based on observations, interviews, and record review the facility failed to protect a cognitively and visually impaired resident's (R1) right to be free from physical abuse from another resident (R2) with known history of aggressive behavior for 1 (R1) of 3 residents reviewed for abuse in a sample of 10. This failure resulted in R1 being physically assaulted by R2. Findings include: 1. R1 is a 63 year old male admitted to the facility on 06/17/2019 with diagnosis including but not limited to Type 2 Diabetes Mellitus; Peripheral Vascular Disease; Schizophrenia; Hypertension;	S9999		

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S9999	Continued From page 2 and Presbyopia. According to R1's MDS (Minimum Data Set) assessment dated 01/05/2024 and 10/10/2023 under section C, R1 has BIMS (Brief Interview of Mental Status) score of 7 indicating severely impaired cognition. According to R1's MDS (Minimum Data Set) assessment dated 01/05/2024 under section GG, shows that R1 required supervision/touching assistance or partial moderate assistance with all functional abilities. According to R1's MDS (Minimum Data Set) assessment dated 03/27/2024 under section GG, shows that R1 was dependent with all functional abilities. R1's Abuse Assessment dated 10/10/2023 shows that R1 is not at risk for abuse, despite Developmental/Intellectual Disability confirmed by R1's BIMS score of 7. R1's care plan dated 03/17/2024 reads in part, "Due to vision impairment resident may enter into the wrong room. The behavior may present as wandering. Assist as needed. Check and assure physical comfort." 2. R2 is a 63 year old male admitted to the facility on 03/15/2024 with diagnosis including but not limited to Schizoaffective Disorder; Anxiety Disorder; Encephalopathy; and Hypertension. According to R2's MDS (Minimum Data Set) assessment dated 03/27/2024 under section C, R2 has BIMS (Brief Interview of Mental Status) score of 13 indicating intact cognition.	S9999		

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R2's Comprehensive Behavioral Health Initial Assessment dated 03/15/2024 shows that R2 has a history of aggression and violence; displays frequent Hallucinations/Illusions and almost constant Delusions; Attitude towards Admittance: angry, confused; Adjustment to Placement: Angry over facility placement; resents placement; Copes through display of anger and hostility."

No care plan related to R2's need for monitoring due to aggressive behavior documented prior to 03/17/2024, the day of the incident.

R2's psychiatry progress note from previous facility dated 02/23/2024 reads in part, "Behavior: agitated, restless, combative, stealing from other residents."

3. On 04/09/2024 at 10:42 AM Surveyor approached R2 on the 2nd floor hallway. Surveyor asked about the incident involving him and R1 on 03/17/2024; however, R2 stated something unintelligibly and walked away. R2 proceeded then to follow surveyor throughout the unit, staring, mumbling unintelligibly, and clinching fists in a threatening way. Surveyor did not observed staff redirecting R2 at any point. R2 is remaining in the facility displaying aggressive and intimidating behaviors as observed by a surveyor and shares a room with another resident at this time.

On 04/09/2024 at 10:49 AM Surveyor interviewed R7. R7 resided in the room directly adjacent to R1 and R2's room at the time of the incident. R7 stated, "I was awake on the night of 03/17/2024. The incident happened around 2:00 AM. R1 was howling: "Somebody help!" while R2 was just beating on him. R1 came into my room, he was bleeding from all over his face. R2 beat R1

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terribly. Staff didn't hear them. There was only one nurse that night, V17 (Licensed Practical Nurse), I don't know where all CNAs (Certified Nursing Assistants) were. R2 is still messing with other residents. Everybody knows what happened that day. Nobody talked to me about the incident, you're the first person who asked me about it. After R1 returned from the hospital, he didn't move anymore, didn't come out of his room like he did before."

According to R7's MDS (Minimum Data Set) assessment dated 02/06/2024 under section C, R7 has BIMS (Brief Interview of Mental Status) score of 15 indicating intact cognition.

On 04/09/2024 at 11:29 AM V1 Surveyor interviewed V1 (Administrator/Abuse Coordinator) who stated in summary: I found out about the incident early, around 4.00 am, on 03/17/2024. V17 (LPN) notified me that R1 had a fall and will be sent out to the hospital. Allegedly, R1 hit his head. While they were waiting for the ambulance, R1 said, "My roommate pushed me". Based on that allegation, I initiated abuse investigation. All neighboring residents, in adjacent rooms and rooms across from R1 and R2 room, were interviewed; all of them said they were asleep and didn't hear or see anything. The door to R1 and R2 room was ajar throughout the night. Staff didn't hear or see anything, including V17 (LPN), V11 (CNA), and V15 (Social Worker). We called local police department as part of the abuse investigation procedure, they awoke R2 to interview him, and R2 denied knowing what happened to R1. When police came, R2's behavior changed, he was walking away from them. After that, R2 became agitated and was sent out for psychiatric evaluation. As an outcome of the investigation, we found that R1 had

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laceration above his right eye but no serious injuries from the incident. When R1 came back from the hospital, he remained in bed, so he wasn't ambulating like before. I spoke to R1's Power of Attorney and discussed moving R1 closer to the nursing station to keep him safe. After few days (on 03/27/2024), R1 was transferred out to the hospital for a medical reason, and he passed away (on 04/06/2024).

On 04/09/2024 at 12:43 Surveyor interviewed V12 (Licensed Practical Nurse) who stated in summary: R2 was admitted to the facility on 03/15/2024 around 3:00 PM, close to the change of shift, I was one of the admitting nurses. R2 seemed agitated. When we tried to orient R2 to his room and point to his bed, R2 told us, "I want to be where I want to be" and said "I'm leaving from here". R2 met R1 in the hallway that day but did not display any aggressive behavior towards him at that time. Couple of residents have brought to my attention later that day (03/15/2024), that R2 walked up behind them, into their personal space, which made them uncomfortable. R1 was very active, talkative, and friendly, seemed very happy. R1's vision was very impaired. All residents liked R1 and looked out for him due to his vision impairment. I saw R1 after the incident (on 03/17/2024), the right side of R1's face was very swollen, he couldn't move, he wasn't able to walk or feed himself, or even sit up. R1 has never gone back to his baseline.

On 04/09/2024 at 12:59 PM Surveyor interviewed V13 (Housekeeper) who stated in summary: The way R2 talks and looks at me, I don't know, I'm trying not to acknowledge him. It feels like R2 is targeting me, and couple other residents as well. You know how he looked at you when you were in the unit today? R2 does the same to me. It

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seems like R2 is looking for trouble. It is hard to understood what he's mumbling under his breath too, but I make sure R2 is never behind my back. R2 also writes in his room and on the bathroom walls. I saw R1 after the incident (on 03/17/2024), and he looked really bad, swollen. Residents are asking me why they (facility staff) are not doing anything about R2, they feel very uncomfortable with him on the unit. Everyone is aware that R2 is aggressive.

On 04/09/2024 at 3:28 PM V1 (Administrator) stated that, per V15's (Social Worker) significant other, she is incapacitated and won't be available for an interview during this survey.

On 04/09/2024 at 10:02 AM Surveyor interviewed V14 (Resident Care Coordinator) who stated in summary: I performed R1's MDS assessment in section GG on 01/05/2024. R1 was ambulatory, required partial to moderate assistance with incontinence care, identifying objects, and positioning for safety due to his visual impairment. R1 was able to perform majority of ADLs but staff assistance was required due to his vision impairment and behavior, such as response to internal stimuli, and cognitive incapacity."

On 04/10/2024 at 10:38 AM Surveyor interviewed V11 (Certified Nursing Assistant) who stated in summary: On 03/172024, I was working on the night shift (10:00 PM to 7:00 AM). I didn't hear or see anything that happened between R1 and R2 at the time of the incident. V17 (LPN) came to get me, between 3:00 AM and 4:00 AM, asking if I saw R1 recently. V17 (LPN) said R1 has a knot on his head. We both went to see R1. R1 had bloody face, swollen right eye, and swelling of the entire right side of his face. There was blood on

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S9999	Continued From page 7 R1's bed and the floor. R1 went to the bathroom to wash his face and hands, I assisted him. I didn't see any blood in the bathroom or on the bathroom floor. If I was going to judge where the incident happened, it would have been by R2's bed, that's where the blood was. In the conversation, R1 said he was punched twice in the face and kicked continuously by R2 while he fell to the floor. While I was awaiting an ambulance with R1, R2 kept coming around and asking how is R1 doing, if he's "ok", and if his eye was "ok". I told R2 to give us privacy, R2 got agitated but went back to his side of the room. I did not assess R2 or looked at his fists. Paramedics came 30 minutes later (around 4:00 AM - 4:30 AM). R2 was in the room the entire time. I usually round the unit every 2 hours. I came in at 10:00 PM, started rounding around 10.30 PM and went every two hours from then on. Last time I saw R1 that night was around 01:30 AM and he was asleep in the bed at that time. R2 was walking throughout the unit most of the night. No one mentioned that R2 required additional monitoring. When there is newly admitted resident in the unit, they should be monitored more frequently. I don't believe there is a specific policy for that, it is my personal experience. On 04/10/2024 at 11:30 AM Surveyor interviewed V2 (Director of Nursing) who stated in summary: Myself and V5 (Clinical Director) are supposed to be part of the team who makes decision about resident placement in regard to appropriate room and roommate, but we are just told where to place residents. Surveyor clarified why are V2 (DON) and V5 (Clinical Director) excluded from roommate placement decision despite their clinical experience, V2 (DON) said, "I have no answer to that." V2 (DON) continued: R2 has a psychiatric background, his referral packet	S9999		

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showed past agitation but not violence. Placing R1 and R2 in the same room was not the decision we made. It would be V16 (Admissions Director). New residents should be monitored for the first 72 hours, nurses should be documenting the behavior, or anything abnormal. I was not a part of R1 and R2's incident investigation, I was off one day. I was told R1 had fallen. Upon hospital record review, I found out that something else happened. Medical record alerted me that there was physical assault that occurred. I presented it to V1 (Administrator) and she said that that the outcome of the investigation is that R1 fell. There were no further interventions for abuse because it was concluded it was a fall; therefore, we implemented additional fall precautions for R1. After R1 returned from the hospital (on 03/18/2024), he wasn't eating, dressing, or ambulating, so there was also referral that was placed for therapy. On 03/27/2024, I was notified that R1 was not himself. When I went up to his room, staff had crash cart at the bedside. R1's oxygen saturation was 80%, he had nonrebreather mask, and his blood pressure was very low. R1's blood sugar read as high which means it was above 600. Nurse practitioner ordered 10 units of insulin before ambulance arrived. EMS took over from there. R1 was admitted with diagnosis of DKA (Diabetic Ketoacidosis). I didn't know he died (on 04/06/2024), I just found out today.

On 04/10/2024 at 11:40 AM Surveyor interviewed V5 (Clinical Director) who stated in summary: V1 (Administrator) has a social service background, so she is qualified to make decision in regard to resident placement. I feel like, when I looked at R2's admission packet, that showed agitation but not violence, I assumed it was safe to have R1 and R2 together, in the same room. We're not

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always familiar with entirety of residents' behavior. I was not part of R1 and R2 incident investigation, I was not here. After R2 returned from his psychiatric evaluation, he was placed back in the same room, R1 was moved to a private room, both were located on the same floor. R2 was placed on 72 hour checks and was referred to see a psychiatrist. I cannot answer why this resident was placed in the same room with a new roommate.

On 04/10/2024 at 12:00 PM Surveyor interviewed V16 (Admissions Director) who stated in summary: I am responsible for resident placement in regard to appropriateness of the room and a roommate. I did not think that R2 should not be placed back in the same room with a new roommate upon his readmission on 03/25/2024. Surveyor reiterated that R2 assaulted another resident (R1) recently, V16 continued: The focus was to remove R1 and place him in another room, but R2 was assessed as safe to return to the same room with a new roommate. I make my decision based on nurses and social service staff assessments when I make room assignments.

On 04/10/2024 at 12:40 PM Surveyor interviewed V17 (Licensed Practical Nurse) who stated in summary: I was doing rounds on 03/17/2024, between 3:00 AM and 4:00 AM, when I found R1 sitting on the edge of his bed with some injuries. I asked him what happened, R1 said that he fell. I did my assessment then and notified the doctor. The doctor ordered to send R1 to the hospital. R1 had injury to his eye and had some bleeding. I assessed the rest of his body and there were no other injuries. R2 was agitated at that time, manic, restless, kept going back and forth all night, and talking to self. He was more agitated

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than usual. R2 was pacing in the hallway, going back to the room occasionally. I did not hear or see the incident and there were no witnesses at the time. I didn't see any blood on the room's floor, maybe a little on R1's sheet. I notified administrator and family in addition to the doctor. R2 was a new resident. I got a report upon beginning of my shift, but I was not endorsed anything special about R2. When we have a new resident, we should monitor every hour for about 3 days. The monitoring occurs between nurses and CNAs. Surveyor clarified if V17 (LPN) addressed R2's escalating behavior on 03/17/2024 before the incident occurred, V17 said, "R2 was sent out to the hospital for behavioral evaluation after the incident"; however, V17 (LPN) did not directly answer surveyor's question.

Based on the record review, no documented interventions for R2's escalating maladaptive behavior on 03/17/2024 between 11:00 PM and 4:00 AM noticed.

Based on the record review, no documentation of R2's new admission monitoring between 03/15/2024 2:30 PM and 3/17/2024 4:10 AM noticed.

On 04/10/2024 at 1:15 PM Surveyor interviewed V19 (Licensed Practical Nurse) who stated in summary: I performed R1's assessment on 03/27/2024. R1 was not responding and not talking, he was lethargic. I had to crush his medications that day. I checked his blood sugar, it was abnormal. I told another nurse, she put him on oxygen, and I went to call 911 and V2 (DON). I've known R1 for a very long time. R1 was almost blind, but he could walk around. R1 could also talk and was able to eat independently. R1

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could even go to the bathroom with minimal assistance. All I know in regard to the incident that happened on 03/17/2024, is that they sent R1 to the hospital but not sure why. I went to R1's unit the following day (03/18/2024) and one of the resident's said that R1 was beat up by another resident. R1 said to me "I was beat up because I was in wrong hand", I don't know what that meant. I've never met R2, but I spoke to one of the CNAs who took care of R2 in another facility, and she said, "What is he doing here? (R2) is very dangerous, (R2) bit me up there".

On 04/10/2024 at 3:23 PM Surveyor interviewed V27 (Medical Director) who stated in summary: I am a medical director of this facility. I don't know specific details about the incident that occurred between R1 and R2 on 03/17/2024, but I was notified that they had an altercation and R1 suffered laceration to the forehead. R1 was intact in regard to his functional ability before the incident on 03/17/2024. R1 was alert to self and had history of non-compliant behaviors. He had BIMS of 7, which means severe cognitive impairment. If R2 had BIMS of 13, that means he is not severely impaired and is able to understand and comprehend. Based on the BIMS score it does not seem these two residents are at the same level. If two residents like that are monitored and assisted, their cohorting may be acceptable; however, if there is lack of supervision and monitoring, it would not be appropriate.

On 04/11/2024 at 1:30 PM Surveyor interviewed V34 (Primary Metal Health Nurse Practitioner) who stated in summary: R2 was referred to psychiatry post the incident on 03/17/2024. I assessed R2 on 04/01/2024. R2 was very aggressive and irritable during my assessment

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that day. R2 was very guarded, not easy to talk to, and not very friendly. Facility should monitor residents like R2 closely and make sure their roommates are safe. Resident displaying agitation would not be appropriate to be placed in the same room with cognitively and visually impaired roommate. Especially, a resident who is visually impaired might invade others' space and appear as wandering into another's resident private space. That can cause a conflict. I would expect that a resident who displays aggressive behaviors, such as psycho motor agitation, in simple words, when someone is trying to hit, kick, bite, push, but also, call names, clench fists, mumble under their breath, or position in fight stand, should be initially admitted into a private room under close monitoring. Aggressive behavior may also take on indirect form, including walking up behind somebody, into their personal space, it's like bullying. R2 was definitely not appropriate to be placed with his roommate (R1).

On 04/15/2024 at 12:19 PM Surveyor interviewed V35 (Certified Registered Nurse Practitioner) who stated in summary: I get report from my company nurse who gets notified of any residents requiring assessment via record review. There is no face to face or phone report, it is exclusively based on record review. I came in and assessed R1 on 03/18/2024, after his hospital readmission. R1 was weak, it was unlike him, usually R1 was able to get up and walk. R1 responded to his name only, unlike before, R1 was able to respond to questions not only to his name. R1 had steri strip and laceration to his right eyebrow. R1 also had some swelling to the right eyebrow. Based on his change in physical condition, I ordered physical therapy. I was told R1 fell, I did not inquire further. I reviewed R1's hospital records, hospital records said it was a physical assault. I asked the nurse

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S9999	Continued From page 13 on the floor for clarification, she said the incident was documented as a fall but R1 said he was assaulted. Based on R1's injury, it could have been either assault or a fall, but the hospital record read it was an assault; I don't know what was the source of R1's injuries. On 04/15/2024 at 1:28 PM Surveyor interviewed V36 (Licensed Practical Nurse) who stated in summary: On 03/18/2024, R1 was readmitted to the same room as before the incident. R1 complained of pain, so I notified NP, she ordered him pain medication and I gave it to him. R1 had laceration on the right side of his face, had steri strips on his forehead. He also had bruising around his right eye area. I didn't have a chance to assess the rest of his body because he refused due to pain. I didn't ask R1 what happened. He was not able to get up and feed himself. Before the incident he was able to walk and feed himself. I only worked with R2 on 04/08/2024. I was not told anything specific about him. We check on resident at least every 2 hours. If residents are yelling, have behaviors, or verbal altercation occurs, we notify social workers, check if they have PRN and notify the doctor. If they have physical aggression, we separate them and send them out to the hospital. If a resident is sent out to the hospital for behavioral evaluation, it is usually a behavior that we are not able to manage in the facility. On 04/11/2024 at 11:07 AM, on 04/15/2024 at 10:47 AM, and on 04/15/2024 at 03:08 PM surveyor attempted to call V15 (Social Worker), no answer, voicemail left. Surveyor did not receive call back from V15 (SW) during the course on the investigation. On 04/17/2024 at 12:38 PM Surveyor interviewed	S9999		

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S9999	Continued From page 14 V40 (Emergency Department Clinical Lead) who stated in summary: We have certain criteria in the emergency department that we use to determine if trauma response needs to be initiated, some of those criteria are penetrating injury or exposed skull fracture. Team purple is trauma team who responds to patients with trauma triggered injuries. Trauma response is not triggered for falls from standing position, it can be triggered for falls from 10 feet and above. Surveyor clarified that team purple was triggered for R1 upon his admission into emergency department on 03/17/2024, V40 said: If trauma response was initiated in the field, we know that patient's injury met trauma criteria and requires specialty team response, such as trauma team. 4. Progress noted dated 03/15/2024 at 2:30 PM by V12 (Licensed Practical Nurse) reads in part, "(R2) arrived on foot by admission staff. (R2) alert X3, confused, aggressive, and hard to redirect. (R2) doesn't want to be touched, don't allow for writer to complete assessment." Facility Reported Incident dated 03/17/2024 reads in part, "On 03/17/2024 at approximately 4:00 AM while in his room, (R1), informed the unit nurse (V17 LPN) that he fell while attempting to go to the bathroom. (R2) later alleged to the CNA (V11), that he had an altercation with his roommate (R2). This allegation was unsubstantiated. Abuse is not found in this occurrence and was not substantiated as this allegation and fall appears to be a sign and symptom of his disease process." Progress note dated 03/17/2024 at 4:10 AM written by V15 (Social Worker) reads in part, "While doing rounds, (R1's) door was ajar and the writer noticed (R1) sitting on the bed in the middle of the night, the writer walked in (R1's) room and	S9999		

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noticed an injury, the writer asked (R1) how did he get the injury but (R1) did not respond. (R1) just pointed to the injury. The nurse and the doctor were notified."

Progress note dated 03/17/2024 at 4:10 AM written by V15 (Social Worker) reads in part, "The writer tried to speak to the (R2), and (R2) was very agitated, talking to himself, making delusional and very un-redirectable. (R2) was irritable every time anybody approached him. The nurse contacted the doctor, and the doctor ordered to send (R2) to local psychiatric hospital."

R1's ambulance sheet dated 03/17/2024 reads in part, "Primary impression: Injury of Head; Chief Complaint: Head Trauma; Injury: Assault with bodily force. Initial Patient Acuity: Emergent; Final Patient Acuity: Emergent. (Ambulance) arrived on scene for (R1) A&Ox3 (alert and oriented to person, place, and time) per normal; now is A&O x1 (alert and oriented to person) head trauma. (R1) was assaulted by his roommate (R2). (R1) has swelling, deformity, and bruising. (R1) did state that he was hit 15 times by his roommate's (R2) fists and feet."

R1's hospital record dated 03/17/2024 reads in part, "(R1) arrives via EMS s/p (status post) possible assault by roommate. Per EMS, (R2) hit (R1) approximately 15 times with hands and feet, (R1) unable to see out of right orbit. Exam: CT heads without intravenous contrasts; Findings: There is a hematoma along the right frontal scalp and right lateral orbital wall; Orbits: increased attenuation in the bilateral orbital globes suggesting vitreous hemorrhage."

R2's hospital record dated 03/17/2024 reads in part, "Chief complaint: (R2) here via (local fire

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department) with involuntary petition from nursing home for aggressive undomiciled behavior per nursing home staff (R2) is unable to be redirected and does not follow commands very well, and hence render a threat to himself and others. All history was obtained from nursing home records as (R2) tends to remain agitated and noncooperative. Past medical history known of unspecified encephalopathy, psychoactive substance abuse, schizoaffective disorder, essential hypertension, CC: bizarre/Paranoid Behavior."

R2's hospital record dated 03/20/2024 reads in part, "(R2), here for an evaluation of Altered Mental Status. History was obtained from nursing home records as (R2) remains agitated and uncooperative. (R2) is awake, restless, agitated, uncooperative, behavior unpredictable, incoherent speech."

Police report dated 03/17/2024 reads in part, "Upon arrival, reporting officer, spoke with V15 (Social Worker) who stated that R2 had battered R1 in (their) room. The reporting officer spoke to V11 (CNA) who stated that (R1) told him that (R2) punched him in the face twice and knocked him down twice. The reporting officer spoke to V17 (LPN) who informed the reporting officer that R2 will be transported to (local psychiatric) hospital for mental health issues and R1 will be transported to (local) hospital for fractured face."

5. The facility "Abuse Policy" dated 09/20 reads in part, "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a

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facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Serious Bodily Injury is an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medica intervention such as surgery, hospitalization, or physical rehabilitation. As part of social service assessment, staff will identify residents with increased vulnerability for abuse or who have needs 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 mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis."

(A)

Statement of Licensure Violations 2 of 2

300.610a)
300.1210b)
300.1210d)6

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The

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S9999	Continued From page 18 policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide adequate supervision and monitoring on a resident assessed to be at risk for elopement due to history of elopement from previous nursing home; failed to ensure the resident did not leave facility	S9999		

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without staff knowledge or supervision; and failed to follow elopement policy on procedures and reporting. These failures affected one (R5) of three residents in a sample of 10 reviewed for elopement risk and supervision. These failures resulted in R5 able to eloped from facility. R5 experienced harm by walking to emergency room without shoes on and having to cross a high-volume traffic intersection at night, while allegedly experiencing chest pain.

Findings include:

R5 is a 75-year-old, female, admitted in the facility on 10/20/23 with diagnoses of Schizophrenia, Unspecified; Schizoaffective Disorder, Unspecified; Dementia in other Diseases Classified Elsewhere, Moderate, with Other Behavioral Disturbance; and Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris. Exit Seeking/Wandering/Elopement Risk Assessment dated 01/17/24 documented that R5 is cognitively impaired with deficits in orientation, decision making related to Dementia, Severe Mental Illness, and was assessed at risk for elopement. Community Survival Skills Assessment dated 10/20/23 recorded that R5 is not able to navigate safely on community streets. MDS (Minimum Data Set) dated 04/01/24 documented R5's BIMS (Brief Interview for Mental Status) score of 9 which means moderate impairment in cognition.

Hospital referral packet dated 10/20/23 recorded that R5 has history of elopement from previous nursing home; and will need placement in a memory care unit.

According to progress notes dated 04/06/24, at around 9:30 PM, V4 (Licensed Practical Nurse,

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LPN) observed the alarm on the back door gone off and sounding. Code Green for elopement was called and headcount on the unit was initiated. One staff went outside to look for a resident who left unattended but reported did not see anybody. Another staff helped with the head count. As staff conducting head count, a staff from another unit received a call that R5 was in the hospital.

On 04/08/24 at 2:12 PM, V3 (Certified Nurse Aide, CNA) was asked regarding incident on 04/06/24 with R5. V3 stated, "On 04/06/24, I was the CNA on the floor, and she (R5) was my resident at the time. Like around 8:00 to 9:00 PM, I started putting residents on bed. She came to me and asked if I was her CNA. I said yes and asked if she needs something. She said she needed a brief and a blanket. I gave it to her, and she went back to her room. She is not incontinent. Then, I continued to put other residents on bed. Suddenly, the door alarmed. V4 (Licensed Practical Nurse, LPN) called me to check the alarm. He (V4), I and V30 (CNA) checked residents in their rooms and did a head count. V30 went outside and looked for the resident who opened the door. While we were doing the head count, V28 (LPN) came down and said that R5 was in the hospital. We were doing the head count for like less than half an hour. V28 turned off the alarm and we continued to check on everybody. I am not aware that she (R5) has history of elopement. She (R5) was always sitting in her bed during my shift. She is alert, oriented, able to move around without assistance. She has a walker."

V4 was also interviewed on 04/08/24 at 2:45 PM, stated, "On 04/06/24, I was the nurse assigned on R5. Around 9:30 PM, I heard an alarm went off from the unit exit door. I asked myself, maybe

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somebody must have used the door. So, I called Code Green right away. Code Green is for elopement. My staff, V3 and V30 went to the door and went outside. While I do the head count, I found out R5 was missing. That would be like 9:40 PM already. As we were doing the head count, V28 came down and said hospital called, said R5 was in the hospital. I called hospital, was told that she (R5) was with them, in the emergency room. I called V1 (Administrator) and reported the incident. To be honest, R5 is not one of those residents that need to be monitored. She does not have a behavior and very compliant. I was unaware that she has history of elopement. She walked with the use of walker, he walked slowly. That time, she was able to leave facility unnoticed."

V28 also stated during interview on 04/08/24 at 3:19 PM that she was working on the second unit when the phone rang. V28 continued, "That was 10:00 PM, I received a call from the hospital stating that they have a lady in the lobby and wants to know if the lady is from our facility. I asked the name and she gave me R5's name. I went to third unit; the code green was on. I told V4 that she (R5) was in the hospital, and I gave him the hospital phone number."

R5 was able to leave facility on 04/06/24 unnoticed, unsupervised. R5 is a resident in the Memory Care Unit in the facility, which is a secured and locked unit on the first floor. Observation on 04/09/24 at 10:25 AM showed that the exit door where R5 exited on 04/06/24 has an alarm. The door will alarm when push bar is pressed and when door is fully opened, a secondary continuous loud alarm will be heard in the entire unit. The hospital is located two blocks east from the exit door. The hospital is situated at

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S9999	Continued From page 22 the intersection of a busy street. On 04/09/24 at 9:58 AM, V5 (Social Services Director) was interviewed regarding R5. V5 verbalized, "She is alert and oriented, sometimes she gets confused. She uses a walker to ambulate. Prior to her coming here, she is already on the list for elopement risk. However, since she'd been here, she never attempted to elope. Basically, it is more on supervision. The staff are made aware of these elopement risk residents. Regarding incident on 04/06/24, I was made aware on Sunday, 04/07/24 that she (R5) eloped and was in the hospital. She (R5) cannot go out by herself, she needs staff or family assistance. She has Dementia, has Schizophrenia and Schizo affective disorders. The exit doors have alarms. When staff heard an alarm, they have to attend to the door and redirect resident who wants to go out. She (R5) came back last night; she was placed on a 72-hour well-being check; I am sure her physician was notified and she remains in the elopement risk and we will be monitoring her - one on one counseling; every 15 minute check; she needs to be supervised all the time." On 04/09/24 at 10:40 AM, R5 was observed sitting in her rollator walker by the nurses' station. She was alert, oriented, wearing yellow nonskid socks. R5 was asked regarding incident on 04/06/24. R5 replied, "I came back from hospital last night. I was in the hospital down there. I had chest pain and I had pain in the stomach and tooth. That time, I told the nurse that I was having chest pain, don't know his name, and he was not paying attention or anything so I walked down there to the hospital. I was scared that I might be having a heart attack, it frightens me. I was gone for a day."	S9999		

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S9999	Continued From page 23 Progress notes dated 04/08/24 time stamped 8:59 PM recorded R5 came back to facility. On 04/09/24 at 11:40 AM, V1 was asked regarding elopement incident on R5. V1 replied, "I am the one investigating her elopement. She is alert, oriented to place, able to ambulate using a rollator. She was placed on the elopement risk upon admission. Her referral paperwork stated that she had history of elopement. All the staff were made aware that she is an elopement risk. For her, she had not displayed any exit seeking behaviors since admission, she was placed in the Memory care unit, Unit 3, which is one of our secured units. She is monitored and supervised - CNAs and nurses do rounds every hour. We also have ambassador rounds which we check residents if they have behaviors, concerns and for needs. These are the basic interventions that we implement and should be in the care plan. I was notified last 04/06/24, like little after 10:00 PM by V4, the nurse, that she (R5) had left the building and was in the hospital. I asked him about the details. He told me that CNA provided her with care around 9:30-9:35 PM and continued with her rounds. The door alarm was activated roughly around 9:45 PM. He said he went down to door where the alarm was and asked other CNAs to come. One went outside to search around but did not see her. They started the headcount, initiated the code green. And that's when she discovered R5 was missing. He was headed to the phone when he was given information that she (R5) was in the hospital. He made his notification to me, to V2 (Director of Nursing) and V32 (Assistant Director of Nursing). We did the debriefing and started the investigation to find out how it happened. We started to do in-services on staff regarding elopement. We did not do any reporting	S9999		

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S9999	Continued From page 24 to local state agency because she was found in less than an hour, probably like 20 minutes and sustained no injuries. I still have no definitive answer as to how she (R5) was able to get out that night. Nobody said that they saw her out the door and was never seen when they looked outside. She exited from the exit door at the end of the hallway. That was the only one activated at the time she was missing. And that was the conclusion that it was the main exit point." On 04/09/24 at 1:32 PM, V30 was asked regarding R5's incident on 04/06/24. V30 verbalized, "On 04/06/24 about 10:00 PM, I started my shift, I will be working night shift. The moment I was coming in the unit, I headed to the break room. As I enter the break room, V4 came into the breakroom and asked me if I heard an alarm. I didn't hear any sounding alarm, but something sounded like a call light. He (V4) said door alarm was going off, and we need to do a head count. It was me and him (V4) doing the head count, while V3 was doing the head count on the other side of the unit. As I do the head count, I immediately noticed that R5 was not in her room. I told V4. I started to look where the alarm was. I went out of the back door and back of facility, but I did not see her (R5). I searched into the back alley but did not see her (R5). It was only me who went and looked outside. I went back and as I was about to enter the unit again, V28 said R5 was in the hospital. When I came in that time around 10:00 PM, I did not hear any alarm but as I entered Unit 3, the alarm already went off. We did head count first, then I went outside to look. We were told during in services that if we hear an alarm, do a head count first, then search from the door where alarm was going off."	S9999		

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	IL6004139	A. BUILDING: _____ B. WING _____	C 04/18/2024

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S9999	Continued From page 25 R5's Hospital Records dated 04/07/24 recorded in part but not limited to the following: Chief complaint - chest pain History of Present Illness - presents to emergency department via emergency medical services for evaluation after found wandering in traffic with a walker and without shoes. Patient (R5) resides at a nursing home. Patient (R5) states she has been experiencing left sided chest pain for three days. She describes a fullness at her chest. She has new onset tooth pain, shortness of breath, and left upper extremity pain. She reports alerting nursing home staff of her symptoms. Patient (R5) became concerned due to having history of a heart attack and decided to leave the facility due to "not getting proper care." Review of systems: HENT (Head/eye/nose throat): tooth pain; Cardiovascular: Positive for chest pain and leg swelling (chronic); Respiratory: Positive for shortness of breath; Musculoskeletal: Positive for left upper extremity pain Clinical Impression: Chest pain, Unspecified type V29 (Physician/Hospital) stated during phone interview on 04/09/24 at 1:27 PM that R5 was found wandering and came to the hospital for chest pain. V29 added, "She is alert, oriented to time, place and person. I was told by resident (R5) that she left on her own and she was having chest pain, and she was admitted in the hospital." V10 (Hospital Staff) also stated, "I was the nurse assigned to R5. That was last Saturday, 04/06/24, she was found in the middle of the road by a bystander. The bystander called paramedics and she was sent here. She had no shoes at the time, said she was having chest pain. She told me that facility told her to leave and helped her out the door. I called facility, spoke to V4. V4 said he saw her leaving the facility but then he changed his	S9999		

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S9999	Continued From page 26	S9999		

story that he did not see her leaving, then changed his story that he just heard the door alarm."

On 04/10/24 at 9:30 AM, R5 was observed in her room, sitting in her rollator walker. Surveyor made a follow up interview on the night she eloped from facility. R5 stated, "When I went to the hospital, I was on my feet, no socks. I walked on the rocks. A lady passed by, and she said if I needed help. She helped me and brought me to the hospital. No one saw me when I left that night, I passed by the nurses' station though."

A follow up interview with V4 was conducted on 04/10/24 at 9:51 AM stating that he did not see R5 leaving the facility and did not speak to the hospital staff about seeing her (R5) leaving the unit. V4 also stated that he has no knowledge and awareness that R5 was complaining of chest pain on 04/06/24.

R5's care plan dated 03/30/24 documented: R5 is at risk for elopement related to physical ability to leave unit/facility, exit seeking behavior at former placement per hospital referral packet. Interventions: Consider potential variables, boredom, thirst, hunger, need for toileting, pain, exercise, companionship, exhaustion and over stimulation.

On 04/10/24 at 11:24 AM, V2 stated during interview, "I believe R5 is on the elopement risk list. The list needs to be updated as needed. The expectation from staff is they do rounds frequently; observe for signs of behavior like exit seeking and residents should be directed. When door alarms, they should get up and see where it is coming from. If it is a door alarm, they need to go to the door, look outside and around the area.

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S9999	Continued From page 27 The rest of the staff are already doing the head count. If there is a missing resident, they should call Code Green. V32 just told me today that she (R5) had an incident of elopement last 04/06/24. I was off during the weekend and just came back today." On 04/10/24 at 3:22 PM, V27 (Medical Director) was asked regarding R5 and elopement precautions in the facility. V27 stated, "R5 was the one who eloped. I was notified that she just eloped, did not find her, tried to look for her everywhere and found that she was in the hospital. She has no history of elopement from what I have known, not sure if she had one. She was placed in a locked unit. If it is a locked unit, staff wants to make sure it is locked all the time, which means it is secured making sure everybody is safe and secured inside. Keep the place locked, secured. Monitor the flow on who is going and coming. I don't know why it happened because it is a locked unit. We need to do an investigation how it happened. Staff needs in-services regarding elopement prevention protocol and see if they follow the protocol, and implement the protocol. Somebody did not follow the process. I am sure there is an elopement protocol that I need to review. She (R5) came back, from what I remember on the same day and there were no injuries, nothing significant based from the nurses' notes from the hospital. I was not aware that she had chest pain. I did not know about it. Typically, if a resident complained of chest pain, take vital signs, make them stable and call paramedics to hospital as I ordered." Facility's policy titled, "Elopement and Management of Missing Resident" dated 03/28/2023 documented in part but not limited to the following:	S9999		

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S9999	Continued From page 28 Policy: It is the policy of this facility to report and investigate all reports of missing residents and to minimize risks of elopement. Procedure: 1. Responding to a Door Alarm: a. It is the responsibility of all staff to respond to activated door alarms to determine the reason for the alarm sounding. b. If able to determine the reason for the alarm sounding, reset the door alarm and no further action is needed. c. If unable to determine the reason for alarm sounding, "CODE GREEN" and the location of the "CODE GREEN" should be announced 3 times over the intercom. 3. Suspected Missing Resident: p. Upon return of the resident to the facility, the Director of Nursing or designee should: vii. If resident sustained injury, a report will be made to local state agency. On 04/11/24 at 10:51 AM, V1 was asked regarding R5's elopement incident notification to local state agency. V1 replied, "On 04/06/24, I was notified by V4 that she (R5) was missing. We did not do any reporting to local health agency because she was located within an hour of missing with no injuries. When she came back, we did not do any reporting as well because she has no injuries. I spoke to R5 when she came back and did not mention that she went to the hospital because of chest pain. I called hospital and was told that she went there because of bunch of reasons but not chest pain." R5's Hospital Discharge Summary dated 04/08/24 recorded diagnosis: Atypical Chest Pain.	S9999		

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S9999	Continued From page 29 R5's care plan dated 04/04/24 documented: Potential for altered cardiac function - Intervention: Monitor for changes in status and report to MD (Medical Doctor) as needed. Facility's policy titled "Incident/Accident Reports" dated 09/2020 stated in part but not limited to the following: Procedure: 12. The Director of Nursing, Assistant Director of Nursing or Nursing Supervisor must notify: a. (Name of local state agency) of any serious incident or accident. "Serious" means any incident or accident that causes physical harm or injury to a resident. Note: Physical harm or injury does not include skin tear or bruise or something covered with a band-aid. Physical harm would include a broken bone, or blood flow not stopped by a band-aid or hospital or emergency room treatment that involves more than diagnostic evaluation. (B)	S9999		