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	IL6001283	A. BUILDING: _____ B. WING _____	C 12/03/2024

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S 000	Initial Comments Complaint Investigation #2499538/IL181288 #2499664/IL181583	S 000		
S9999	Final Observations Statement of Licensure violation: 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	S9999		

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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.

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 interviews and record reviews, the facility failed to follow their policies and procedures for abuse prevention and behavior management by not calling for assistance or physically intervening during a resident-to-resident verbal and physical altercation; the facility also failed to identify an incident of abuse. This failure applied to two (R2, R3) of two residents reviewed for abuse and resulted in R2 sustaining a compression fracture of the spine, developing anxiety, and feeling unsafe in the facility after an altercation with another resident.

Findings include:

R2 is a 62-year-old male with a diagnoses history of Bipolar Disorder, Depression, Muscle Wasting, and Atrophy who was admitted to the facility on 11/05/2024.

On 11/25/2024 at 12:11 PM, R2 stated that last Thursday (11/21/2024) morning at around 6 AM, the nurse came to his room and, cut on the light

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and advised she wouldn't leave it on for too long. R2 stated he responded that it was ok because he didn't get sleep anyway. R2 stated the nurse was in the room caring for another resident who was dependent on staff for care. R2 stated during his conversation with the nurse, R3 began making nasty comments about the light being on and him being on the phone, and he replied that he didn't complain when R3 was playing his music loud all night. R2 stated shortly after this R3 grabbed him by the neck, knocked him over the bed and stood over him choking him. R2 stated he tried to defend himself. R2 stated while this was happening, he heard yelling from the hall, stating they were fighting. R2 stated it took staff a few minutes to respond to his room, and there was no security on the floor at all. R2 stated after R3 attacked him, he sustained a compression fracture in his lower back and couldn't stand for too long, so he had to use a walking stick. R2 stated because of this incident, he now has anxiety. R2 stated he has no trust in the facility because there is no security, and he doesn't feel safe. R2 stated there should be security on every floor.

R2's progress notes dated 11/21/2024 between 7:11 AM to 5:11 PM documents he was observed in an altercation where he was the recipient and found with a small scratch on his forehead, he was sent to the hospital for evaluation, and returned to the facility with a diagnosis of a compression fracture of the spine with a cervical collar in place.

R2's x-ray report dated 11/21/2024 documents he arrived via ambulance with complaints of being attacked by his roommate due to a conflict about loud music; he complained of pain in his neck, back, and right shoulder and was found on

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examination with a compression fracture of (L3 Vertebra) the spine.

R3 is a 39-year-old male with a diagnoses history of Single Episode Major Depressive Disorder, Anxiety Disorder, Cocaine Abuse, and Suicidal Ideations who was admitted to the facility 09/27/2024.

R3's progress note dated 11/21/2024 at 07:00 AM documents he was observed demonstrating aggressive behavior towards a room peer.

Final Abuse Investigation Report dated 11/28/2024 with witness statements included documents it was reported by staff that on 11/21/2024 at approximately 6:20 AM R3 was aggressive towards R2 and R2 sustained a scratch to his forehead; R3 was petitioned for transfer to the hospital for pscyh evaluation, and R2 was sent to the hospital for further evaluation; R2 reported that R3 came over to his corner of the room and attacked him after they exchanged words; two staff members reported they were present and while in the process of staff redirecting both residents away from each other R3 suddenly and abruptly charged towards R2; R2 was examined at the hospital and an X Ray revealed a compression fracture of the spine and an order was placed for a back brace; After investigation it was determined by the facility that R3 was responding to internal stimuli based on his diagnoses of Severe Mental Illness and history of depression, and substance use and abuse did not occur and was unsubstantiated. A witness statement from V5 (Registered Nurse) dated 11/21/2024 documents that at approximately 6:20 AM, he heard voices coming from R2 and R3's room, and when he responded, he observed R3 rush from his bedside towards

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R2. He attempted to separate them, and as R3 let go, he stood behind the door when he heard security. A witness statement from V18 (Registered Nurse) dated 11/21/2024 documents that while passing medication, she heard the nurse assistant shouting for security, as she approached the nurses station, she saw the nurse assistant V19 (Certified Nursing Assistant) calling for the elevator, she immediately walked past V19, and paged
security and they arrived a few seconds later, and they all entered R2 and R3's room. A witness statement from V19 documents on the morning of 11/21/2024 at approximately 6:15 AM, while conducting rounds with a patient, she heard a noise, and before arriving at the area where the noise was coming from, the nurse already separated the residents.

On 11/25/2024 between 11:15 AM - 12:15 PM V5 (Registered Nurse) stated he was working the 11 PM -7AM shift on the morning of 11/21/2024 during the physical assault incident with R2 and R3. V5 stated he was at the nurse's station performing medication administration between 6:20 AM - 6:30 AM, and V7 (Certified Nursing Assistant) was in R3 and R2's room providing patient care to another resident during the incident. V5 stated while preparing medications, he heard a high voice, went to R2 and R3's room, and opened the door. when he entered the room, he saw V7 behind another resident's closed curtain and R3 heading towards R2. V5 stated R2 was sitting on the side of his bed on closest to the door and R3 was approaching R2. V5 stated he attempted to stop R3 by calling his name and asked what was going on and attempting to redirect him. V5 reported R3 stated he wanted to hurt R2 and felt like choking him.
V5 stated he told R3 to stop and reminded him he

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had no right to hurt another resident. V5 stated R3 ignored this and continued making threats towards R2. V5 stated that R2 was responding to what R3 was saying, but he could not hear what R2 said. V5 stated he attempted to stop R3 from reaching R2 by sticking his hand out; however, R3 pushed past his hand and overpowered him, pounced on R2, and grabbed R2 by the neck. V5 stated that when R3 began attacking R2, he yelled out and told V7 to call security for him. V5 stated that V7 then left the room, and security was paged. V5 stated during this time, R3 was still on R2's neck, and they eventually fell on the floor. V5 stated he attempted to separate them, but he couldn't. V5 stated they were struggling then got up, R3 grabbed R2 again and was holding him, and they were arguing back and forth. V5 stated that during the struggle, they were blocking the door. V5 stated he pleaded with R3 to let R2 go. V5 stated V16 (Security) was the first to respond and had to knock on the door multiple times because the door was blocked. V5 stated he was able to move them from the door although they were still holding onto one another. V5 stated he then opened the door and security entered the room. V5 stated V16 and two other security staff were able to separate R3 and R2. V5 stated V7 was already in the room when he initially heard yelling coming from the room and he is not sure what took place during that time before he entered the room.

On 11/25/2024 at 3:53 PM, V7 (Certified Nursing Assistant) stated on the morning of 11/21/2024, she knocked on the door, turned on the light, and told R2 she wouldn't be long because she knew he didn't like the light on that early in the morning. V7 stated she was preparing to get another resident in the room dressed and R3 has a speaker and was playing music. V7 stated R3

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responded to what she told R2 about the light saying (profane word) that he don't run (profane word) in this room you can turn the light on. V7 stated that R2 responded well, I don't say anything about you having your speaker on all night. V7 stated R3 responded back to R2 with a comment regarding no one saying anything about him being on the phone. V7 stated R3 then got up and just charged at R2 and began choking him. V7 stated she was in the process of providing incontinence care to the other resident during this situation. V7 stated R3 physically attacking R2 happened so fast she was caught off guard and just began yelling out for security. V7 stated the V5 (Registered Nurse) responded immediately and entered the room. V7 stated after V5 entered the room, she ran out the room to get security because they had not come up to the floor yet. V7 stated she went down to the first floor to get security and encountered them on the first floor. V7 stated security were already on their way up. V7 stated V16 (Security) and another male security staff went up to respond to the incident. V7 stated she attempted to verbally redirect R3 during their argument however he wasn't receptive or following redirection, and she tries to stay out of his way because he is aggressive. V7 stated she couldn't intervene when R3 attacked R2 because she could potentially be hurt. V7 stated when residents become verbally aggressive, she is trained to go and get the charge nurse and try to deescalate the situation by separating the residents before it becomes a bigger issue. V7 stated R3 was at times aggressive. V7 stated R3 does not like redirection and if asked to do something by nurses he'll just become defiant and verbally aggressive.

On 11/25/2024 at 4:19 PM V1 (Administrator) stated all staff are trained on CPI (Non-Violent

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Crisis Prevention and Intervention) techniques.

On 12/02/2024 at 3:09 PM V1 (Administrator) stated there are only security stationed on the behavioral unit but not the other areas of the facility. V1 stated she expects any and all staff to intervene in an incident of physical assault. V1 stated that the expectation is that during a verbal altercation, the staff will intervene immediately and stop the verbal altercation before it escalates. V1 stated during the incident between R2 and R3 this could have been done by staff by verbally redirecting the resident, calming them down, reassuring them that they are nearly done with their duties, and offering them the option to step outside or allowing them to get the nurse to temporarily place them in a different room, as well as talking them down from their aggression. V1 stated if the resident is not receptive to redirection, she would expect staff to seek help from someone else by calling the nurse, and not leaving patients unattended to in the meantime. V1 stated if a verbal altercation escalates such as in the case of R3 and R2 where it escalated from verbal aggression to physical aggression, staff could have initiated CPI (Non-Violent Crisis Prevention Intervention) or attempted to separate them. V1 stated while R2 and R3 were arguing V7 (Certified Nursing Assistant) should have called for help. V1 stated V7 reported that after a short verbal exchange between R3 and R2, that R3 rushed at R2. V1 stated if there was more dialogue that occurred than what was reported and the residents were not receptive to verbal redirection, staff should have called for support immediately before anything escalated. V1 stated staff are expected to verbally and physically intervene in the middle of residents being physically aggressive ensuring the safety of the residents while support staff arrive to the area of

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incident. V1 stated once R3 physically attacked R2 the expectation is that V7 would hold R3's wrist and guide his hand away from R2. V1 stated this would have allowed V7 to feel a lot safer because once she's able to grab hold of R3's arm and walk him away she wouldn't have to worry about removing anyone from each other. V1 stated once V5 (Registered Nurse) entered the room V5 could have assisted V7 by physically intervening and performing a side by side and then removing R3 from the room. V1 stated V5 and V7 should have ensured that R3 and R2 were physically separated prior to V7 leaving to go and get security. V1 stated there were numerous other staff present on the unit on 11/21/2024 during the incident when R3 attacked R2 and if V5 could not physically separate them he could have yelled for help and any staff could have assisted. V1 stated she wasn't aware that V7 was uncomfortable with intervening in an incident of physical aggression between residents. V1 stated she expects every staff in the facility to be aware of their responsibility in ensuring the resident's safety and understand their roles and responsibilities in doing so or either resigning if they don't feel comfortable with intervening with residents during incidents of physical aggression.

On 12/03/2024 at 12:03 PM V1 (Administrator) stated abuse was not substantiated regarding R3 becoming physically aggressive with R2 because both have a diagnosis of mental illness and R3 was exhibiting poor impulse control, and it was more of a sporadic event. V1 stated in this situation with R3 she would say his actions were not willful, were impulsive, and he's never been this way before. When asked by surveyor if she believed R3 physically attacking R2 after becoming verbally aggressive with him were

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accidental V1 stated R3's behaviors were out of character for him. V1 stated examples of willful behavior include premeditation, and high intent. V1 stated to her willful sounds like something planned or orchestrated. V1 stated she considers the verbal aggression and physical attack by R3 towards R2 accidental.

The facility's Abuse Policy received 11/26/2024 states:
"The facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse of residents."

"This will be done by:
Identifying occurrences of potential mistreatment."

"Abuse means any physical or mental injury inflicted upon a resident other than by accidental means. Abuse is willful infliction of injury with resulting physical harm or mental anguish to a resident. This assumes all instances of abuse of residents cause physical harm or mental anguish. The term (willful) in the definition of (abuse) means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."
"Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, and kicking."
"Verbal abuse is the use of oral language that willfully includes disparaging and derogatory

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terms to residents regardless of the individuals age, ability to comprehend, or disability."

The facility's Behavior Management Policy received 11/26/2024 states:
"Residents who exhibit aggressive behavior pose care challenges to staff and other residents."
"Strategies to Reduce Aggressive Behavior
De-escalation: When confronted with situations where the resident is becoming combative or has begun to be combative;
" Redirection - Provide options for other activities or places if appropriate.
" Environmental Control - If a resident is becoming violent, assess the surrounding areas and move other residents to a safer location.
" CPI (Non-Violent Crisis Prevention and Intervention) Techniques - Use techniques learned in CPI training."

The facility's CPI Policy received 11/26/2024 states:
"Crisis intervention is a small segment of time in which staff members must intervene with another person to address behavior that may escalate into disruptive or even violent incidents. The goal is to intervene in a way that provides for care, welfare, safety and security of all who are involved in a crisis situation."
"Responsible Party: All Staff." (A)