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	IL6005227	A. BUILDING: _____ B. WING _____	C 07/12/2024

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S 000	Initial Comments Complaint Investigations: 2485073/IL174975 2485094/IL174961 Facility Reported Incident of June 19, 2024/IL175037 Facility Reported Incident of June 24, 2024/ IL175035 Facility Reported Incident of June 20, 2024/IL175038	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3)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. Section 300.1010 Medical Care Policies	S9999		

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S9999	Continued From page 1 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

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further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 by:

Based on observation, interview and record review, the facility failed to follow professional standards of practice and facility policy in maintaining a safe environment free of injury, failed to follow a resident's (R2) care plan, failed to follow up on residents' complaints of pain for two, and failed to protect two (R1, R2) residents' rights to be free from physical and verbal abuse (R2, R5) out of a sample of three residents. These failures resulted in R2 experiencing new onset of right foot pain which started on 6/24/24 and R2's physician was notified four days later on 6/28/24. X-Ray was obtained for R2 on 6/30/24 with findings revealed a new healing subacute fracture of distal right fourth metatarsal. These failures also resulted in R5 experiencing left knee pain for one week and a left femoral condyle

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fracture diagnosed on 7/10/2024, 7 days after injury on 7/3/2024.

Findings Include:

On 7/9/2024 at 10 AM R5 stated on 6/20/2024, R5 went down the outside ramp of the facility while sitting in her wheelchair. R5 stated, "I plowed into a brick wall, and I broke my knee cap." R5 stated both knees hurt after the incident, but the left knee hurt worse than the right knee. The facility sent R5 to the hospital where R5 stated she was diagnosed with a left broken knee cap. R5 stated, "They gave me a knee brace for my left knee." R5 stated on 7/3/2024 a Certified Nurse Aide (CNA) was assisting her to bed and R5's right knee bumped into the bedframe. R5 stated, "It hurt. It was a '10' on a scale of 1-10. I was in such agony. They have been giving me pain medicine and pain patches, but I would like an x-ray to see if something has been broken or fractured." R5 stated during the day on 7/3/2024, R5 was starting to do good in therapy. R5 stated, "The therapist said the next time I would stand for 10 minutes. I walked from the bed to and from the bathroom twice and the physical therapist was very pleased. He said I would do more tomorrow and then I bumped the bedframe with my right knee evening. Since I bumped my knee, I have not been able to do much in therapy." R5 stated, "I am not currently walking. I am very dependent now. I was walking prior to hitting my right knee on the bedframe. The therapist was a bit dismayed they haven't taken x-rays of the right knee." R5's right knee was observed to be swollen and had ecchymosis with a pea-sized scabbed area at medial-lateral distal right knee. A white patch with the word "Lidocaine" was observed rolled in a trifold on the right lateral knee with a handwritten date of 7/7/2024 on the

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patch. R5 stated, "That pain patch has been on a few days." The left knee was observed to be swollen with a white patch with the word "Lidocaine" across the distal left knee. R5 stated, "They put pain patch on the other day." There was no date on left knee lidocaine patch.

On 7/9/2024 at 10:30 AM V4 (Licensed Practical Nurse) measured an ecchymosis area on the right knee as two inches by one half inch. V4 described the right knee as "Discolored, purple, bruised, swollen. Rt knee is very swollen with a little gash is scabbed over. There is no drainage." V4 described the left knee as swollen. V4 removed the lidocaine patch on the left knee and stated there was no opening to the skin and no bruising. V4 stated, "There may be a little redness under the lidocaine patch." V4 stated, "I am not sure how often we are changing the left knee pain patch. I will check the right knee pain patch. The patch on the left knee is dated 7/7/2024. [R5] was out with activities and tried to go down the ramp along and hit the wall. is what happened with the left knee. Both knees were x-rayed on day and the left knee was fractured, not the right. This is the first I am aware of the right knee. I got no report about the right knee." V4 reviewed R5's progress notes and stated there were no notes of an injury to the right knee on 7/3/2024.

On 7/9/2024 at 10:50 AM, V5 (Physical Therapist) stated, "I was working with R5 last week. Occupational Therapy (OT) was working with R5 too. I was taking care of R5 before R5 fell down the ramp. When R5 fell, R5 hurt her left knee. R5 hit the right knee too, but the fracture was of her left knee. I saw R5 on 7/1/2024 and 7/2/2024. R5 was hesitant on 7/1/2024, but she was able to shift weight on both sides and stand for 2 minutes. She did better and had more confidence

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on 7/2/2024". V5 stated when he saw R5 on the 7/5/2024, R5 "Could not even move her right knee. That was a change. She wasn't able to stand up because of right knee pain. She said she hurt her right knee when she hit it on the bed on Wednesday night 7/3/2024." V5 stated, "I talked to the nurse and told them there was new swelling and bruising on the right knee. I recommended an x-ray. I think I spoke to a different nurse on 7/8/2024 and told her about the swelling. The CNAs said they had the same observation. We used a mechanical lift on the 7/8/2024 to get R5 up to the wheelchair. We haven't tried to put weight on the right leg. Once the issue with the right leg is cleared up, we will work with her on walking again. I don't know if they notified the doctor or if an x-ray was done."

On 7/9/2024 the Physical Therapy (PT) note dated 7/5/2024 stated in part: Comments: Subjective/objective: noted with swelling and 10/10 pain on right knee. Pain and tenderness upon palpation and upon active/passive movement of the affected joint. Nurse on Duty (NOD) made aware, recommending x-ray to rule out fracture. Patient reports hitting right knee on the bed during bed to/from wheelchair transfer. Provided right leg rest to support and protect right lower extremity for comfort when sitting in wheelchair. Review of PT progress note dated 7/8/2024 stated in part: Comments: Subjective/Objective: noted with swelling and bruising on right knee with 10/10 pain upon active and passive movement of affected joint. Ability to reposition self greatly limited due to pian on right knee. Defer weight bearing on right lower extremity due to complaints of pain, to rule out possible fracture from acute injury. NOD made aware.

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On 7/9/2024 at 11:15 AM V2 (Director of Nursing) stated at the time of the fall down the ramp, both knees were x-rayed. V2 stated there has been no report of further injury or accident since R5 fell down the ramp. V2 stated there has been no verbal report or incident report of an injury to R5's right knee on 7/3/2024. Surveyor and V2 visited R5 and R5 stated she hit her right knee on the bedframe when the CNA was transferring her to bed on the evening of 7/3/2024. R5 stated since time, R5 has not been able to get out of bed other than with a mechanical lift transfer into the wheelchair so R5 can take a smoking break.

On 7/9/2024 at 11:57 AM R5 observed with no movement, lying in bed, the pain in the right knee is seven on a scale of one to ten with one being little to no pain and ten being the worst imaginable pain. The pain on the left side is five out of ten with no movement when lying in bed. R5 stated with movement, the pain worsens, but it is hard to rate the pain because it depends on the type of movement.

On 7/9/2024 at 3:08 PM V22 (Certified Nurse Aide) stated on 7/3/2024, another CNA asked V22 to help her transfer R5 into the bed. V22 stated R5 did not say anything during the transfer and had no complaints.

On 7/9/2024 at 3:12 PM V23 (Certified Nurse Aide) stated she helped R5 back to bed. V23 stated, "We transferred R5 from the chair to the bed with two-person assist. R5 could walk and stand. We put on the gait belt and two of us transferred R5 to the bed. It was easy. The nurse came to check R5 because the other CNA told V23 sometimes the nurse has to see if the person is ok. R5 was already in bed." V23 stated R5 did not have any complaints after the transfer. When

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V23 was asked if any part of R5's body hit the wheelchair or the bed during the transfer, V23 stated, "No Ma'am". V23 stated R5 asked for water and ice, but V23 did not know what R5 needed the ice for.

On 7/10/2024 at 9 AM, review of R5's electronic health record include a "general note" by V2 (Director of Nursing) and was dated 710/2024 at 5:30 AM. The Note Text stated: X-ray report impression completed and reviewed with medical doctor. Impression: Intraarticular fracture involving the right femoral condyle. This appears to be a complex fracture, please consider CT scan for further evaluation. Soft tissue swelling and joint effusion. New orders given for resident to be transferred to outside facility for a CT scan. Clinical Team made aware.

On 7/10/2024 at 9:22 AM the MDS dated 5/30/2024 was reviewed and stated the R5's BIM score was 15.

On 7/10/2024 at 9:26 AM V19 (Activity Aide) stated, "R5 went down the ramp and got hurt. R5 went outside. I told R5 to wait for me. R5 didn't listen and R5 went down the ramp. R5 was sitting in the wheelchair with her knees against the wall when V19 got to her. V19 stated R5 listens most of the time, but R5 likes to do things on her own. V19 stated there are usually three staff working during smoke breaks. On 6/20/2024, there were two staff working during the smoke break". V19 stated the other activity aide was on the porch with R5 when R5 went down the ramp.

On 7/10/2024 at 10:04 AM V18 (Director of Life Enrichment) stated, "R5 was unable to propel so she needed assistance going up/down the ramp. R5 was dependent in her movement in the

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wheelchair." V18 stated V18 was not physically there when R5 fell, but the life enrichment aides were helping other residents down to the porch to smoke. V18 stated, "R5 was supposed to be next to go down to the porch, but R5 didn't wait. R5 was non-weight-bearing so she could not keep herself from falling. R5 was impulsive."

On 7/10/2024 at 11:53 AM V2 (Director of Nursing) stated R5 was sent local hospital this morning where she will undergo a CT of her right knee. "It is an ER visit. They are going to do an ER visit too."

On 7/10/2024 at 1:27 PM V2 (Director of Nursing) stated V2 followed up about R5's complaints of right knee pain and R5's report of a 7/3/2024 incident. V2 stated, "I spoke to V5 (Physical Therapist) yesterday. He should have let me know, or his supervisor know, R5 complained of an injury on 7/3/2024 and had pain in the right knee. V5 thought the nurse knew what was going on with R5's right knee." V2 stated, "I have suspended two nurses and one certified nurse's aide for not reporting a change in condition pending my investigation of what happened to R5 on 7/3/2024. The staff have had in-services, so they know they have to let me know if an incident occurs." V2 stated V5 had moved R5 from ambulating to a mechanical lift transfer after the 7/3/2024 incident. V2 stated, "I wasn't aware."

On 7/11/2024 at 8 AM R5 was observed lying in bed with bilateral knee immobilizers in place. R5 stated, "The doctors said my right knee is fractured. They put a brace on my right knee. The pain is not as bad with the brace on. On a scale of one to ten with zero to one being little to no pain and ten being the worst imaginable pain, R5 stated the pain in her right knee was an "eight"

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and the pain in her left knee was a "five".

On 7/11/2024 at 10:49 AM V1 (Administrator) and V2 (Director of Nursing) stated the 6/20/2024 event resulted in a fracture of the left knee, but both knees were injured. When R5 was sent to the hospital, R5 was diagnosed with a left knee fracture. On 7/5/2024 Physical Therapy worked with R5 and R5 complained of right knee pain. V2 stated R5's pain was being addressed on 7/5/2024. The doctor was called for complaints of pain and Tylenol was ordered. V1 stated he spoke to R5 on 7/9/2024 and R5 stated both knees were hurting after the 6/20/2024 incident. The left knee was hurting more than the right knee. V2 stated R5 told her on Monday the right knee was hurting. Lidocaine was ordered on 7/8/2024 and V2 knew R5 was seeing the orthopedic physician on 7/11/2024 so V2 told R5 to talk to the doctor about the right knee pain. V1 stated he suggested x-rays of the right knee on 7/9/2024. V1 stated, "The assumption is the right knee fracture occurred on 6/20/2024. R25 (Physician) thinks the fracture of the right knee occurred on 6/20/2024." V1 stated, "Because I am a nurse and I saw the right knee on 7/9/2024, I knew as a nurse we needed to look at the right knee and get an x-ray."

On 7/11/2024 at 12:17, CT of the right knee dated 7/10/2024 was reviewed. Findings/impression: Acute inter-articular, displaced fracture of the lateral femoral epicondyle and condyle. There is some cortical irregularity and buckling noted within this region. A large fracture plan extends into the lateral aspect of the femoral notch posteriorly and lateral femoral trochlear anterolaterally. This extends into the patellofemoral joint laterally and knee joint centrally within the notch region. Moderate-sized

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lipohemiarthrosis is present within the knee joint. Diffuse decreased bone density is noted some areas of suspected hemorrhage are noted within the distal femur. Moderate lipohemarthrosis and adjacent subcutaneous fat stranding/edema. Extensive arterial calcifications.

On 7/11/2024 at 12:30 PM, V25 (Physician) was interviewed and stated, "If there are new findings, then it is new. CT scan is saying acute. This appears to be acute. I will say the resident probably had injury to the right knee on 6/20/2024. The incident on 7/3/2024 made it worse. I cannot tell whether the fracture occurred on 6/20/2024 or 7/3/2024. It is hard to know whether there is an acute fracture occurred on 6/20/2024 and 7/3/2024. There was probably a contusion on 6/20/2024 was worsened by the 7/3 incident."

On 7/11/2024 at 1:23 PM V29 (Orthopedic Physician) was interviewed and stated V29 saw R5 last month for a left knee fracture. V29 stated R5 was in the Emergency Room at an outside facility yesterday for acute onset of right knee pain. V29 stated the right knee findings are "a new injury occurred after the 6/20/2024 injury."

Policy titled "Change in Resident's Condition or Status with no date stated in part:
Policy: It is the policy of the facility to ensure the resident's attending physician or representative are notified of changes in the resident's condition or status.
Procedure:
1. The nurse will notify the resident's attending physician when:
Bullet number 1: The resident is involved in any accident or incident results in injury including injuries of unknown origin.

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Bullet number 3: There is a significant change in the resident's physical, mental or psychological status.
2. Unless otherwise instructed by the resident (if the resident is alert and oriented and their own representative) the nurse will notify the resident's representative when:
Bullet number 1: The resident is involved in any accident or incident results in an injury including injuries of unknown origin.
Bullet number 3: There is a significant change in the resident's physical, mental or psychosocial status.

Policy titled "Outside Community Pass Privileges Policy" revised 11/2014 stated in part:
Policy: Facility emphasizes the safety of all residents, visitors and staff...Many individuals admitted to the facility have a medical need requiring clinical supervision.
Procedure: b. Bullet point two: Yellow Pass: Residents who may go out in the community with a responsible party.

Policy titled "Standard Supervision and Monitoring" dated 5/17/2023 stated in part:
Purpose: This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs.

Policy titles "Incidents/Accidents/Falls" with no date stated in part:
Policy: It is the policy of the facility to ensure any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge...The facility will

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ensure incidents and accidents occur involving residents are identified, reported, investigated and resolved.
Procedure:
1. If a resident is involved in an incident/accident an immediate assessment of the resident will be completed by the nurse.
4. The nurse will notify the resident's attending physician, nurse practitioner, director of nursing, administration and the resident's responsible party.
7.The occurrence will be documented (usually in the Risk Management section of the electronic health record). The progress note within the resident's medical record is to be included. Documentation in the medical record should include the following: Description of the occurrence to include time and place, physical and mental status of the resident, time of physician notification and physician response/orders, time of notification of resident's family/representative-including all attempts made until successful.
10. The occurrence is to be communicated shift to shift as part of the report until the resident is stabilize.

On 7/10/24 at 1:05 PM, surveyor interviewed R2. R2 stated that R2 and R1 had a fight on 6/24/24 at around 1:00 PM. R2 stated, "[R1] walked up to me from the elevator aggressively. I felt threatened so I scooped [R1] up from his legs and slammed [R1] on the floor then I landed on top of him. I accidentally stood up from my wheelchair when I grabbed [R1]. It had bad impact on my right foot. They sent me to the hospital for psych eval but my right foot kept hurting. The hospital didn't do anything because I was just there for psych. I came back to the

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facility, and I kept complaining to the nurses that my right foot was hurting. They kept ignoring me. I don't remember who the nurses were. I told a lot of nurses. What I did was I wrapped it because it hurts. Then finally [V10 Licensed Practical Nurse] listened to me and [V10's] the one that made the appointment for my right foot for the X-ray. It was a week that I was hurting. It's healing now but I was hurting for a week. I didn't hurt my foot anywhere or bumped it anywhere only that time with [R1] when I stood up and picked [R1] up and slammed him on the floor. I was not supposed to stand up but out of anger I did so I hurt my foot."

On 7/10/24 at 9:49 AM, a phone interview conducted V10 (Licensed Practical Nurse). V10 stated that V10 witnessed R1 and R2 in the first-floor hallway on the floor grabbing each other and fighting. At 1:46 PM, a second phone interview conducted with V10. V10 stated that V10 saw R2's right foot wrapped with an All-Cotton Elastic (ACE) wrap on 6/28/24. V10 asked R2 what happened and R2 said R2's right foot was hurting. When V10 assessed R2's right foot, it looked swollen. V10 stated that V10 informed V25 (Physician) and ordered an X-ray of the right foot.

On 7/10/24 at 2:03 PM, interviewed V14 (Certified Nursing Assistant). V14 stated that R2's right foot looked swollen and red right after the incident that happened with R1. V14 stated that R2 could not stand up. V14 stated that R2 used to stand up on his own before, but after the altercation with R1, R2 could not stand up anymore. V14 stated that R2 told [V4 Licensed Practical Nurse] that R2's right foot was hurting.

On 7/10/24 AT 2:36 PM, interviewed V4 (Licensed Practical Nurse) and stated that after

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the altercation with R1, R2 complained of pain on R2's right foot because R2 stood up and R2 was not supposed to stand up. V4 stated that V4 administered R2's pain medication on 6/27/24, but no documentation that V25 was notified of R2's right foot pain and no documentation that it was assessed.

On 7/10/24 at 6:38 PM, a phone interview conducted with V25 (Physician). V25 stated if a resident is having a new complaint of pain, the expectation is for the nurses to assess the resident and provide complete information and description of the resident's pain to the resident's healthcare provider. V25 stated that depending on the location of the pain for example if it's a bone, an X-ray would be ordered. V25 stated that if there was a visible injury or looks like possibility of injury or fracture X-ray is ordered. V25 stated that healthcare providers rely on the nurses to assess and notify the providers of the residents' condition so that providers can address and provide orders appropriately. Surveyor asked V25 what the meaning of R2's X-ray result of "New healing subacute fracture distal 4th metatarsal". V25 stated it means the fracture is some time ago because healing cannot occur a day or two after the fracture. V25 stated after a day or two, the swelling might not be seen in the first few hours or even after a day.

On 7/11/24 at 11:35 AM, interviewed V2 (Director of Nursing) and V1 (Administrator). V2 stated that after the altercation with R1, R2 went to Psychiatric hospital and was assessed for behaviors. V2 stated Psychiatric hospital does not do X-rays and only addresses behavioral issues. V2 stated the facility did not receive R2's discharge summary report from the psychiatric hospital. V2 stated that V2 expects the nurses to

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assess and call the doctor if any resident has new onset of pain. V1 stated that any staff can report the residents complains of pain to the nurses and the expectation is for the nurse to assess and notify the doctor.

R2's clinical records show an initial admission date of 8/26/23. R2's Minimum Data Set (MDS) dated 5/15/24 shows R2 is cognitively intact. R2's "Sit to stand" functional abilities in the MDS was answered, "Not attempted due to medical or safety concerns" and R2 uses a manual wheelchair. R2's pain care plan interventions read in part, "Assess physical as well as, psychosomatic reasons for the pain. Recognize that psychosomatic pain may cause physical distress. Explore possible causal factors for pain" and "Notify MD for any new resident complaints of pain and/or S/S of pain to obtain new order for medication regimen or break-through pain management".

R2's psychiatric hospital records dated 6/24/24 shows R2's assessment was aggressive behavior and right foot injury. R2's X-Ray result dated 6/30/24 shows, "New healing subacute fracture distal right 4th metatarsal. Correlate clinically. Soft tissue swelling." R2's hospital records dated 7/1/24 History of Present Illness (HPI) reads in part, R2 "is a 26 year old presenting to the emergency department who presented with complaints of right foot pain. [R2] says that [R2] was involved in an altercation about 1 week ago. [R2] said that [R2] had foot pain at the time. [R2] is currently using his wheelchair because [R2] has an injury in the past and [R2] is in a nursing facility because of that. The patient endorses pain of the right foot but denies any numbness or tingling."

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On 7/10/24 at 1:05 PM, R2 stated R1 and R2 had a fight on 6/24/24 at around 1:00 PM. R2 stated, "I was eating lunch and [R1] was defecating in the bathroom with the door open and I could smell it. I got mad. I went up the nurse's station and talked to [V10 Licensed Practical Nurse]. I said [R1] got to go. [R1] was being disrespectful to me. I came back to the room and [R1] started talking sh*t. [R1] was disrespecting me. I went back to the nurses' station and told [V10] that [R1] was cursing at me. [R1] followed me at the nurses' station. [R1] stood up by the elevator yelling at me saying 'fu*k you'. [V10] heard. Everybody heard. They did not do anything. Nobody could do anything. Everybody was ignoring [R2]. [R1] walked up to me from the elevator aggressively. I felt threatened so I scooped [R1] up from his legs and slammed [R1] on the floor then I landed on top of [R1]. I accidentally stood up from my wheelchair when I grabbed [R1]. It had bad impact on my right foot. They sent me to the hospital for psych eval but my right foot kept hurting. The hospital didn't do anything because I was just there for psych. I came back to the facility, and I kept complaining to the nurses that my right foot was hurting. They kept ignoring me. I don't remember who the nurses were. I told a lot of nurses. What I did was I wrapped it because it hurts. Then finally [V10] listened to me and [V10's] the one that made the appointment for my right foot for the X-ray. It was a week that I was hurting. It's healing now but I was hurting for a week. I didn't hurt my foot anywhere or bumped it anywhere only that time with [R1] when I stood up and picked [R1] up and slammed him on the floor. I was not supposed to stand up but out of anger I did so I hurt my foot."

On 7/9/24 at 10:49, V12 (Social Service Director) stated that V12 heard a commotion and

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witnessed R1 was grabbing R2's shirt.

On 7/9/24 at 11:20 AM, V14 (Certified Nursing Assistant) stated V14 witnessed R1 and R2's altercation. V14 stated that it was around 1:00 or 1:30 PM, R2 came out the room and asked if someone can get R1 out of the bathroom because R1 was using the bathroom with the door open and R2 was eating in the room. R2 said R1 was making noises. R2 was talking with V14 and V10 at the nurses' station when R1 came out the room and heard R2. R1 said something to R2 and then R2 rolled towards the elevator, and they were verbally arguing in the hallway. R1 and R2 were swearing at each other. V14 said R1 and R2 always going 'back and forth at each other' and do not get along. R1 and R2 were roommates. On 7/10/24 at 2:03 PM, V14 stated that R2's right foot looked swollen and red right after the incident that happened with R1. V14 stated that R2 could not stand up. V14 stated that R2 used to stand up on his own before, but after the altercation with R1, R2 could not stand up anymore. V14 stated R2 told [V4 Licensed Practical Nurse] that R2's right foot was hurting.

On 7/10/24 at 9:49 AM, during a phone interview V10 (Licensed Practical Nurse) stated that V10 witnessed R1 and R2 in the first-floor hallway on the floor grabbing each other and fighting. V10 stated, "[R2] and [R1] were in the room arguing. So, I was walking towards the front of the nurses' station, I could hear that the arguments getting loud. Then [R2] came up to the nurses' station and informed us that [R1] was using the bathroom with the door opened. As I heard them arguing I began to proceed at the front by the time I got there they were grabbing each other. [R2] was saying, "This rude motherfu*ker [R1] made a bowel movement in the bathroom and I

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was eating and [R1] didn't close the door"." At 1:46 PM, a second phone interview conducted with V10. V10 stated that V10 saw R2's right foot wrapped with an All-Cotton Elastic (ACE) wrap on 6/28/24. V10 asked R2 what happened and R2 said R2's right foot was hurting. When V10 assessed R2's right foot, it looked swollen. V10 stated that V10 informed V25 (Physician) and ordered an X-ray of the right foot.

On 7/10/24 AT 2:36 PM, interviewed V4 (Licensed Practical Nurse) and stated that after the altercation with R1, R2 complained of pain on R2's right foot. V4 stated that V4 administered R2's pain medication on 6/27/24, but there was no documentation that V25 was notified of R2's right foot pain and no documentation that it was assessed.

On 7/9/24 at 11:36 AM, interviewed V1 (Administrator) and stated when there's abuse, V1 expects the staff to first intervene immediately and separate the residents and report to the supervisor immediately. V1 stated, "First is the safety of the residents. Separate them and keep an eye on them." V1 stated the types of abuse are physical, financial, verbal, involuntary seclusion, emotional, mental abuse, and sexual. V1 stated that an example of a physical abuse between resident to resident is physical interactions that are not welcomed by the resident. V1 stated that examples of verbal abuse are yelling, calling names, or swearing. V1 further stated that every single resident has the right to a safe environment and has the right to not experience unwelcome physical or verbal interactions.

R2's progress notes dated 6/24/24 to 6/27/24 do not show that V25 (Physician) was notified of

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R2's right foot pain and no documentation on a follow up related to R2's right foot injury. R2's progress notes dated 6/24/24 at 9:45 PM written by V32 (Registered Nurse) revealed that R2 came back from psychiatric hospital with no discharge paper. No documentation if facility did any follow up of R2's assessments from the psychiatric hospital. R2's progress notes revealed R2 received pain medications on 6/25/24 at 8:06 PM, 6/26/24 at 8:03 PM, and 6/27/24 at 12:29 PM, but no documentation of where the pain was and no documentation of notification to R2's healthcare provider. R2's electronic health records do now show a clinical pain assessment was completed from 6/24/24 to 6/28/24.

R2's X-Ray result dated 6/30/24 shows "New healing subacute fracture distal right 4th metatarsal. Correlate clinically. Soft tissue swelling."

R2's hospital records dated 7/1/24 History of Present Illness (HPI) reads in part, R2 "is a 26 year old presenting to the emergency department who presented with complaints of right foot pain. [R2] says that [R2] was involved in an altercation about 1 week ago. [R2] said that [R2] had foot pain at the time. [R2] is currently using his wheelchair because [R2] has an injury in the past and [R2] is in a nursing facility because of that. The patient endorses pain of the right foot but denies any numbness or tingling."
The facility's policy titled; "ABUSE PREVENTION PROGRAM" dated 1/19 reads in part:
The facility desires to prevent abuse, neglect, exploitation, misappropriation, and a crime against a resident by establishing a resident-sensitive and resident-secure environment.
Verbal Abuse: Any use of oral, written, or

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gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability.
Physical Abuse: Hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.
(A)

Statement of Licensure Violations (2 of 2):

300.610a)
300.1210b)
300.1210c)
300.1210d)6)

Section 300.610 Resident Care Policies

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

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

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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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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, interview and record review, facility failed to ensure a resident (R3) with history of unsafe and self-harmful behaviors was supervised and monitored while in the day room. This failure affected one resident (R3) out of a sample of three residents resulting in R3 sustaining a nasal fracture.

Findings:

On 7/9/2024 at 10 AM, R3's Electronic Health Record was reviewed. R3's diagnoses with onset of 4/8/2024 included schizoaffective disorder,

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depressive type, autistic disorder, gastroesophageal reflux disease without esophagitis, pain in left shoulder, delirium due to known physiological condition, weakness and other abnormalities of gait and mobility. R3's additional diagnosis with onset date of 6/19/2024 was fracture of the nasal bones. R3's Care Plan included the following areas of focus: paranoia, suicidal ideation, rummaging, severe mental illness, history of physically aggressive behavior towards nursing staff, unsafe behavior, mood distress, agitation, cognitive loss, maladaptive behavior symptoms, history of self-harmful behavior, psychosocial well-being. R3's Minimum Data Set Section C dated 4/15/2024 documents a Brief Interview for Mental Status (BIMS) score of six.

On 7/9/2024 at 10 AM, R3's facial bone x-ray report was reviewed. Impression was a very subtle fracture lucency with irregularity along distal tip of the nasal spine. No acute osseous findings.

On 7/9/2024 at 1:15 PM R3 was observed to have a pea-size discoloration to the corner of R3's right eye. R3 was unable to state name. R3 provided verbal tones, but no words.

On 7/9/2024 at 3:28 PM V2 (Director of Nursing) stated that on 6/17/2024, staff said R3 was observed hitting himself in the face in the dining room. On 6/19/2024 it was noticed he had discoloration to his facial area. V28 (Licensed Practical Nurse) noticed the discoloration, called the doctor and the doctor ordered x-rays to the facial area. X-rays were completed and showed a fracture of the nasal bridge area. V2 stated, "There were no other incidents around this time would have created the fracture." V2 stated, "V30

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(Certified Nurse Aide) was in the dining room when this happened when R3 started hitting himself. V30 called for help which is when V27 went in to the dining room."

On 7/11/2024 at 9:43 AM V10 (Nurse) stated, "I worked with R3 on 6/19/2024 and sent him to the hospital. I got report we were monitoring him and laying eyes on him and documenting his actions. It was a safety precaution for himself and the other residents. There was an incident prior to day." V10 stated, "There was yellow bruising to R3's eye which is why we were monitoring him. There was an incident where R3 was found in the dining room hitting himself. I am not sure if anyone was with him. is what was endorsed to me. He became agitated in the dining room and was hitting himself. I can't recall specific date happened. It was before 6/19 because I came in at 7 AM he was already being monitored."

On 7/11/2024 at 9:13 PM V30 (Certified Nurse Aide) was interviewed and stated, "I found R3 in the day room by himself. R3 was scratching his face. I went immediately to R3 and held his arm and called V27 for help." V30 stated, "It was last month, but I don't remember the date or the day of the week. I was not assigned to R3 day. I just saw R3 in the day room."

On 7/11/2024 at 9:15 PM V27 (Licensed Practical Nurse) stated, "I don't remember the date. I remember I was coming off the elevator and V30 called me and said R3 was banging himself on his face. I called the nurse and stayed with R3. The nurse gave R3 a medication." V27 stated, "R3 was aggressive on day. R3 was trying to punch himself and trying to move the table. The only thing I saw was R3 punching his face." V27 stated, "I looked at R3's face, but I didn't see

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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) COMPLETE DATE
S9999	Continued From page 24	S9999		

anything. The next day, a nurse told me to look at his face and I noticed yellow and redness to his face. The other nurse called the doctor and got an order for the x-ray."

On 7/12/2024 at 8:35 AM V28 (Licensed Practical Nurse) stated, "Back in June, R3 was noted to have discoloration to his face. It was a light-yellow discoloration under the eye and around the nose on the left side of the face. It was super faint. The doctor ordered x-rays. R3 doesn't voice too much pain. We just have to observe him. When I noticed the discoloration, I don't recall if he was on monitoring like every 15-minute checks. We are constantly monitoring him though because of his behavior. In general, R3 has psych issues. He can't express himself. He expresses himself through body languages. Watching him is hard because of staffing. We try to check on R3 as frequently as possible."

On 7/12/2024 at 11:33 AM, V2 (Director of Nursing) stated the day R3 hit his face was 6/17/2024. V2 stated, "R3 was being supervised. He was in the dining room. Staff were with him. V30 (Certified Nurse Aide) was present when R3 started to hit himself."

On 7/12/2024 at 2:47 PM, outside facility records were reviewed. History or Present Illness dated 6/20/2024 at 5;16 AM stated: "Sent from nursing home because of self-injurious behavior. Has been striking his head against the wall."

Lakeview Nursing Observation Sheet documented 15-minute checks on R3 were initiated at 6:30 PM on 6/17/2024.

Review of Electronic Medical Record entry by V2 (Director of Nursing) dated 6/17/2024 at 22:56 as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005227	A. BUILDING: _____ B. WING _____	C 07/12/2024

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S9999	Continued From page 25	S9999		

a late entry stated in part: Writer was contacted resident was observed on the unit hitting himself in facial areas while in supervised dining area."

6/19/2024 eInteract Transfer form completed 19:22 stated, "Wondering into other resident rooms combative. Not easily directed, self-harming hitting self in the face".

6/24/2024 Admission/Readmission Alterations in Skin Integrity completed at 21:03 - No alterations in skin integrity documented.

Policy titled "Change in Resident's Condition or Status with no date stated in part:
Policy: It is the policy of the facility to ensure the resident's attending physician or representative are notified of changes in the resident's condition or status.
Procedure:
1. The nurse will notify the resident's attending physician when:
Bullet number 1: The resident is involved in any accident or incident results in injury including injuries of unknown origin.
Bullet number 3: There is a significant change in the resident's physical, mental or psychological status.
2. Unless otherwise instructed by the resident (if the resident is alert and oriented and their own representative) the nurse will notify the resident's representative when:
Bullet number 1: The resident is involved in any accident or incident results in an injury including injuries of unknown origin.
Bullet number 3: There is a significant change in the resident's physical, mental or psychosocial status.

Policy titled "Guidelines for Handling and

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S9999	Continued From page 26 Addressing Behavioral Emergencies" dated 3/18/2023 stated in part: 1. the first step involves recognizing and handling behavior in the earliest stages: A. Assess whether the anger/acting out is related to mental illness, dementia or other probable and perhaps transient factors. 2. The Escalating Resident A. Staff need to be aware of how likely a resident is to lose control and exhibit a behavior-especially a behavior will escalate-this comes from knowledge obtained on resident assessment as well as care plan. 1. ...The duration of 1:1 supervision or every fifteen minute checks will be based on each individual/resident. (B)	S9999		