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S 000	Initial Comments Facility Reported Incident of 9/26/24/IL179130	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.615a) 300.615e) 300.615f) 300.615g) 300.615j) 300.625a) 300.625b) 300.625c)1)2) 300.625d) 300.625e) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240f) 300.3240g) 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.	S9999		

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Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

a) For the purpose of this Section only, a nursing facility is any bed licensed as a skilled nursing or intermediate care facility bed, or a location certified to participate in the Medicare program under Title XVIII of the Social Security Act or Medicaid program under Title XIX of the Social Security Act.

e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the

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resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.

j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

Section 300.625 Identified Offenders

a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks.

b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

c) If the results of a resident's criminal history background check reveal that the resident

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is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:

1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender.

2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

d) The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act.

e) All name-based and fingerprint-based criminal history record inquiries shall be submitted to the Department of State Police electronically in the form and manner prescribed by the Department of State Police. The Department of State Police may charge the facility a fee for processing name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry. (Section

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S9999	Continued From page 4 2-201.5(c) of the Act) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel,	S9999		

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representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

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)

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These requirements were not met as evidenced by:

Based on interviews and record review, the facility failed to ensure two residents (R2 and R7) were free from abuse from a resident (R3). The facility failed to ensure R3's criminal background check was completed within 24 hours of admission and the facility failed to acquire a fingerprint-based criminal history record inquiry to be requested on the identified offender resident (R3); failed to identify R3's known behaviors

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placing other residents at risk for abuse; failed to ensure a care plan was developed for R3's violent behavior to address R3's known aggressive behaviors and history of aggressive behaviors; failed to accurately complete assessments that identify R3's aggressive behaviors and blindness; and failed to submit a final investigation report regarding physical abuse to the state survey agency within 5 business days. These failures resulted in R3 physically assaulting 2 residents (R2 & R7) and causing multiple facial fractures to one resident (R7).

Findings Include:

R3's clinical record indicated in part the following:

On 8/21/24, R3 was admitted with medical diagnosis that includes but not limited to aphasia following cerebral infarction; major depressive disorder, recurrent, unspecified; essential (primary) hypertension; unspecified psychosis not due to a substance or known physiological condition; other specified diabetes mellitus without complications; polyosteoarthritis, unspecified; arthropathy, unspecified; gastro-esophageal reflux disease without esophagitis; long term (current) use of aspirin; insomnia, unspecified; hyperlipidemia, unspecified; vascular dementia, unspecified severity, with other behavioral disturbance; bipolar disorder, current episode mixed, unspecified; cerebral infarction, unspecified; dysphagia, oropharyngeal phase; cognitive communication deficit; other Alzheimer's disease.

R3's Referral records, the facility received prior to R3's admission, fax date of 8/16/24, documents, in part, "(R3) with a history of dementia,

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depression, and anxiety was transferred from a local nursing home for direct admission. He (R3) was involved in a physical altercation with a fellow resident ... He (R3) remains anxious, irritated, confused, and bizarre, with no recollection of why he (R3) is being treated. Due to his (R3) dysregulated mood, aggression, and confusion, he (R3) poses a danger to himself and others ... Verbal aggression during pt (patient) care ..."

On 10/16/24 at 11:50am, when asked if the facility was aware of R3's history of aggression and prior physical altercation at the preceding facility R3 was residing at, V9 (Nurse Consultant) replied, "In R3's referral it did state R3 had an altercation with another resident, but it did not state who hit who."

R3's CHIRP (Criminal History Information Response Process), dated 8/27/24, documents, in part, documents that R3 has multiple convicted criminal offenses including forgery, theft, and theft of a firearm. "HIT... (R3) ... FELONY CONVICTION(S)... Date of Arrest: 03/10/1997 THEFT/CONTROL/FIREARM/2ND... "

V9's (Nurse Consultant) e-mail, dated 10/16/24 at 11:04am), documents, in part, "Spoke with the social service director (R3) was not fingerprinted."

On 10/17/24 at 2:51pm, V17 (Social Work Consultant) and this surveyor reviewed R3's criminal background check as follows: V17 confirmed R3 was admitted on 8/21/24 and the "Resident Background Check" form was initiated for a CHIRP (Criminal History Information Response Process) on 8/27/24 which is greater than 24 hours from R3's admission. V17 confirmed there were no fingerprints completed for R3 even though R3 had multiple arrests

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including theft with a firearm. V17 said, "The CHIRP is run within 24 hours of admission of a new resident. Once we (facility) get the CHIRP back we (facility) have 72 hours to schedule fingerprints, 72 hours to put it in portal, and then a forensic investigator comes out. The investigator interviews and gives a criminal analysis within 45 days showing what their (residents) risk level is. They (criminal investigators) make recommendations for plan of care implementations. I (V17) do just believe it was a lapse in timing with transitioning employees coming in for the reason R3's CHIRP was not done, and the fingerprints were not ordered. There was a new person coming in and there was a lot going on."

On 10/16/24 at 11:04 AM, V9 (Registered Nurse Consultant) stated via email that V9 spoke to V8 (Social Service Director) and R3 was not fingerprinted.

Record review of R3's electronic health record does not indicate that R3 was fingerprinted after receipt of the criminal convictions identified on the CHIRP.

R3's progress note, dated 9/7/2024 at 1:41pm, transposed by V3 (Licensed Practical Nurse/LPN), documents, in part, "Resident (R3) combative with all staff when asked to remain in his wheelchair for safety; refused blood glucose check and midday medicine pass; attempted to open secured doors on the unit. Resident (R3) used vulgar language with Writer. Family notified ... R3 was combative with staff, refusing medications (including insulin) and blood glucose testing. On 9/26/24 at 7:20 AM, R3 was observed with a cane in R3's hand and blood was noted from R3's roommate's (R2) head. On 9/26/24, R3 had another altercation with another peer in the

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dining room and was verbally aggressive and combative with staff. Subsequently, R3 was sent to the hospital for a psychiatric evaluation and returned on 9/28/24. On 10/10/2024, R3 was observed punching another resident (R7) out of the wheelchair and on to the floor. R3 additionally struck the CNA and was verbally aggressive to the nurse. R3 was sent to the hospital for psychiatric admission on 10/10/24".

R3's progress note, dated 9/26/2024 at 7:20am, transposed by V5 (Licensed Practical Nurse/LPN) documents, in part, "Informed by CNA (certified nursing assistant) upon rounds resident (R3) had a cane in his hand and blood was coming from roommates head. All staff proceeded to room ... When asked what happened, resident (R3) stated, "I (R3) thought someone was in my house. I (R3) didn't know he (R2) was supposed to be here". No concerns at this time."

On 10/15/24 at 12:46pm, with translator V6 (Certified Nursing Assistant/CNA) present to translate for R2, this surveyor inquired about the altercation with R2 and R3 on 9/26/24. R2 replied, "R3 hit me on the head with my cane. I (R2) was in the bathroom and R3 came up behind me and told me to get out of his apartment, grabbed my cane, and hit me in the head with it. I (R2) turned and seen R3. I (R2) am positive it was my roommate. I (R2) was bleeding from my head. R3 hit me good. The nurses took me to a different a room and I (R2) no longer stayed with R3. I (R2) wasn't happy R3 was still here. I (R2) would see him walking around even though the nurses tried to keep him in the wheelchair. Didn't know if he (R3) would try to attack me (R2) again." When asked if R2 feels safe here at the facility, R2 replied, "I (R2) don't want to answer cause we

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don't know."

R2's Face Sheet, documents, in part, medical diagnosis including but not limited to peripheral vascular disease, unspecified; other specified soft tissue disorder; and constipation, unspecified.

R2's Minimum Data Set (MDS), dated 8/26/24, documents, in part, R2's Brief Interview for Mental Status (BIMS) score is 13 which indicates R2 is cognitively intact.

V10's (CNA/certified nursing assistant) Facility Reported Incident of 9/26/24 Witness Statement, dated 9/26/2024, documents, in part, "I (V10) walked into (R2's) room he (R2) was walking out saying (R3) hit him with his cane. (R3) came out of the room yelling, get him out of my apartment."

R2's Facility Reported Incident of 9/26/24 Witness Statement, dated 9/26/2024, documents, in part, "(R3) hit him (R2) head."

On 10/16/24 at 1:10pm, V10 (Certified Nursing Assistant/CNA) said, "I know R2. That morning (9/26/24) I (V10) just came in. I (V10) came in and did my rounds. I (V10) was coming back down the other hall and saw R2 staggering out of the room with a bleeding wound on his head. R2 said he (R3) was hitting him. R3 was cursing and yelling. R3's baseline is if you tell him (R3) what to do he'd get agitated. R3 was regularly agitated, every other day. We try to talk to him (R3) and calm him down. Just a lot of foul language. Yeah, I (V10) felt like he (R3) could do something like again cause he (R3) didn't listen."

On 10/17/24 at 2:15pm, V5 (Licensed Practical Nurse/LPN) said, "Yes, I (V5) am familiar with R3. I (V5) was there 9/26/24 with the R2 and R3

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altercation. (R3) has moments of anxiousness and combativeness. CNA came and got me and showed me the opening on R2's head with blood. R2 said R2 was hit with a cane by R3. R3 is aggressive 50/50 percent of time. R3 had some bad days and some chill days. At times I (V5) was worried R3 would hurt other residents. Not sure what R3 was capable of. There are other residents are more helpless than me and can be harmed by R3."

Upon review of R3's EMR (Electronic Medical Record), this surveyor observed the following:

1. Record review of R3's Minimum Data Set (MDS) dated 8/28/24 documents in part a brief interview of mental status summary score of 10 indicating R3 has cognitive impairment, documents R3 has behavioral symptoms and wandering. R3 has behavioral symptoms that occurred 1 to 3 days and has adequate vision. The coding of B1000: Vision indicating that R3 has adequate vision is inaccurate as R3 is legally blind.

2. Record review of R3's CAA (Care Area Assessment) Worksheet (dated 8/28/24) documents in part R3 had behavioral symptoms and wandering. V8 signed the CAA worksheet stated R3's behaviors would be addressed within R3's Care Plan.
3. Record review of state final reportable of the physical abuse investigation occurred between R2 and R3 on 9/26/24, documents in part the R2 and R3's care plans were updated after the incident. This is inaccurate as the care plan was not updated until 10/10/2024 to address R3's behaviors.
4. Record review of R3's care plan documents in part R3's aggressive behaviors were

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addressed on 10/10/24 after the incident between R3 and R7. R3's care plan was not updated with the MDS dated 8/28/24 in response to the CAA worksheet completed by V8 or after the final report and investigation of the incident occurred between R2 and R3.

5. Inaccuracy of R3's "Screening Assessment for Trauma Factors Including Abuse/Neglect," dated 10/10/24 with a lock date (changes were made) of 10/16/24. R3's Screening Assessment for Trauma Factors Including Abuse/Neglect documents, in part, "Question 1. History of Abuse/Neglect including physical, sexual, verbal, emotional, financial, domestic violence, involuntary seclusion and/or unexplained injuries prior to admission. Answer NO." This answer is not accurate as evidenced by prior to admission R3 was in a physical altercation at the previous facility he (R3) resided at with another resident. Documented in hospital records prior to R3's admission is a history of aggression both verbal and physical. "Question 2. History of presences of dysfunctional behavior (e.g., provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space. Answer Unable to be determine." This answer is not accurate as evidenced by R3's criminal history and R3 invading R2's space when R3 hit R2 ion the head with a cane on 9/26/24.

6. Inaccuracy of R3's "Screening assessment for indicators of aggressive and/or harmful behaviors." R3's "Screening assessment for indicators of aggressive and/or harmful behaviors,' documents, in part, "Question A. 1. General awareness, insight, judgement, reasoning, memory, concentration and

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orientation, including diagnosed dementing illness (i.e. Alzheimer's Disease, Vascular Dementia NOS, Pick's Disease, OBS, Substance Induced Dementia). Answer 0." This answer is not accurate as evidenced by R3's diagnosis of Alzheimer's disease and vascular dementia. "Question D 1. History of Abuse/Neglect including physical, sexual, verbal, emotional, financial, domestic violence, involuntary seclusion and/or unexplained injuries prior to admission. Answer NO." This answer is not accurate as evidenced by prior to admission R3 was in a physical altercation at the previous facility he (R3) resided at with another resident. Documented in hospital records prior to R3's admission is a history of aggression both verbal and physical. "Question D 2. Factors increase resident's vulnerability (e.g. dementia, confusion, disorientation, poor insight/poor judgement, poor communication skills, poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, history of exploitation, heavy care needs, unable to make needs known, on psychotropic meds)? Answer Unable to be determine." This answer is inaccurate as evidenced by R3's diagnosis of vascular dementia. "Question D 3. Psychiatric history and/or mental health diagnosis, including psychotic symptoms (e.g. delusional thoughts, hallucinations) and possible misinterpretation of events and the intentions of peers? Answer Unable to be determine." This answer is inaccurate as evidenced by R3's mental health diagnosis including but not limited to bipolar disorder, current episode mixed, unspecified; Alzheimer's disease; dementia; major depressive disorder. "Question D 6. History of presences of dysfunctional behavior (e.g., provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or

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otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space. Answer Unable to be determine." This answer is not accurate as evidenced by R3's criminal history and R3 invading R2's space when R3 hit R2 ion the head with a cane on 9/26/24.
On 10/22/24 at 9:53 AM, V8 (Social Services Director) stated the social services department is responsible for creating a plan of care for residents with behaviors. Inappropriate behaviors, aggression, or refusal/combativeness to care would all be care planned by the social services department. V8 reviewed R3's plan of care and affirmed R3's behaviors were not care planned until after both incidents (9/26 and 10/10). V8 stated R3's aggressive behaviors should have been addressed in R3's care plan upon admission when the history of aggression/abuse was identified. V8 did not know why the R3's behaviors were not addressed in R3's care plan. Record review of R3's care plan does not indicate that the facility identified R3's criminal background or developed a plan of care to address R3's criminal background.

On 10/22/24 at 9:57 AM, V8 (Social Services Director) stated the screening for aggressive behavior is to be completed with every MDS (quarterly, annually significant change) and if aggressive behavior occurs. V8 did not know why the aggression screening assessment was not completed after R3's incidents of violent behavior on 9/26 and 10/10. V8 stated these assessments are important because they help to trigger staff to develop a plan of care to address the aggression.

On 10/22/24 at 11:08 AM, V20 (MDS Coordinator, Licensed Practical Nurse) stated that one of focuses/purposes of the MDS is to identify

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resident needs and drive the care plan. V20 confirmed R3 was legally blind and was visually impaired. V20 reviewed R3's 8/28/24 MDS and stated that R3's vision in B1000 should have been coded as impaired. V20 stated that if assessments are not completed accurately, care needs may not be developed in the care plan. V20 reviewed R3's care plan and affirmed that R3's blindness was not addressed on the care plan and affirmed that if B1000 was coded correctly, a Care Area Assessment (CAA) would have triggered for visual function.

On 10/15/2024 at 11:50 AM, V9 (Registered Nurse Consultant stated, "If documentation cannot be produced, then it didn't happen".

On 10/15/24 at 3:18 PM, R7 recalled a few days ago, R7 was sitting by R7's bed and R7's back was turned away towards the door. R7 stated R7 began getting punched in the head from behind with a closed fist, "many times". R7 stated R7 tried to grab the person punching R7 to prevent getting punched further but R7 stated R7 was "in a daze from the punches and I almost got knocked out". R7 remembered having face pain at the time of the incident and staff came in and broke up the fight. R7 stated R7 was sent to the hospital to see if R7 was injured. R7 stated, "I don't know if I feel safe here anymore".

In R7's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 at 1:07pm, documents, in part, "(R7) is the receiver in a physical altercation with peer. (R7) was knocked down to the floor by peer."

In R3's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note,

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dated 10/10/2024 at 2:42pm, documents, in part, "Writer and staff heard yelling in the hall from a resident's room. All staff reported to another resident's room where (R3) was observed punching the resident out of his wheelchair to the floor. When removing (R3) from the room he became combative with his CNA (certified nursing assistant) striking her. Writer intervened and the resident became combative with writer using verbal aggression and vulgar language to staff. Resident petitioned out to (Hospital) via 911. POA (power of attorney) Family."

In R3's EMR (electronic medical record), V3's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 3:04pm, documents, in part, "Resident sent to (Hospital). Family notified."

In R3's EMR (electronic medical record), V4's (Licensed Practical Nurse/LPN) progress note, dated 10/10/2024 3:59pm, documents, in part, "(R3) discharged to: 10/10/2024 3:08 PM. Reason for transfer: Physical aggression ... The following people were notified of transfer: Physician Family Yes - Current reconciled medication list provided to the subsequent provider."

In R7's EMR (electronic medical record), V5's (Licensed Practical Nurse/LPN) progress note, dated 10/11/2024 at 1:44am, documents, in part, "(R7) returned from hospital with two fractures to cheek and fracture to nose."

R7's Face Sheet, documents, in part, medical diagnosis including but not limited to fracture of unspecified part of neck of right femur, sequela; other cervical disc degeneration, unspecified cervical region; fusion of spine, cervical region; and seizures.

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R7's Minimum Data Set (MDS), dated 10/07/24, documents, in part, R7's Brief Interview for Mental Status (BIMS) score is 07 which indicates R7 has severe cognitive impairment.

R7's hospital records, dated 10/10/24, documents, in part, "Sent from (Facility) after assaulted by another resident there. Apparently, this resident was punching multiple other residents and punched this patient in the head, knocking him out of his wheelchair. On 10/10/24 at 9:30 PM, R2's hospital records document a CT (computed tomography scan was completed) and documents the following findings: fracture of the nasal bones, small fracture of the lateral wall of the right orbit, small fracture of the right arm of the zygomatic arch, dehiscence of the floor of the right orbit. "These fractures are of indeterminate age; clinical correlation is recommended. At 9:46 PM, R2's physician documented, "Likely mix of new and old injuries."

V3's (Licensed Practical Nurse/LPN) Facility Reported Incident of 10/10/24 Witness Statement, dated 10/11/2024, documents, in part, "Writer and staff heard yelling in the hall from a resident's room (R7's room). All staff reported to room where the yelling was heard; Upon arrival (R3) had punched (R7) out of his wheelchair to the floor. When staff attempted to remove (R3) he became combative with his CNA (certified nursing assistant) taking a swing striking her. Writer intervened and the residents became combative with writer using verbal aggression and vulgar language with threats."

V15's (CNA/certified nursing assistant) Facility Reported Incident of 10/10/24 Witness Statement, dated 10/11/2024, documents, in part,

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"(R3) was very aggressive he (R3) was about to hit me (V15) so I (V15) step out of the room. Using abusive language toward everybody."

R7's Facility Reported Incident of 10/10/24 Witness Statement, dated 10/10/2024, documents, in part, "(R3) went to (R7's) room and hit him (R7) on the side of the face."

On 10/16/24 at 11:50am, V1 (Administrator) said, "I (V1) got abuse training on hire and multiple times after. Training began with HR (Human Resource), then I (V1) reviewed companies' policies on physical, emotional, negligence, misappropriation of funds, sexual, verbal, and mental abuse. Abuse is causing any king of harm falls under those categories. Abuse is harm with intent. When someone willfully is doing any of those actions. Making a choice to cause harm. We (facility) did not substantiate abuse for either incident because dementia residents do not have the mental capacity to make a choice to harm."

On 10/16/24 at 11:50am, V9 (Nurse Consultant), "In R3's referral it did state R3 had in an altercation with another resident, but it did not stay who hit who. We've (facility) been cited every month for abuse. I (V9) started being in the building every day". When asked what was put into place after R3 hit R2 with a cane, V9 replied, "behavior monitoring, offer activities, sister visiting more to assist with behaviors." When asked for the documentation of R3's behavior monitoring, V9 replied, "I (V9) need to see if V8 (Social Service Director) has the behavior monitoring sheets upstairs". When asked if R3 has ever seen a therapist, V9 replied, "I'm not sure. I'll have to check with social service team. Assessments are done on admission, updated when changes. The assessment should indicate

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if there were changes and if aggressive to staff or residents." No behavior monitoring for R3 could be produced by the facility by the end of the survey.

On 10/17/24 at 11:33am, V15 (Certified Nursing Assistant) said, "Yes sir, I (V15) am familiar with R3. R3 had his moments when we (staff) couldn't tell R3 anything cause R3 would get upset/agitated and call us (staff) names like, 'You bitch'. Even if you (staff) tried to calm R3 down R3 wouldn't calm down. Yes, R3 would be physical. R3 would get aggressive with me (V15). R3 would grab my hand and try punching me. I (V15) was working day (10/10/24). I (V15) heard a little commotion and went towards R7's room. I (V15) tried to help him (R3) calm down. R3 was very aggressive. R3 grabbed my hand. R3 kept coming at me. R3 walks. R3 stands up from his wheelchair. R3 won't sit down. I (V15) just heard R3 screaming. R7 was complaining of pain in face. We (staff) didn't know when R3 would get upset. When R3 just got the urge R3 would just get aggressive. I (V15) was worried R3 would hurt me. R3 was a strong guy. Yes, I (V15) was definitely worried R3 would hurt the other residents. I (V15) believe, everyone (all employees) knew R3 would get upset. There was no training for R3. You (staff) can have a conversation with R7. He (R7) remembers almost everything. Just can be a little forgetful but R7 would not forget anything like this. Since happened R7 always brings it up. I (V15) would say R7 remembers things, sometimes forget things, but he remembers most things. I (V15) don't think R7 would make up a story of what happened to him (R7). R3 is not appropriate to have a roommate. R3 was aggressive toward staff since the beginning. "

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On 10/17/24 at 12:03pm, V3 (Licensed Practical Nurse/LPN) said, "Yes, I (V3) am familiar with R3. He'd (R3) get up from the chair and curse you out. Gets very vulgar and then more vulgar. We (staff) try to redirect R3. R3 has swung at me (V3) before but never actually made contact. I (V3) was sitting at the nurse's station, heard someone yelling, CNAs (certified nursing assistants) and I (V3) got up and went to see what was happening. R3 was up over, standing over R7. I (V3) assessed R7, helped him up, and removed R3 from the room. R3 got aggressive with the CNA and me. R3 was full of aggressiveness, vulgarity, and more aggression. R3 struck the CNA. R3 walked up on me with his fist and swung, but I (V3) backed up. R3 continued being vulgar. My documentation, I (V3) admit, sucked. I (V3) asked if a resident's daughter visiting witnessed it and the family member said yes. When I (V3) asked the family member if she (family member) seen R3 strike R7, she (family member) said yes. The family member was in tears. Staff was with R3 in the dining room but R3 will roll out of the dining room, we'll watch him role out, but R3 has right. R3 has the freedom to roll back and forth. Residents have the freedom to roll around. I (V3) have been worried R3 would hurt me. I (V3) have been concerned R3 would hurt other residents. I (V3) never notified anyone; I (V3) just diffused the situation. R3 was 50/50 percent aggressive all of the time. R3 could be decent and then would just snap."

On 10/17/24 at 12:19pm, V16 (CNA), said, "I (V16) was working 10/10/24. I (V16) heard yelling, ran, and the other nurse followed. R7's wheelchair was flipped over and R3 was standing over R7. R7 said R3 punched him (R7) and knocked him (R7) over. R7 is pretty much oriented, forgets here and there, but for the most

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part R3 remembers even like missing a shoe. No, R7 wouldn't make up a story. Half of the time R3 is aggressive."

On 10/22/2024 at 10:48am, V18 (Medical Director) said, "I (V18) was the attending physician for R3. R3 had Bipolar, dementia, anxiety depression, Psych issues. Medically ok. Main reason was psych issues as far as I (V18) remember. I (V18) did his (R3) admission, and he (R3) had some altercation at other facility and's why other facility transferred him out to our facility. Based on R3's history of aggression towards other residents, I (V18) don't know if he (R3) had a roommate." When asked if it was appropriate for R3 to have a roommate, V18 replied, "Difficult to answer. There are a lot of psych, and they can have behaviors and stabilize. When I'm (V18) admitting a patient I (V18) assume they are stabilized. With identified behaviors prior to admission, the facility should have increased R3's supervision and observation. Yeah, when we see there R3 required increased monitoring. Nursing homes don't have a lot of staff, so if we (facility) can't care for them appropriately, we (facility) send them to the hospital. I (V18) was aware of 10/10/24 altercation with R2 and R3. We sent R3 out. No, I (V18) don't remember a change of condition. When I (V18) went in the room R3 was using vulgar language. Being hit in the head and falling out of a wheelchair cause facial fractures definitely caused harm to (R7). The severity of harm happens after a resident is hit in the head can vary depending on the velocity of the hit, the size of the resident. Facial fractures can be caused by a punch to the head or falling out of a wheelchair. R3's plan of care should have been developed to address those behaviors. Dementia and psych are very challenging. We try to control

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the behaviors but if it's out of control we (facility) send them out. If the Plan of care isn't done, the resident's aggressive behaviors can continue. We (facility) need to address it because other residents are at risk. If a resident is assessed incorrectly, can harm be caused? is a hard question. Behaviors change. If behaviors changed the assessments should be redone."

On 10/28/24 at 1:10pm, V9 (Nurse Consultant) said, "We (facility) do not have an assessment policy or a policy specifically for completing the aggression screening and trauma assessment. We (facility) follow the RAI (Resident Assessment Instrument) guidelines for Assessments."

Record review of R3's medication administration record (October 2024) documents in part R3 has an order for Seroquel (Quetiapine Fumarate) give 1 tablet by mouth every 8 hours as needed for agitation for 14 days began on 10/1/2024. The medication administration record indicates this medication was not given in on 10/10/24 when R3 displayed agitation.

Record review of CMS's RAI (Resident Assessment Instrument) 3.0 Manual Chapter 3 MDS Items [B] (dated October 2024) documents in part the following: "9. Behavioral Symptoms In the world at large, human behavior varies widely and is often dysfunctional and problematic. While behavior may sometimes be related to or caused by illness, behavior itself is only a symptom and not a disease. The MDS only identifies certain behaviors but is not intended to determine the significance of behaviors, including whether they are problematic and need an intervention. Therefore, it is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is

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problematic and to identify underlying causes. The behavior CAA focuses on potentially problematic behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking, scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms ... The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent the behavior places the resident or others at risk for harm, and any related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, reduce the frequency of truly problematic behaviors, and minimize any resultant harm."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 24	S9999		

Record review of initial report to the state survey agency (Illinois Department of Public Health) dated 9/26/24, documents in part that a physical altercation occurred between R2 and R3. No final report to the state survey agency was noted within the investigative documents.

Facility presented e-mail from V1 (Administrator) that documents, in part, "Subject: Facility Reported Incident (R2) and (R3) Final 9.26.24. Date: Wednesday, October 16, 2024, at 11:42 AM Central Daylight Time. From: (V1, Administrator). To: (Illinois Department of Public Health)", indicating that the final investigative report was sent to the state survey agency on 10/16/2024 (20 days after the incident occurred and 20 days after the initial report was sent).

On 10/16/24 at 11:50am, V1 (Administrator) affirmed that V1 is the abuse prevention coordinator for the facility and that V1 conducted the investigation for the alleged abuse that occurred on 9/26/24 between R2 and R3. V1 stated that V1 could not find evidence that the final investigation report was submitted to the state survey agency, so V1 "submitted it (the final report) again today". V1 stated that all allegations of abuse require an initial report to be sent to the state survey agency within 2 hours of the allegation and a final report is to be sent in within 5 business days.

Facility policy titled "Behavior Management for Agitated Behavior" (undated), documents in part, "Targeted Behavior: Agitated Behavior, which represents a danger to self and others, due to Alzheimer's disease with anxiety, dementia, mental illness or other illnesses. Preventative Measures: ...2. When resident's voice is loud,

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	IL6014641	A. BUILDING: _____ B. WING _____	C 10/31/2024

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offer drink, food, toileting, take for a walk, or redirect to activity of interest ...3. Observe resident for behavior escalation of anxiety, aggression such as loud voice tone, hand ringing, swearing, yelling, and/or other irritability. Interventions if Behaviors Escalates and/or Reoccurs: 1. Remove from problem area, separate from other, when necessary, APPROACH from the front ... 4. If uncontrolled anger, aggression or anxiety cannot be redirected, i.e. the resident is in danger of harming self or others after attempting the above interventions, administer physician ordered medication for anxiety for the symptoms being exhibited. **** ...6. Document all interventions attempted and administered and the resident's response to medical interventions ... 8. Monitor the response to drug therapy 1:1 until dangerous symptoms are reduced. If the resident responds to the medication by becoming quiet and anxiety free and aggressive acts have minimized, i.e. no longer harm to self and others 1:1 monitoring will be discontinued ..."

Facility policy titled "Abuse Prevention Facility Policy and Procedure" dated 1/4/2018, documents in part: " ... Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services needed to attain or maintain physical, mental or psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse or mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this

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definition of abuse, means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm ... II. Pre-Admission Screening of Potential Residents: this facility shall check and review the criminal history background for any resident seeking admission to the facility in order to identify previous criminal convictions.
This facility will: - request a Criminal History Background Check within 24 hours after admission of a new resident, - check for the residents and sex offender registration website. www.isp.state.il.us - Check for the resident's name on the Illinois department of Corrections sex registrant search page. www.idoc.state.il.us - While the background or fingerprint checks, and/or Identified Offender Report and Recommendations are pending, the facility shall take steps necessary to ensure safety ... IV. Establishing a Resident Sensitive Environment
This facility desires to prevent abuse, neglect exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: ... Resident assessment: As part of the resident social history and evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendations Report into the identified offender's plan of care including the security measures listed ..."

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S9999	Continued From page 27 Facility policy titled, "CHANGE IN RESIDENT'S CONDITION" (reviewed 11/2023), documents in part, " ... RESPONSIBLE PARTY: RN, LPN, Social Services ... 5. The Care Plan for the residents will be updated as indicated." Facility policy titled, "CARE PLAN" (undated) documents in part, "A. POLICY: All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status ..." Facility policy titled "Abuse Prevention Program Facility Policy and Procedure" (dated 1/4/2018), documents in part, " ... External Reporting ... 2. Five-day Final Investigation Report. Within five working days after the report of the occurrence, a completed written report of the conclusion of the investigation, including the steps the facility has taken in response to the allegation, will be sent to the Department of Public Health ..." (A)	S9999		