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	IL6008155	A. BUILDING: _____ B. WING _____	C 04/26/2024

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S 000	Initial Comments Complaint Investigation: 2482134/IL170954	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.610c)2) 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. c) The written policies shall include, at a minimum the following provisions: 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including	S9999		

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laboratory and x-ray);

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)

These regulations were not met as evidenced by:

Findings include:

Based on interviews and review of records, the facility failed to protect the residents' right to be free from physical abuse by resident (R2) against another resident (R1). The facility failed to follow their abuse policy by not having preventative measures in place for a resident with a history of physical, verbal, and sexually inappropriate behavior. The facility failed to have preventative measures in residents (R1) care plan before and after a resident (R1) was physically abused. These failures led to a resident (R2) physically assaulting another resident (R1) causing multiple injuries.

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Findings include:

Facility reportable dated 8/1/2023 between R1 and R2: Per report facility substantiated the incident of physical abuse between R1 and R2 did occur, and that due to the incident R1 sustained injuries. Per hospital records dated 8/2/2023 R1 sustained multiple bruises to the right side of her face, under her right eye, right upper arm and forearm, left shoulder, and scratches to her left forearm.

R1 is 67 years old, initially admitted in the facility on 9/6/2022. R1's medical diagnosis includes atherosclerotic heart disease of native coronary artery. R1's cognition is intact with a brief interview of mental status (BIMS) dated 2/12/2024 with a score of 15. On 4/23/2024 at 12:40 PM, R1 was seen sitting on her bed inside her room. R1 was alert, verbally responsive, and able to express her thoughts during conversation. R1 stated that 8/1/2023 was the day when R2 hit her on her face. R1 stated that when R2 was first admitted it became clear that R2 has changes in behavior and becomes darker and darker, violent, and bullies her. R1 said that she is afraid that R2 will hurt another person in another facility. R1 said that R2 was very violent and that R2 was even physically aggressive with a social worker staff in the facility.

R2 is 56 years old, initially admitted in the facility on 4/28/2023. R2's medical diagnosis includes psychosis, schizophrenia, restlessness, auditory hallucination (threatening to harm himself and others), and agitation. R2's cognition is intact with a brief interview of mental status (BIMS) dated 5/4/2023 with a score of 15. Per census record, R2 was discharged from the facility against medical advice on 8/18/2023. Identified Offender

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Report of R2 recorded the following: Armed habitual criminal, unlawful use of weapon, multiple aggravated battery, multiple domestic battery, multiple aggravated robbery, home invasion, resisting peace officer.

Per R2's progress notes, R2 has multiple incidents of physical, verbal, and sexually inappropriate behavior to both staff and residents in the facility. Progress notes of R2 are as follows: On 5/2/2023, V22 (Activity Aide) documents: R2's diagnosis includes depression with psychosis, auditory hallucination, hearing voices, threatening to harm self and others, seeing dead bodies, non-compliant with medication. On 6/8/2023, V23 (Social Worker) documents: R2 yelling and angry said barely got sleep due to his roommate being loud and calling his name. 6/13/2023 R2 was horse playing with another resident, R2 was being too rough with that resident. On 6/13/2023, V19 (Registered Nurse) documents: R2 was raising voice towards staff and co-resident because of co-resident's complaint of disturbing his sleep due to female resident present in his room. On 6/15/2023, V9 (Registered Nurse) documents that R2 was under suspicion of drinking ETOH or alcoholic drinks. On 7/5/2023, V20 (Licensed Practical Nurse) documents: R2 started playing loud music at 10:30 PM and was verbally inappropriate toward staff and residents. On 7/2/2023, V19 (Registered Nurse) documents that R2 was agitated and verbally aggressive towards staff and refused to let female resident leave the room. 7/3/2023 documents: R2 was ordered by V16 (Psychiatrist/Physician) via involuntary petition due to aggressive behavior. Police intervention was needed prior to transfer to the hospital. On 7/27/2023, V9 (Registered Nurse) documents: R2 was reported to attempt to touch on another staff

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buttocks while the staff was getting the food cart. On 7/31/2023, V21 (Director of Nursing) documents: dietary staff reported that R2 touched her inappropriately by brushing against her. On 8/1/2023, V9 (Registered Nurse) documents that R2 was physically aggressive to R1 resulting in multiple injuries. On 8/2/2023, V8 (Licensed Practical Nurse) documents that R2 was admitted for aggressive behavior to the hospital. On 8/15/23, V9 (Registered Nurse) R2 was readmitted back to the facility. On 8/18/2023, V11 (Social Worker) documents: R2 assaulted writer (V11), hit her in the head three times, once in the ear and twice on the neck.

On 4/24/2024 at 12:38 PM, V11 (Former Social Worker) stated that since the start of her employment in the facility around July 2023, R2's behavior was making her feel uncomfortable. R2 was very aggressive and violent. He (R2) punched another Social Worker (V10) very hard on his face. V11 stated when she saw R1's face after the incident that happened on 8/1/2023 it was hurt badly. V11 confirmed that R1 and R2 are in a relationship. V11 stated that there was no determination or assessment as to R1 and R2's safety in their relationship with R2's behavioral concerns.

On 4/24/2023 at 1:08 PM, V10 (Former Social Worker) stated that R2 assaulted him and V11. R2 was abusive to staff members and also directed his abuse to residents. R2 targets certain residents, including R1 even before the incident on 8/1/2023 happened. V10 stated R1 and R2 were separated and that he told R2 that he was restricted to go to a specific floor. V10 did a care plan on his (R2) behavior.

Abuse Prevention Program Facility Procedures

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S9999	Continued From page 5 dated November 18, 2016, reads: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain, or mental anguish. Under pre-admission screening of potential residents. The facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal conviction. While the background or fingerprint check, and/or Identified Offender Report and Recommendation are pending, the facility shall take steps necessary to ensure safety. Under resident assessment, as part of the resident social history evaluation and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, or misappropriation of resident property or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify 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. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendations Report into the identified offenders plan of care including the security measures listed. Abuse policy of the facility clearly instruct for facility staff to identify residents with increased vulnerability of abuse or who have behavior that might lead to conflict. R2's care plan does not address any of the incidents on R2's progress notes to address his physical, verbal, and sexually inappropriate behavior.	S9999		

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No psychiatric notes or any medical notes by physician(s) were documented on R2's progress notes that addresses R2's inappropriate behavior. On 4/24/2024 at 2:48 PM, V1 (Nurse Consultant) was informed about R2's lack of documentation and that he wasn't seen by a psychiatrist or any physician on his progress notes. After V1 reviewed R2's electronic record, V1 stated that she cannot find any documentation. V1 stated that there should be a sit down and facility staff should work together to determine that residents are safe and that R2 needs to be seen by a psychiatric or medical doctor when initially admitted and readmitted within 72-hours after admission. V1 said, "I don't know why there is no documentation that R2 was not seen by any doctor."

As to R1's care plan, it does not address potential abuse prior to and actual abuse after the physical abuse incident happened on 8/1/2023.

On 4/24/2024 at 11:45 AM, V7 (Social Service Director) stated that currently she is in-charge of the whole facility and all residents since she is the only social worker in the facility. V7 was asked about R1 being a victim of abuse and if there is a need for this to be care planned. V7 said, "I am new to this position. I don't know that an abuse incident should be care planned for the resident that experienced abuse. For me, I will talk to the admin for best practices." V7 was asked if there is a need to determine safety of both residents for residents that are couple. V7 said, "If both can give consent. I don't know if I need to check on the safety of residents that are a couple even when a resident has a record of domestic violence. Hypothetically, I don't really know the guidelines on how to protect the victim from the perpetrator. These are all new to me." V7 then

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S9999	Continued From page 7 stated that room changes and coordination of outside services for domestic violence are possible interventions. After request for behavioral services, policies, and procedures V7 said, "I don't know what are those (sic) behavioral services that the facility offers." The facility's Behavioral Management Protocol and Guidelines for Handling Behavioral Emergencies and Reducing Hospitalization dated January 2019, reads: Staff need to decide how likely a resident is to lose control by determine (sic) if there is a history of aggressive and /or unpredictable behavior. If a resident is the person making delusional (untrue) statements. If a resident behavior is illogical. The facility's Abuse Prevention Program Facility Procedures dated November 18, 2016, reads: Through the care planning process, staff will identify any problems, goals and approaches which would reduce the changes 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. (B)	S9999		