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S 000	Initial Comments Investigation of Facility Reported Incident of 6/4/24/IL174919	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.3240f) 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 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.	S9999		

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

f) Resident as perpetrator of abuse. 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 requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to prevent abuse for four of seven residents (R9, R10, R11, and R12) from resident-to-resident physical abuse and failed to prevent resident-to-resident sexual abuse for one resident (R3) reviewed for abuse in the sample of 26. These failures resulted in R3 physically assaulting R11 by hitting R11 in the left arm, R3 physically assaulting R10 by shoving R10 down to

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the ground resulting in R10 having a contusion of the scalp and severe pain requiring an emergency room visit, R3 punching R9 in the face, and R3 throwing water on R12. These failures also resulted in R4 sexually assaulting R3 by putting his left hand down R3's pants and briefs when R3 went into R4's room.

Findings include:

The Abuse, Prevention and Prohibition Policy dated 1/24 documents Statement of Intent "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Policy "This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The resident must not be subjected to abuse by anyone. The facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect. Annually, the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement." Prevention: "The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion.

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The owner, licensee, Administrator, employee, or agent of the facility shall not abuse or neglect a resident and must prohibit the misappropriation of resident property. Resident behaviors will be monitored for changes, which trigger abusive behaviors. The facility will reassess care plan interventions on a regular basis. Intervention strategies based on resident screenings will be implemented to prevent occurrences of abuse."

1. R3's Face Sheet documents R3 was admitted to the facility on 3/27/24. This same form documents the following, but not limited to, diagnoses: Unspecified Dementia and Major Depressive Disorder.

R3's MDS (Minimum Data Set) Assessment dated 4/2/24, documents, R3 is severely cognitively impaired, has delusions and behaviors of physical and verbal aggression that impacts others, wanders and significantly intrudes on the privacy or activities of others, wanders and is at significant risk of getting to a potentially dangerous place, is at significant risk for physical illness or injury, puts others at significant risk of physical injury, and significantly intrudes on the privacy or activity of others.

R3's Care Plan dated 6/25/24, documents R3 has behaviors of being verbally aggressive towards staff, being physically aggressive with others, and is known to wander into other residents' rooms. This same care plan does not include interventions addressing R3 shoving down R11.

R3's Behavior Note written by V4/Licensed Practical Nurse/LPN dated 3/30/24 at 1:26 PM, documents "(R3) was in the room when CNA (Certified Nursing Assistant) attempted to redirect (R3) out of the room. (R3) became

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agitated/verbally aggressive and started swinging at CNA. (R3) told CNA to get out. (R3) then came out of the room and went down the hall and asked another resident (R11) to help (R3) and (R3) then punched and shook another resident (R11) on left arm."

R3's AIMs (Assessment Intercommunicate Management) dated 3/30/24 documents that R3 appears to have been involved in an altercation with a peer (R11). Just prior to the time of the event R3 appears to have been in another resident's room. V32/CNA stated R3 was in another room and V32 attempted to redirect R3 and R3 became aggressive. The incident happened in the hallway. R3 has a history of physical aggression towards staff and other residents at other nursing (facilities).

R11's current computerized medical record, documents R11 is an 84 year old female that admitted to the facility on 11/8/22 with diagnoses which included Dementia, with Psychotic Disturbance, Depressive Disorder, and Chronic Obstructive Pulmonary Disease.

R11's MDS (Minimum Data Set) Assessment dated 5/23/24 documents a BIMS (Brief Interview for Mental Status) Score of 4/15, indicating (severe cognitive impairment).

R11's Nursing Note written by V4/LPN dated 3/30/24 at 1:41 PM, documents, "CNA reported that another resident (R3) came up to (R11) and asked (R11) to help (R3) then proceeded to hit (R11) in the left arm and shake (R11's) arm. CNA was able to intervene. Voice mail left for administrator at 1:11 PM d/t (due to) no answer."

On 7/2/2024 at 9:04 AM, V32/Agency CNA

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stated, "I haven't worked at (the facility) for a few months. When I was working at (the facility) there was a resident (R3) who was swinging on everyone that day. (R3) punched and shook (R11's) left arm. (R3) was swinging her arms so hard, she even swung herself to the floor. (R3) was being very aggressive and trying to punch everyone."

On 6/30/24 at 3:15 PM, V25/R11's Power of Attorney/POA stated that earlier this year she was notified that R11 was hit in the back of the head and shook by another resident (unidentified). V25 asked if R11 had done anything to the resident to provoke the incident. V25 was told "No, (R11) did not do anything to the other resident."

2. The Final Report sent to the (State agency) dated 5/21/24 at 8:06 AM, documents that on 5/16/24 R10 BIMs/Brief Interview of Mental Status of 15 (indicating cognition intact) and R3 BIMs of 0 (indicating severe cognitive impairment) had a verbal altercation. Witness statements stated that they heard R10 yelling at R3 "What are you doing." "Get out of here." Before staff could intervene, R3 pushed R10 and R10 fell hitting her head. This event happened as R10 was leaving the bathroom. R10 was assessed with no injuries but was sent to the Emergency Department for an evaluation due to hitting her head.

R3's Behavior Note written by V18/LPN dated 5/16/24, at 4:27 PM, documents "(R3) is agitated. (R3) was yelling and pushing (V18). (R3) tried shutting the door on (V18). (R3) is refusing to allow roommate (identified as R10) into (R3's) room. (V18) talked calmly to (R3) and (R3) calmed down. (R10) asked CNA to get something out of room. (R3) placed hands on the CNA and

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was pushing and yelling at the CNA and trying to shut the door on the CNA. (R3) reached out to scratch CNA on the face. (V18) stepped in and asked (R3) to stop and remove her hands from the CNA. (R3) did. Then (R3) became angry and yelling at (V18). (R3) was raising her hand to scratch or hit (V18). (V18) and CNA left the room."

R3's Behavior Note written by V18/LPN dated 5/16/24 at 5:05 PM, documents "(R3's) roommate (identified as R10) was in the bathroom. There was an altercation between (R3) and (R10). (R10) ended up on the floor in the adjoining room. (R10) stated she bumped her head on floor."

R3's current Care Plan does not include interventions addressing R3 shoving R10 down.

R10's current computerized medical record, documents R10 is an 85-year-old female that admitted to the facility on 11/21/23 with diagnosis which Dementia, Depression, Essential (Primary) Hypertension, and End Stage Renal Disease.

R10's MDS (Minimum Data Set) Assessment dated 5/30/24, documents a BIMS (Brief Interview for Mental Status) Score of 9/15, indicating moderate cognitive impairment.

R10's AIMS dated 5/16/24 and signed by V18/LPN documents that R10 had an unwitnessed change in plane at approximately 5:05 PM on 5/16/24. Just prior to the time of the event R10 appears to have been using the bathroom in her room. R10's account of the event is R10 stated her roommate (identified as R3) was standing in the doorway. The next thing R10 remembered was them arguing and R10 ending up on the floor. Staff responded when R10 was

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yelling for help. R10 stated her only pain was the bump on the back of her head. V18/LPN sent R10 to the local ED (Emergency Department) because of a golf ball size bump on the back of R10's head.

R10's Nursing Note dated 5/16/24 at 5:1 PM written by V18/LPN documents, "(R10) sent to the hospital because of golf ball sized bump on back of head from incident and right pupil not responding to light."

R10's ED (Emergency Department) discharge note dated 5/16/24 documents, "Primary Diagnosis: Contusion of scalp. Reason for Visit: Assault Victim and Neck Pain. (R10) here from (the facility). (R10) was hit by her roommate (R3) causing (R10) to fall to the ground. (R10) hit the back of her head. Originally not complaining of any pain but EMS (Emergency Medical Services) reports that in route (R10) started to complain of head and neck pain. C-collar applied. Trauma: Reports headache and neck pain. Neck Pain: associated symptoms- headache."

R10's Statement dated 5/17/24 documents another resident (identified as R3) pushed R10 down. R10 was standing in the bathroom doorway talking to someone in the next room. R10's roommate (R3) came up and pushed R10 down.

V4/LPN Written Statement dated 5/20/24 about the incident between R3 and R10 documents that R3 gets upset/agitated upon redirection and/or others raising their voice at R3. R3 is difficult to redirect. R10 raises her voice loudly and will yell out to others" Why are you in there?" "What are you doing?" "Get out of there."

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On 6/30/24 at 10:19 AM, R10 stated, "I don't remember what exactly happened. I just know someone pushed me down and my neck and head were hurting. I went to the hospital."

On 7/1/24 at 10:27 AM, V20/R10's POA stated that she was told R10's roommate (R3) pushed R10 and R10 fell hitting her head and was sent to the hospital. (R3) would take R10's clothes. After R10 was pushed and hit her head R10 was moved to another room. R10 is not able to express herself now. V20 was asked how R10 would have felt about being pushed by someone when R10's cognition was intact. V20 stated that R10 had a rough childhood and R10 would have been aggravated and upset.

On 7/1/2024 at 4:08 PM V18/LPN stated, "I did not witness the altercation between (R3) and (R10), but (R10) was cognitively intact then. (R10) told me (R3) was trying go in the bathroom where (R10) was, (R10) was telling (R3) to get out and (R3) went up to (R10) and shoved her down."

3. The Final Report sent to the (State agency) dated 6/18/24 at 2:53 PM, documents that V12/Certified Nursing Assistant/CNA alerted nursing staff that R9 reported that R3 "Punched (R9) in the face" and told R9 to get out of bed. R9 was assessed and there were no apparent injuries. Conclusion: R3 got in roommate R9's bed. R3 wanted R9 to get out of the bed due to R3 thinking it was her bed. Neither resident remembers the event after it occurred.

R3's Nursing Note written by V26/LPN dated 6/14/24 at 5:38 AM, documents "CNA alerted (V26) that (R3) had punched (R3's) roommate (R9) in the face and told her to get out of bed.

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CNA separated the residents from each other and (R3) laid down in (R9's) bed. (V26) with another nurse was able to get (R3) to her own bed with no altercation."

R3's current Care Plan dated 6/25/24 does not include interventions addressing R3 punching R9.

R9's current computerized medical record, documents R9 is a 75 year-old female that admitted to the facility on 7/28/23 with diagnosis which included Osteoarthritis, Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, Dementia, Delusional Disorder, and Alzheimer's Disease.

R9's MDS (Minimum Data Set) Assessment dated 5/12/24 documents a BIMS (Brief Interview for Mental Status) Score of 4/15, indicating severe cognitive impairment.

R9's Progress Note dated 6/14/24 at 5:42 AM written by V26/LPN documents that a CNA alerted V26/LPN that R9 had been punched in the right side of her face. R9 stated that R3 punched R9 in the face and told R9 to get out of bed. The CNA separated the R3 and R9 and R3 then laid down in R9's bed.

V12/CNA Written Statement dated 6/14/24 documents that R3 was in her roommate (R9's) bed. R9 wanted R3 to get out of R9's bed. R3 hit R9 in the face.

On 6/30/24 at 7:34 PM, V19/R9's POA stated that she was told R9 was hit in the jaw by R9's roommate (identified as R3). The facility moved the roommate (R3) to another room. There were several times before the incident happened when V19 went to visit R9, and the roommate (R3)

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would be in R9's bed or messing with R9's clothes. V19 also stated "I would start to say something to the roommate (R3) and (R9) would say "Oh, no, leave (R3) alone its ok." V19 was asked if she thought R9 was afraid of R3. V19 stated "That's very possible. I know (R9) never wanted me to say anything to her roommate (R3) and (R9) was not that way with anyone else."

On 7/2/24 at 9:06 AM an attempt was made to contact V12/CNA with no answer or return call back.

4. R3's Nursing Note written by V4/LPN dated 6/19/24 at 5:22 PM, documents "(R3) threw a partial glass of water on another resident (R12). (R3) keeps trying to get more water to throw on staff and other residents."

R3's current Care Plan dated 6/25/24 does not include interventions addressing R3 throwing water on R12.

R12's current computerized medical record, documents R12 is an 88 year old male that admitted to the facility on 2/6/24 with diagnosis which included Alzheimer's, Dementia, and Essential (Primary) Hypertension.

R12's MDS (Minimum Data Set) Assessment dated 5/24/24 documents a BIMS (Brief Interview for Mental Status) Score of 9/15, indicating moderate cognitive impairment.

R12's current computerized medical record, documents no evidence of the incident between R3 and R12 on 6/19/24.

On 6/29/24 at 2:00 PM V4 stated, "I was here on 6/19/24 when (V13/CNA) came and told me (R3)

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threw a half glass of water on (R12). I reported it to the (V1/Administrator) immediately. (V1) told me it was not abuse and it was just a behavior and to document on it. I received an order for Haldol (antipsychotic) because (R3) was throwing on staff as well and trying to take the water pitcher off my nursing cart. (R3) kept getting water other places as well and was trying to throw it on everyone. We (the staff) were having a hard time re-directing and getting (R3's) behavior to stop."

5. The Final Report sent to the (State agency) dated 6/10/24 at 3:16 PM, documents Incident Description "CNA walking by (R4's) room and saw (R4) sitting in recliner leaning over toward (R3), (R3) was laying in (R4's) bed) CNA went into (R4's) room to remove (R4's) hand from inside (R3's) pants. (R3) and (R4) were immediately separated." "Resident and staff interviews completed. (R3) wanders and had gone into (R4's) room to lay in (R4's) bed. (R3) was laying on her side with her back to the door talking to (R4) when the staff went into separate them. (R3) was upset and didn't want to leave the room. (R3's) Care Plan updated to reflect aggression when trying to re-direct and wanders in rooms. (R3) to be monitored closely while wandering. (R4) to be monitored for inappropriate sexual behaviors. Medication for (R3) was adjusted to assist with agitation."

R4's current computerized medical record, documents R4 is a 90-year-old male that admitted to the facility on 1/8/24 with diagnosis which included Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, and Major Depressive Disorder.

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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 12	S9999		

R4's MDS (Minimum Data Set) dated 4/22/24 documents a BIMS (Brief Interview for Mental Status) Score of 00/15, indicating (severe cognitive impairment). This same MDS documents R4 has no upper or lower extremity impairment, uses a wheelchair or walker for mobility, and requires supervision for ADL's (Activities of Daily Living).

R4's Progress Note written V18/Agency LPN dated 6/4/24 at 3:00 PM, documents, "CNA's stated (R4) was in the chair next to the bed. A female resident (R3) was lying in the bed next to the chair. (R4) leaned over and had his hand down the front of the female resident (R3) pants."

R3's Behavior Note dated written by V4/ LPN dated 6/4/24 at 6:33 AM, documents "(R3) is wandering and rummaging in others (other residents) rooms."

R3's Nursing Note written by V18/LPN dated 6/4/24 at 3:00 PM, documents "CNAs stated (R3) was lying in another resident's bed. A male resident (R4) was sitting in the chair next to the bed. (R4) leaned over and had his hand down the front of (R3's) pants." V18 notified V1/Administrator and V29/Unit Manager.

Written Witness Statement by V16/Agency CNA dated 6/4/24, documents "At 2:40 PM while doing rounds, we enter (R4's) room to find (R4) leaning over (R3) while (R3) was laying on bed. (R4) drew his hand back and sat up and closed his eyes. We instructed (R3) to get up and come out for snack. (R3) resisted. We stepped outside door. We peeked back in room to find (R4) leaned over again with his hands down (R3's) pants. At that point we helped (R3) put her shoes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005797	A. BUILDING: _____ B. WING _____	C 07/06/2024

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S9999	Continued From page 13 on and guided (R3) to the TV (television) room." Written Witness Statement by V13/CNA dated 6/4/24, documents that at 2:40 PM while doing afternoon rounds V13 entered R4's room to find R4 leaning over R3 while R3 was lying in a bed. As R4 set up R4 drew his hand back and closed his eyes. R3 was asked to please get up and R3 resisted. V13 stepped outside R4's room to figure a plan to get R3 out of R4's room. V13 looked back in the room to find R4 leaned over again with his hand down R3's pants. R3's shoes were put on her and R3 was taken out of R4's room. The incident was reported to the unit nurse immediately. Written Witness Statement by V4/LPN dated 6/10/24 documents that R3 wanders and roams in and out of multiple rooms. R3 is difficult to redirect and come can become verbally and physically aggressive. On 6/28/24 at 3:00 PM V13/CNA stated, "(R3) wandered into (R4's) room and laid down in (R4's) roommate's bed. I had noticed (R3) in (R4's) room so (V16/Agency CNA) and I entered (R4's) room. When (V16) and I entered the room was in the recliner leaning over to the bed (R3) was lying in. I immediately noticed (R4) jerk his hand away from (R3) and sat up in the recliner. (V16) and I attempted to re-direct (R3) out of the room. (R3) started kicking and slapping us, so I just said let's leave (R3) alone because we are not going to be able to get (R3) out when she is agitated. When (V16) and I got past the doorway to (R4's) room we turned around in the doorway and noticed (R4) was leaning over the bed (from the recliner) where (R3) was laying and had his left hand underneath her pants touching (R3's) private area. (V16) and I then immediately	S9999		

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entered the room and was able to immediately separate them and get (R3) out of the room."

On 6/30/24 at 10:00, V16/Agency CNA stated, "(V13/CNA) was training me the night the incident occurred between (R3) and (R4). That was my first night working at the facility and it was just us two for CNA's back on the unit. We walked into the room because we saw (R3) laying in (R4's) roommates' bed, and it was not her room. When I walked in the room (R4) was in the recliner leaning over by (R3). (R4) immediately pulled his hand back from (R3) when we walked into the room. I did not see where (R4's) hand was at that time. (V13) and I tried to remove (R3), but she was being aggressive. (V13) and I decided to leave the room to figure out a plan because (R3) was being aggressive. When (V13) and I got past the doorway we turned around and (V13) and I saw (R4's) left hand down (R3's) pants and underpants. (V13) and I went back in the room and (R4) removed his hand from her underpants again. We then removed (R3) from the room."

On 6/29/24 at 4:06 PM, V14/R4's POA stated she was told something about R3 pants but did not remember exactly what it was about. V14 also stated "We (R4's Family) have had to run (R3) out of (R4's) room several times."

On 6/29/24 at 1:57 PM, V13/R3's POA was asked if he had been notified about R3 being in R4's room and R4 had his hands in R3's pants. V13 stated "I was not." V13 was asked if he had any idea how R3 would feel about the incident happening and V13 stated "I have no idea." V13 also stated "I feel bad that it happened, but I don't know what can be done to prevent it."

On 6/28/2024 at 3:35 PM, R3 was ambulating

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independently down the hallway on the locked unit towards the double doors that go out to the other hallways. R3 was exit seeking and observed to be agitated. R3 was kicking and punching at the doors. R3 then turned around and was ambulating down the hallways past other residents. No CNA or Nurses were observed in the hallway during that time.

On 6/29/2024 at 1:00 PM, R3 was in her room asleep in her roommate's bed.

On 6/30/24 at 11:00 AM V2/Director of Nursing/DON verified no new interventions were put in place to prevent R3 from abusing residents. V2/DON stated, "I do not see where (R3's) care plan addresses her resident-to-resident altercations with (R9, R10, R11, or R12) or interventions."

On 6/30/24 at 12:00 PM, V1/Administrator stated, "The facility staff should not leave someone alone if they are experiencing aggression but should remove other resident's away from that person during that time to prevent abuse from happening."

(B)