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	IL6001341	A. BUILDING: _____ B. WING _____	04/18/2024

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610a) 300.1210b) 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. 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 are not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from abuse for 9 of 25 residents (R30, R35, R36, R39, R50, R63, R64, R85 and R88) reviewed for abuse, in the sample of 59. This failure resulted in R30 biting R50 and R50 being treated for a human bite and seeing the wound nurse for treatment. This failure also resulted in R85 being thrown out of wheelchair by R39, and R39 attempting to smash R85's head with the wheelchair causing an abrasion to R85's left ear, upper left arm, and face. Findings include: 1.R30's Physician Order Sheet (POS) for February 2024 documented a diagnosis of Unspecified psychosis not due to a substance or known physiological condition, unspecified asthma, morbid obesity, hypertension, major depression disorder, anxiety disorder, Schizophrenia, legal blindness, and post-traumatic stress disorder. R30's Minimum Data Set (MDS), dated 2/19/2024, documented that R30 was severely impaired for cognition for activities of daily living. R30 was able to walk ten feet and required	S9999		

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supervision or touching assistance. R30 had no impairments on the upper or lower extremities.

R30' Care Plan, with multiple dates, documented, "(R30) is at risk for abuse and/or neglect related to anxiety and major recurrent due to suicidal ideations and significant mental health issues." On 10/11/2022, it documented, "(R30) was physically and verbally aggressive towards another resident that he shared a room with. (R30) will destroy his own property, i.e., guitar. Resident has diagnosis of Schizophrenia and may display symptoms that include but are not limited to; being out of touch with reality (delusional or hallucinations), may have disorganized speech or erratic behavior, decrease in activities. Diagnosis of mental illness." On 2/16/23 it documented, "Having delusional thoughts." It continued, dated 09/30/23, "Experienced delusions." On 10/12/2023, it continues, "Experienced delusions." R30's care Plan did not address the altercation on 2/1/2024.

R30's Care Plan, dated 8/2/2023, documented, "(R30) is legally blind. He stated he was born with blindness in both eyes. (R30) qualifies for Subpart S programming to diagnosis major depression disorder, recurrent, sever, focus areas include community living, medication management and self-maintenance. Diagnosis of mental illness. At risk for abuse and neglect related psychosis, anxiety, and schizophrenia."

R30's Initial Incident Report, dated 2/1/2024 at 8:30 AM, documented, "Resident (R30) and (R50) entered into a verbal disagreement about (R50) working for a seed company that (R30) used to work for. The verbal argument became physical and (R30) bit (R50) on the right hand.

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S9999	Continued From page 3 Puncture wound/bite marks that drew blood to right hand of resident (R50)." On 4/11/2024 at 9:22 AM, R30 stated, "(R50) and I were roommates. (R50) was aggressive, and I am legally blind. (R50) was always threatening me and stealing my chips and candy bars. (R50) came right up into my space and I had to do something, so I bit him. I can see shadows and he was threatening me, so I bit him on the arm. They moved me downstairs now and I like it better. (R50) was always threatening me and they never did anything about it. When (R50) got close to me on my side of the room, I bit him to defend myself, he said he was going to beat me up. I did not do anything wrong." An Incident Report, dated 2/14/2024, documented, "(R50) got into a verbal disagreement with roommate (R30) about working at the same seed company in the past then (R30) bit him on the right hand. Root cause: Both residents are cognitively impaired and became agitated resulting in (R50) being bit by (R30) on the right hand. Intervention: Residents were moved to separate rooms on a different hall. Supervision provided to both residents for change in status." R30's Progress Notes/Nurse's Notes did not document anything related to R30 biting R50. On 4/11/2024 at 9:32 AM, V18, Licensed Practical Nurse (LPN) stated, "(R30) use to be upstairs but they moved him down here with me now. He is legally blind, and he can see shadows. When he was upstairs, he bit (R50) and then they moved him down here and I have not had any issues with him. He told me (R50) was taking his stuff and threatening him and he was defending	S9999		

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S9999	Continued From page 4 himself. (R50) has a history of starting stuff with residents." On 4/9/2024 at 8:00 AM, all abuse investigations were requested for the past year. On 4/9/2024 at 5:15 PM, V21, Corporate Nurse stated, "We had a change in Administration, and we were only able to find one abuse investigation. At this point, we do not have any other abuse investigations in the building, and we have looked in multiple places and this is all we have. I do not have any other abuse investigations." No abuse investigation for R30 was provided by the facility for the incident on 2/1/24. 2. R85's POS for April 2024, documented a diagnosis of dissociative and conversion disorder, chronic obstructive pulmonary disease, idiopathic aseptic necrosis of bone, psychoses, hypertension, peripheral vascular disease bipolar disorder, major depression, and suicidal ideations. R85's MDS, dated 2/2/2024, documented that he was cognitively intact for decision making of activities of daily living (ADL). R85's Care Plan, dated 10/27/2022, documented, "(R85) has an alteration in comfort related to idiopathic aseptic necrosis of the bone in his hip." R85's Care Plan Focus Area, dated 7/30/2022, documented, "Resident reported being the recipient of verbal/physical aggression. On 8/19/2023, it documented, "(R85) was on the receiving end of peer-to-peer incident." It continues, "Intervention: Both residents separated and had psychosocial follow-up." On 4/16/2024 at 3:35 PM, R85 stated, "I got	S9999		

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S9999	Continued From page 5 thrown out of my wheelchair and onto the floor. (R39) is a hot head and he was mad at me in the dining room, and he can walk but I can't, and he got mad, he rushed me and threw me out of my chair. I think he would have killed me if he would have had more time." R85's Nurse Notes, dated 8/19/203 at 4:53 PM, "As told by the 400 hall CNA, resident was thrown out of his wheelchair by another resident to the floor. As told by the resident he was thrown out of his wheelchair by another resident. Both residents separated from each other by staff. 911 was called." R85's Incident Report, dated 8/19/2023, documented, "As told by the 400 hall CNA, resident was thrown out of his wheelchair by another resident to the floor. Both residents were separated by staff. Abrasion to left ear, upper left arm, and face." On 4/17/2024 at 3:12 PM, V2, Director of Nursing stated, "We have had a lot of staff changes and I was not working at the time or the interim Administrator when this happened." On 4/17/2024 at 3:23 PM, V27, Certified Nursing Assistant (CNA), stated, "I was in the dining room and (R85) bumped into (R39) and (R39) turned around and picked (R85) up and threw him out of his wheelchair and then he picked up the wheelchair and was going to try and smash his head in and I got there in time and stopped him from hitting him with the wheelchair but (R85) was slammed on the floor. It happened a while ago, and I do not remember all of the other details, but I know he wanted to smash his head in and would have if I would have not got there in time."	S9999		

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3. R39's Progress Note, dated 8/19/2023 at 5:38 PM, documented, "Approximately 1530 (3:30 PM) this said RN (Registered Nurse) was down the hall when I heard loud voices coming from the 300 hall. I ran to assist, and that is when I saw (R85) on the floor with CNA holding (R85's) wheelchair. CNA stated that he stopped (R39) from hitting (R85) with the wheelchair, and that (R39) had thrown/knocked (R85) out of his wheelchair. I assessed the situation and called 911 believing that (R39) was still a threat to others. While on the 911 call, I notified the Administrator, DON, NP (Nurse Practitioner) for DR (doctor)."

The Facility's Incident Report, dated 8/19/24 at 4:19 PM, documented, "Nursing Description: As told by the 400 Hall CNA resident (R85) was thrown out of his w/c (wheelchair) by another resident (R39) to the floor. Resident Description: As told by the resident he was thrown out of his w/c by another resident." Immediate Action Taken: Both residents were separated from each other by staff. "

No other information regarding investigation of this resident-to-resident altercation was provided by the facility when requested.

R39's Face Sheet, printed 4/10/24, documented that his diagnoses were Schizophrenia, Vitamin D Deficiency, Hyperlipidemia, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Bipolar Disorder and Hypertension.

R39's MDS, dated 3/27/24, documented that he was cognitively impaired, and has rejected care

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S9999	Continued From page 7 daily. R39's Care Plan, dated 11/26/18, documented, "(R39) is at risk for abuse and/or neglect related to history of physical/verbal aggression, use of psychotropic medications, hallucinations/delusions, confusion/disorientation/forgetfulness, offensive anti-social habits, poor personal hygiene and DX; SCHIZOPHRENIA, BIPOLAR DISORDER, and DEMENTIA." It continues, "Interventions: 1:1 counseling as needed and as resident allows. Administer medications as per MD orders. Notify MD if behaviors are worsening. If resident becomes aggressive attempt to remove resident from situation and assist him/her to a quiet place. Encourage resident to vent his/her feelings about situation. Remind resident that behavior is not acceptable. Resident is involved in anger management focus groups learning different techniques on maintaining his anger. Resident was sent to the ER for evaluated. He was admitted. Staff to encourage resident to attend daily group therapy." On 04/12/24 at 12:57 PM, V1, Administrator, stated that he has not been able to locate the investigations surveyors have requested of the resident-to-resident abuse investigations and abuse investigations. He stated he has reached out to the two previous administrators who stated the investigations should be here, but he has looked in all the file cabinets and closets and the abuse investigations are not here anywhere. 4. On 4/11/24 at 11:18 AM R50 was lying on his bed. He had a crusty yellow scab at the base right first finger with no dressing or drainage noted. R50 shook his head when asked if he had any pain in his right hand from being bit.	S9999		

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S9999	Continued From page 8 R50's Wound Physician Note, dated 2/6/24, documented the description of the bite wound to his right hand as a full thickness open ulceration wound measuring 6-centimeter (cm) x 1.3 cm x 0.2 cm with light serous exudate that is being treated with Augmentin (antibiotic). R50's Treatment order, dated 2/6/24, documented, "Silver Sulfadiazine, apply twice daily, cover with bordered gauze and wrap with kerlix." R50's Wound Physician Progress note, dated 4/9/24, documented, "(R50's) wound is now a scab and he removes his dressings, so treatment was changed to skin prep daily." R50's Face Sheet, print date 4/10/24, documented that he was initially admitted to the facility on 4/5/17 and his diagnoses included Schizophrenia, Maxillary Fracture, Left Side, Fracture of Nasal Bones, Fracture of Orbit, Unspecified Psychosis Not Due to a Substance or Known Physiological Condition, Paranoid Personality Disorder, Unspecified Lack of Coordination, Major Depressive Disorder, Anxiety Disorder, and Insomnia. R50's MDS, dated 3/10/24, documented that he was severely cognitively impaired, and had no behavior symptoms during the look-back period for that assessment. R50's Care Plan, dated 8/20/20, documented, "(R50) is at risk for abuse and neglect related to use of psychotropic medication, physical/verbal aggression, isolation, resistive to care, poor hygiene and diagnosis of Anxiety, Schizophrenia, Depression, and Psychosis. It continued,	S9999		

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S9999	Continued From page 9 "Interventions: 1:1 visits for emotional support as needed." It continues, "Administer medications as directed by MD and monitor for possible side effects and for effectiveness. If resident becomes difficult during care, make sure resident is safe and walk away. Allow resident time to calm down, then reapproach. Keep resident safe from harm at all times. Report any suspected abuse and/or neglect immediately to Administrator. Social Services to provide information regarding Hotline, Ombudsman, Community resources and residents rights as needed. Social services to review/assess resident history and assess risk factors for Abuse/Neglect quarterly and PRN. Staff to provide education/counseling if behaviors are noted. Staff will demonstrate respectful/non-threatening approaches." R50's Progress Note, dated 2/1/2024 at 12:08 PM, documented, "Resident noted with blood stains on his coat. Resident assessed for injuries and noted abrasion to right hand. MD (Medical Doctor) notified new orders clean with wound cleaner and apply Triple Antibiotic Ointment daily until healed. Resident is own responsible party." R50's Progress Notes, dated 2/4/2024 at 12:05 PM, documented, "Resident on abt (antibiotic) therapy r/t (related to) bite to hand; no ase (adverse side effects) noted. Will continue to monitor." R50's Progress Notes, dated 2/9/2024 at 2:50 PM, documented, "Resident changed rooms; resident notified and aware; resident own responsible party; attempted to call (R50's family) but the number was disconnected; called placed to (R50 family) with no answer; (R50 family) called and notified of room change; said he would	S9999		

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S9999	Continued From page 10 let the family know; no concerns voiced." R50's Order Summary Report, dated 4/11/24, documented, "Silvadene External Cream 1 % (Silver Sulfadiazine) Apply to Right Hand topically every day shift for To Promote Wound Healing; Telfa Non-Adherent Pad (Gauze Pads & Dressings) Apply to right hand topically every day shift for To Promote Wound Healing; Kerlix Gauze Roll Medium Miscellaneous (Gauze Pads & Dressings) Apply to right hand topically every day shift for To Promote Wound Healing." R50 Physicians order, dated 4/10/24, documented, "Skin Prep Wipes Miscellaneous (Ostomy Supplies) Apply to Right Hand topically everyday shift for To Promote Wound Healing for 30 Days." On 4/10/24 at 3:00 PM, V2, Director of Nursing, stated that she has not been able to find any abuse investigations regarding abuse allegations or resident to resident physical altercations involving R50. R50's Incident Report, dated 2/1/24 at 8:30 AM, documented, "Nursing Description: Resident was bit by peer RB (R30). Refused to go to the hospital. Resident Description: Resident unable to give description. Immediate action taken: Description: Immediately separated, both refused to go to the hospital. Both skin assessed. NP (Nurse Practitioner) notified. Injuries Type: No injuries observed at time of incident." This incident report also documented that R50 was alert and ambulatory without assistance. R50's Incident Report, dated 9/30/23, documented, "Nursing Description: Resident was seen in bed laying down with his roommate	S9999		

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standing over him yelling about being hit. Resident description: Stated he did not do anything to that man. Immediate Action Taken: Resident was put on a one to one; and rooms are being changed. Mental status: Oriented to person; Predisposing Environmental Factors: Other; Predisposing Physiological Factors: Non-compliant with safety guidance, recent change in cognition, and Predisposing Situation Factors: Recent room change."

R50's Incident Report, dated 9/28/23 at 2:01 AM, documented, "Nursing Description: CNA (Certified Nursing Assistant) shouted out to this nurse that they were fighting. This nurse entered the room and observed this resident and another punching each other in the face and chest area while in the bathroom. I attempted to close the bathroom door to cease the fighting and this resident put his feet in the door in attempts to reopen. The other resident has sat down and calmed himself at this this time. this resident was then screaming, "I said turn off the lights, turn them off". I asked the resident to if he could stop screaming in attempts to not awake other sleeping residents. He then responded, "Fuck you, you, you, you I will kill all you guys. " Several attempts were made to redirect/calm this resident by it only agitated him even more so I allowed him space to calm himself. Resident still at this time continued screaming, making gestures and threats. Resident Description: Unable to give description. Immediate Action Taken: Residents were separated. The aggressor was escorted from the room to ensure safety of other residents. MD called/texted. Management contacted. EMS (Emergency Medical Services/Police contacted. Resident sent to Gateway for a psych eval. " The incident report documented R50 is ambulatory without assistance, oriented to person, place,

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S9999	Continued From page 12 time and situation. Predisposing Environmental Factors: other, poor lighting. Predisposing Situation Factors: Dislikes roommate, recent room change." R50's Incident Report, dated 9/9/23 at 4:00 PM, documented, "Nursing Description: resident was seen by a staff member blood on resident masked. This nurse examined all that I could. Resident was angry yelling. A scratch examined on resident nose and under eye. Resident description: Resident states a guy hit him and he fell. Resident stated he does not know who hit him. Immediate Action Taken: Skin assessed. 2 small scratches noted under his eye near his nose. Skin cleansed with normal saline. Physician, police, and resident's responsible party resident sent to ER (emergency room) for eval and treatment. Predisposing Environmental Factors: other. Predisposing Physiological Factors: confused, gait imbalance. Predisposing Situation Factors: Ambulating without assist." R50's Progress Note dated 9/9/2023 at 3:07 PM, documented, "Note Text: resident was seen by a staff member blood on resident masked. This nurse examined all that I could. resident was angry yelling. a scratch was examined on resident nose and under eye." R50's Progress note dated 9/30/23 at 7:11 AM documented, "Resident roommate c/o being physically assaulted by him. Resident denied allegations of abuse. Resident was yelling w/ roommate; roommate stated that he was struck by (sic); MD was notified, order was given to send resident to ED for eval of altered mental status; Belleville PD were called to assist EMS; resident's roommate filed report; this resident refused to go to ED for eval; residents were	S9999		

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S9999	Continued From page 13 separated immediately, this resident remains on one to one; MD made aware of changes." On 4/11/24 at 11:08, V16, LPN/Scheduler stated that she did the incident report on 2/1/24 when (R30) bit R50 on his hand but she did not witness what happened and could not remember who reported it to her. She also stated that she did provide wound care to R50's bite and that the bite did break the skin and it was bleeding. She also stated that he was followed by the wound nurse practitioner for a while because of the wound. V16 continued to state she did not know anything about R50 being hit by another resident on 9/9/23 causing facial fractures. On 4/11/24 at 11:25 AM V21, Corporate Nurse and V22, Corporate Travelling Administrator, both stated that they do not have any investigations for abuse allegations or resident to resident altercations for R50. V21 stated, "We have given you (surveyors) everything we can find. We have looked everyplace for investigations and have not found them." On 4/11/24 at 11:40 AM V23, Nurse Practitioner stated that she assessed R50's wound from another resident biting him on the day after it happened. She stated the bite did break his skin and they always treat a human bite with antibiotics, but she did not feel that the wound from the bite was ever infected. She stated that R50 had prolonged healing from the bite because he is non-compliant with treatment and refuses hygiene most of the time. 04/12/24 at 12:57 PM, V1, Administrator, stated that he has not been able to locate the investigations surveyors have requested of the resident-to-resident abuse investigations and	S9999		

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abuse investigations. He stated he has reached out to the two previous administrators who stated the investigations should be here, but he has looked in all the file cabinets and closets and the abuse investigations are not here anywhere.

5. The facility report to the State Agency, dated 3/30/24 at 12:23 PM, documented, "Resident/ Victim/Perpetrator": (R63/R64) Initial Incident Description: Resident reported that he got into an argument with another resident over the food cart and the other resident poked him and hit him. Residents were separated and assessed for injury and minor injury was treated. Residents monitored to prevent recurrence." The Initial Report documents R63, as the victim and R64, as the perpetrator.

The facility's Follow-up Investigation Report, undated, documented, "The victim describes the incident as a disagreement over the access to the hallway meal cart during lunch. The victim states that he asked the other party to close the door to the cart and not to take food out of it. This discussion escalated to a verbal argument followed by the other resident approaching the victim and, with cupped hands, shoving his hands into the neck area of the victim and lightly poking him with a fork. Victim said there were no staff or residents present as the location was out of view of the nursing staff at the time. The victim stated that the other resident said he was allowed to access the cart. The victim displayed no expression of distress after the incident and during the follow up discussion with the Administrator on 4/1 and 4/2. He appeared to be in good spirits and expressed understanding of the other residents' initial actions due to the misunderstanding of the access allowed to the meal cart by residents." Under interview of

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S9999	Continued From page 15 alleged perpetrator, it documented, "The resident is not cognitively able to express himself as to the intent of his actions due to a past brain injury but is alert." It continues, "Based on staff interviews there were no additional reports of similar incidents uncovered involving these or other residents. A staff member did indicate that the victim has a history of directing other residents and that the alleged perpetrator coincidentally does not take direction well from other resident." It continued, "Conclusion statement, Not verified. Unsubstantiated." It continues, "The facility residents have diagnosis of bipolar, depressive disorders and behavior histories. The investigation uncovered the source of the altercation as a misunderstanding of the facility procedures for access to the hallway meal cart rather than a deliberate attempt by the alleged perpetrator to willfully harm the victim. The victim expressed this in his statements as well. The injury sustained by the victim were relatively minor and required basic first aid and apparently resulted from an initial verbal disagreement. Upon further discussions, the victim expressed no fear or feelings of being unsafe. Based on review of the medical records, resident history, as well as the disagreement involved and related to his need for behavior intervention plan, which is in place. At this point the police report has not been received but has been requested by the facility. If there are changes to the results of the investigation based on the content of the police report, the final report will be adjusted." R63's Face Sheet, undated, documented diagnoses included Bipolar Disorder, Current Episode Mixed, Moderate, Major Depressive Disorder, Single Episode, Unspecified and Anxiety Disorder, Unspecified.	S9999		

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S9999	Continued From page 16 R63's MDS, dated 4/1/24, documented that R63 was alert and oriented and had no behaviors. R63's Care Plan dated 5/18/23, documented, "Has symptoms such as mood swings, impulsive behavior and attention seeking behavior related to a diagnosis of bipolar disorder and major depression disorder. Goal: Resident will demonstrate an ability to manage affect/mood swing without difficulty at least twice/week; Resident will not have a relapse of symptoms through the next review. Interventions: Administer Medication as prescribed by the physician. Encourage and counsel on the importance of medication compliance as needed. Encourage participation in activities. Encourage participation in recommended programming." R63's Care Plan, dated 5/18/23, documented, "ABUSE: (R63) is at risk for abuse and neglect r/t Bipolar Disorder, MDD, and Anxiety." It continues, Assess resident for abuse and neglect upon admission and quarterly. Continue to in-service the staff about abuse and neglect." 6. R64's Face Sheet, printed 4/12/24, documented diagnoses of Type 2 Diabetes Mellitus, Aphasia Following Non-Traumatic Subarachnoid Hemorrhage; Mixed Receptive-Expressive Language Disorder; Epilepsy, Unspecified, Intractable, with Status Epilepticus; Muscle Weakness; Bipolar Disorder; Cognitive Communication Deficit; Major Depressive Disorder; Personal History Traumatic Brain Injury; and Alcohol Abuse. R64's MDS, dated 1/8/24, documented that he was alert and oriented. R64's Care Plan, dated 3/30/24 documented,	S9999		

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S9999	Continued From page 17 "(R64) is at risk for abuse and/or neglect related to: history of TBI, Schizoaffective, depression, history of chemical/substance abuse, persistent anger/fear/anxiety, confusion/disorientation/forgetfulness, and poor judgement skills. Has difficulty in communications, history of verbal and physical aggression." It continues, "Administer medications as directed by MD and monitor for possible side effects and for effectiveness. If resident becomes difficult during care, make sure resident is safe and walk away. Allow resident time to calm down, then reapproach. Keep resident safe from harm at all times. Provide resident with psychosocial programming for anger management. Report any suspected abuse and/or neglect immediately to Administrator. Social Services to provide information regarding Hotline, Ombudsman, Community resources and residents rights as needed. Social services to review/assess resident history and assess risk factors for Abuse/Neglect quarterly and PRN. Staff to provide education/counseling if behaviors are noted. Staff will demonstrate respectful/non-threatening approaches." It continues, "1:1 Anger management counseling with social services when res is aggressive. 1:1 counseling as needed and as resident allows. If resident becomes aggressive attempt to remove resident from situation and assist him/her to a quiet place. Encourage resident to vent his/her feelings about situation. Remind resident that behavior is not acceptable. If resident becomes upset, give him/her time to calm down before re-approaching. If resident refuses care, care giver should leave room and try again later. Separate residents as needed. Staff will ensure that each resident is safe. Staff to encourage resident to attend daily group therapy. Will be encouraged to attend Reality Awareness group."	S9999		

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S9999	Continued From page 18 On 4/16/24 at 12:50 PM, V9, Social Service Designee, stated that they did have a point system for attending groups, but they no longer have any funding for groups and therefore there is no country store to offer the residents a place to spend their points. She stated attendance in groups has declined since they no longer have incentives to offer for attending them. She stated after residents are involved in 1:1 altercation with other residents she or her psycho-social staff do 1:1 with those residents to see if there is any post-traumatic stress following the incident and they make sure they are staying separated. She stated they are encouraged to attend psycho-social groups. V9 also stated that R63 does not attend psycho-social groups and R64 rarely attends them. On 4/17/24 at 2:55 PM V1, Administrator, stated that he did not feel abuse was substantiated in regard to the incident between R63 and R64 because, based on the facility's population, there was no willful intent to cause harm. V1 also stated that R63 likes to tell others what to do and R64 does not like anyone to direct him. V1 stated that there was superficial harm when R64 scratched R63 on the right cheek, but due to there being no intent, abuse was not substantiated. 7. Resident to resident Initial Investigation, dated 2/26/24, documented that V34, LPN heard yelling coming from the dining area. She then went to assess and noted R36 laying on her back against a chair with staff in between her and a peer. R36 then voiced that R35 had taken her bag from a table in the dining room and when R36 attempted to retrieve her belongings, R35 pushed her away and hit her. Then R35 voiced that R36 grabbed	S9999		

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S9999	Continued From page 19 R35's hair resulting in them falling back on to chair. Attempted to call V34, LPN without answer and R36 refused interview. When R35 was asked about the incident, he didn't remember the incident. An Investigation was requested from the facility, and V1, Administrator, stated that he has called the former staff, and they were not helpful. The final report staff and resident interviews were not provided during this investigation. R35's Care Plan, dated 2/3/24, documented that R35 can be verbally and physically aggressive. R35's intervention was to remove resident from the situation and administer medications. R35's Electronic Health Record, undated, documented that R35 has the diagnoses of Schizophrenia, Unspecified Dementia, and Unspecified Psychosis. R36's MDS, dated 2/23/24, documented that R36 was cognitively intact. R36's Care Plan, dated 3/14/24 documented that R36 qualified for subpart S. R36 displayed difficult behavior when dealing with peers and/ or staff and by the next review, R36 will not insult or direct vulgar behavior toward staff or peers. R36's Electronic Health Record Diagnoses list, undated, documented that R36 was bipolar disorder and Schizoaffective. On 4/17/24 at 12:50 PM, V2, DON stated that if one resident takes the other residents belongings then they would Initially separate the residents and assess them for injuries and then we would monitor them for 72 hours. The Facility Abuse Policy and Prevention	S9999		

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S9999	Continued From page 20 Program, dated 2022, documented, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, and misappropriation of property, deprivation of goods, and services by staff or mistreatment. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his and her safely as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including but not limited to the separation of residents." (B) 2 of 3 300.610a) 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 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.	S9999		

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S9999	Continued From page 21 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 are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident's coffee was served at temperatures that would not burn aresident for 1 of 12 residents (R30) reviewed for accidents in the sample of 59. This failure resulted in hot coffee being spilled on R30 and R30 sustaining burns to thigh and abdomen. Findings include: 1. R30's Physician Order Sheet (POS) for	S9999		

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S9999	Continued From page 22 February 2024 documents diagnoses of unspecified psychosis not due to a substance or known physiological condition, unspecified asthma, morbid obesity, hypertension, major depression disorder, anxiety disorder, Schizophrenia, legal blindness, post-traumatic stress disorder. R30's POS has an order dated 3/12/2024 at 3:07 PM, "Silvadene external cream 1%, apply to abdomen topically every day shift for blister. Clean with wound cleaner then apply Silvadene and cover with dry dressing daily until healed. Apply to abdomen topically every day shift to promote wound healing." R30's Minimum Data Set (MDS) dated 2/19/2024 documents R30 was severely impaired for cognition. R30's Care Plan date initiated of 8/2/2023 documents, "(R30) is legally blind. He stated he was born with blindness in both eyes. (R30) qualifies for Subpart S programming to diagnosis major depression disorder, recurrent, severe, focus areas include community living, medication management and self-maintenance. Diagnosis of mental illness. At risk for abuse and neglect related psychosis, anxiety, and schizophrenia." R30's Nurse's Notes dated 2/20/2024 at 3:52 PM, documents "Resident witnessed with open red area to upper left abdomen. (Medical Doctor) notified new orders Silvadene and dry dressing to affected area until healed. Resident is own responsible party. Plan of care will continue. (Draft)." There was no documentation to how R30 sustained this wound. R30's Progress Notes dated 2/26/2024 at 3:52	S9999		

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S9999	Continued From page 23 PM, "Resident witnessed with open area to upper low left abdomen. MD (Medical Doctor) notified, new order Silvadene and dry dressing to affected area until healed." R30's Wound Report dated 2/27/2024 documents, "Burn wound of left abdomen partial thickness, wound size 13 (length) x 15 (width) x 0.1 cm (centimeters), surface area 195.00 cm2, cluster wound open ulceration area of 78.00 cm2, no exudate, skin 60%. Silver sulfadiazine apply twice daily for 30 days. Secondary dressing, gauze island w/ bdr apply twice daily for 30 days. Burn Wound of the left thigh, partial thickness, etiology, burn, further etiology detail, 'hot liquid', duration less than four days, wound size Length 0.8 L x 0.6 w x d 0.1 c." Incident Reports provided by the facility do not document any incident for R30. R30's Nurse's Notes do not document when R30's accident/burn occurred or how the incident occurred. R30's Wound Notes dated 3/1/2024 at 9:00 AM, "Resident has reddened area on left abdomen upper and lower, scabbed over, purulent drainage noted, cleansed area, applied Silvadene and a bordered gauze, applied Silvadene to left upper leg at this time, resident is scratching at wound at this time." R30's Wound Report dated 3/5/2024 documents hot liquid burn, wound size 13 (length) x 9 (width) x 0.1 cm. Patient has a wound on his left abdomen, left thigh. Further etiology detail: Hot liquid. Silver sulfadiazine apply twice daily for 30 days. Secondary dressing, gauze island w/ bdr apply twice daily for 30 days.	S9999		

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S9999	Continued From page 24 R30's Skin and Wound Evaluation dated 3/5/2024 at 9:28 AM, "Burn, second degree, front left thigh, New, Wound measurement area 3.2 cm (centimeters), length 2.3 cm, width 2.1 cm." On 4/11/2024 at 9:22 AM, R30 stated, "I got that area on my belly from coffee that spilled on me. I can hold the cup and the (V20, certified nursing assistant CNA) spilled the coffee on me and it burned me on my stomach and thigh. I was in my room when the coffee was spilled. I burnt my stomach and thigh." On 4/11/2024 at 9:24 AM, R30 had a wound on his left stomach approximately 4 inches in length and 2 inches in width, pinkish in color, appearing as old wound, with an area in the center the size of a dime that had healed over. No exudate or pus was present, or foul odors. R30's thigh was healed over and had no open areas. On 4/11/2024 at 9:32 AM, V18, Licensed Practical Nurse (LPN) stated, "(R30) use to be upstairs but they moved him down here with me now. He is legally blind, and he can see shadows. He has that area on his belly that is almost healed up. I can do treatments on him without any issues. He got burnt when coffee was spilled on him. I am not sure when this happened. He had an area on his thigh and stomach from the coffee burn." On 4/11/2024 at 9:52 AM, V20, Certified Nursing Assistant (CNA) stated, "(R30) had a cup of coffee that he tipped over and it burnt him. I was not there but that is what (R30) told me. (R30) had a burn on his thigh and stomach." On 4/11/2024 at 8:02 AM, V10, Dietary Manager stated, "The coffee machine breaker part has been ordered and we are waiting for the part for	S9999		

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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 25 the coffee hot water machine to work. It was not working correctly." On 4/11/2024 at 4:30 PM, V1, Administrator stated there was no policy on heat/burns. (B) 3 of 3 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	04/18/2024

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S9999	Continued From page 26 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. (B) 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: 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. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide interventions to address weight loss for 1of 9 residents (R108) reviewed for weight loss in the sample of 59. This failure resulted in R108 losing 45.5 pounds (#s), a 16.98% loss of body weight in less than 2	S9999		

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S9999	Continued From page 27 months. Findings include: R108's Face sheet documents R108's admission date of 2/15/2024 with diagnoses of Hemiplegia, Hemiparesis following Cerebral Vascular Accident, Weakness, Dysphagia, Gastronomy tube status. R108's hospital discharge records dated 2/15/2024 documents R108's discharge weight of 268 pounds (#s). R108's Admission Observation dated 2/16/2024 documents Formula 250 milliliters every 6 hours. R108's order sheet dated 2/16/2024 documents Nepro at (@) 250 milliliters (ml) every 6 hours via gastric tube. Discontinued 4/11/2024. R108's Minimum Data Set, MDS, dated 2/21/2024 documents R108 cognition is severely impaired. R108's MDS documents upper extremity left side impairment and is dependent on staff for all Activities of Daily Living. R108's Care Plan dated, 3/7/2024, documents R108 is nutritionally compromised as evidenced by obesity. The Care Plan documents R108 is at risk for further compromise in nutrition and hydration status due to diagnosis of dysphagia, aphasia, hypertension, and dependence on tube feeding for all nutrition and hydration. R108's Progress notes dated 2/23/2024 at 4:18PM, written by V24, Registered Dietician, RD, documents Note Text: Nutrition at Risk Review Monitoring for admission, 2/15, and Tube Feeding. Weights. Diet: Jevity 1.5 Cal/Fiber Oral	S9999		

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S9999	Continued From page 28 Liquid. Give 250 ml/hour via G-Tube four times a day until Nepro comes in. R108 is Nothing by Mouth, NPO, No weight/height in chart. Plan/Monitoring: Recommend adding height/weight to chart for complete assessment. Will follow with weekly weights. Continue plan of care. Registered Dietician available as needed. R108's Dietary Nutrition at Risk Initial dated 2/27/2024 documents weight at 240#. Will follow up with weekly weights. Recommend clarifying tube feed order, continue plan of care. Registered Dietician available as needed. R108's Dietary Evaluation dated 3/7/2024, written by V58, RD, documents no known weight loss, and no weight changes. R108's facility weight log documents weights dated 2/28/2024 240#, 3/5/2024 240#, 3/14/2024 230.2#, 3/21/2024 236#, 3/27/2024 234#, 4/5/2024 221.5#, and 4/9/2024 222.5#. R108's Progress notes dated 3/21/2024 at 2:29PM, written by V58, documents Nutrition at Risk Review. Monitoring for admission, 2/15, and Tube feeding, TF. Weights: 236# (3/21), 230.2# (3/14), 240# (2/28), 240# (3/5) BMI: 33.9 Diet: Nothing by Mouth, NPO; Nepro @ 250 ml/hour via G-Tube four times a day Skin: intact Review: Tolerating TF well, will continue to follow. Plan/Monitoring: Continue with weekly weights. Continue plan of care, Registered Dietician available as needed. R108's order sheet dated 4/11/2024 documents Six times a day for nutritional support 250ml. Nepro bolus via g tube every 4 hours for nutrition. R108's progress notes dated 4/11/2024 at	S9999		

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S9999	Continued From page 29 2:28PM documents Monitoring for Tube Feeding. BMI 31.9. Diet: Nothing by Mouth. Nepro @ 250milliliters an hour via G tube four times a day. Skin intact. Review R108 has had -7.7% weight loss since admission. Current order meeting caloric needs yet weight loss occurring, no tolerance issues noted. Plan/monitoring: Recommend changing tube feed order to Nepro 55ml/hour times 20 hours, 350ml flushes every 4 hours (providing 2004kcals, 95g PRO, 177g carbs, 106g fat, 2900mL total fluids). Continues with weekly weights. Continue plan of care, Registered Dietician available as needed. On 4/11/2024 at 12:00PM V11, Licensed Practical Nurse, LPN, provided nutritional supplement to R108 with no issues. V11, LPN, stated R108 has lost weight. V11 stated "I am not sure why he has been losing weight." On 4/11/2024 at 11:00AM V23, Nurse Practitioner, stated R108 had a lot of edema when he first arrived. Some of his weight loss is probably related to the edema. His supplement was just increased from every 6 hours to every 4 hours. On 4/11/2024 at 2:45PM V24, Registered Dietician, stated "A resident on a tube feeding should not be losing weight. I was not notified of (R108's) weight loss. We had a meeting today and changed his feeding to 55ml an hour for 20 hours a day with 50cc of water three times daily." Facility Tube Feeding policy with a review date of 4/2024 states "Continuous tube feedings are based upon a 22-hour consumption period or other time frame based on individual resident need per Registered Dietician assessment and delivered over a 24-hour period. All residents	S9999		

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S9999	Continued From page 30 admitted on a tube feeding will be reviewed at the first care conference and quarterly to determine if the tube feeding is till congruent with the resident and family goals for care." (B)	S9999		