STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000137	A. BUILDING: _____ B. WING _____	C 12/20/2024

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S 000	Initial Comments Complaint Investigation 24810221/IL182583	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.3210t) 300.3240b) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

These regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to protect residents'

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rights to be free from mental and physical abuse for 1 out of 4 residents reviewed for abuse. This failure does not conform with facility's abuse policy and affected one resident (R1), who experienced hair pulling by another resident (R2), resulting in R1 expressing anguish, fear for her safety, and danger of harm.

Findings include:

R1 is 44 years old, initially admitted at the facility on 04/11/2022. R1's diagnosis includes visual impairment, anoxic brain damage, bipolar disorder, and depression. R1's BIMS (Brief Interview of Mental Status) dated 10/03/2024 is 15 out of 15 indicating that R1's cognition is intact.

On 12/17/2024 at 12:16 PM, R1 was seen inside her room alert and verbally able to express her thoughts well during conversation. R1 stated last Sunday (12/15/2024) while she was walking in the hallway, R2 grabbed her ponytail again. R1 showed her back hair that was long. R1 stated that R2 grabbed her hair multiple times in the past. R1 said, "R2 constantly abused me, and I don't feel safe." R1 stated that she is visually impaired and does not have peripheral vision, and that it is hard for her to see R2 when coming from her side. R1 pointed to the stick that she uses to guide her when she walks. R1 stated that pulling of her hair also happened in the smoking area when R2 grabbed her ponytail, and that staff did not monitor R2 because R2 was in the smoking area although R2 does not smoke. R1 stated that R2 was able to go inside her room around 12:15 AM and that made her (R1) scared of her safety. R1 stated that there are two (2) other residents, R3 and R4, that had also experienced physical aggression from R2. R1

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stated that she spoke to V5 (Social Service Worker) about being transferred to another facility last October or November, but nothing has been done. R1 said, "I spoke to V5 the social worker, who told me, this is his (V5) exact words, "bear with us, we are trying to find another place for her (R2)." R1 stated that she has been in the facility for three (3) years, and she does not feel safe.

Behavioral notes dated 12/15/2024 written by V6 (Registered Nurse) documents "R2 pulled R1 hair that led to R1 yelling towards R2." Similar incident also happened on 11/01/2024 as recorded on R2's behavioral notes by V8 (Licensed Practical Nurse) that documents R2's physically aggressive and that R2 assaulted R1 by pulling her hair. Another incident note by V8 dated 10/23/2024 documents that R2 went inside the room of R1 at 12:08 AM. R1 was noticeably shaking and stated, "I don't feel safe here with this woman still here. Why is she in my room? Why? I've been attacked by her several times. I don't want her killing me before they realize she is not supposed to be here."

On 12/17/2024 at 01:40 PM, R3 was seen alert and able to express her thoughts within topic during conversation. R3 confirms that R2 hit her back multiple times, punching with her fist behind her (R3) head, (R3 made a punching motion behind the right side of her back). R3 said that she turned to R2, and R2 just laughed. Per R3, staff allowed R2 to do those things, and she (R3) just keep distance with R2, as long as R2 keep distance from her.

Behavioral notes dated 07/22/2024 by V9 (Registered Nurse) documents that in the dining room, R2 hit R3 and threw milk on R3's face.

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R2 is 40 years old, initially admitted at the facility on 05/25/2024. R2's diagnosis includes restlessness and agitation, schizophrenia, bipolar disorder, major depressive disorder. R2's BIMS (Brief Interview of Mental Status) dated 09/05/2024 is 09 out of 15 indicating R2's cognition is moderately impaired. On 12/17/22024 between 12:05 PM to 03:20 PM R2 was seen in the hallway, sitting on a chair, and wandering. Every time R2 goes to a specific direction, facility staff goes to redirect. It takes multiple staff to monitor and/or redirect R2. R2 was not able to be redirected at times.

On 12/17/2024 at 02:50 PM, V1 (Administrator) stated that another incident happened over the weekend, on Saturday (12/14/2024), when R2 pulled R1's ponytail. According to V1 none of the facility staff told her about what happened and that V6 (Registered Nurse) was expected to report to her (V1) any incident or allegation of abuse. V1 states that the facility does not have any designated abuse coordinator during the weekend because she still accepts calls. When she came on Monday (12/16/24), before she left for the day, R1 told her about the incident that R2 pulled her hair. V1 said, "that was the time I knew that R2 pulled the hair of R1." V1 then said that she did a grievance form for R1. V1 was asked why she did not do a reportable after she knew what happened between R1 and R2. V1 replied that abuse incident or allegation needs to be reported immediately or within 2 hours upon knowing of the incident. Since the incident happened on 12/14/2024, it was too late to report and investigate. V1 stated that the incident that happened on 12/14/2024 between R1 and R2 was abuse, because R1 does not like what was being done to her. V1 states that the act of R2 to R1 causes an effect on R1, physically or mentally.

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Per V1 one on one monitoring to R2 is ongoing and R2's transfer to the hospital for a psych eval will take place when there is an available bed. V1 stated that currently R2 is being monitored one on one, and arrangement is being made to transfer R2 to the hospital for psych evaluation. V1 was informed that based on documentation in R2's behavioral notes the incident of R2 pulling R1's hair happened on Sunday, 12/15/2024 (same as R1's statement) not Saturday (12/14/2024). V1 said that she will correct her documentation.

On 12/17/2024 at 03:49 PM, V6 (Registered Nurse) stated that the incident between R1 and R2 on 12/15/24 happened around 09:30 AM, the time she was passing medication. V6 stated that she heard R1 yelling. V6 said, "I saw R1 behind R2 and R1 said "R2 pulled my hair." So, I just did 1 on 1 monitor. I need to report, I knew R1 was telling the truth, but I forgot to tell." V6 stated she just documented the incident and did not report to her supervisor. Per V6 abuse incidents need to be reported immediately but forgot to report it. V6 stated that abuse happened when R2 pulled the hair of R1, and it needs to be reported immediately. Per V6 the CNA (Certified Nursing Assistant) assigned to R2 was attending to another resident during the incident.

On 12/18/2024 at 09:37 AM, V3 (Director of Nursing) stated that incidents like pulling of R1's hair will affect R1 mentally. V3 said, "If I were in her (R1) shoes, I will feel scared too." V3 stated that it may lead to more aggressive actions than pulling of hair. V3 reviewed the full care plan of R1, and after review, V3 said, "I don't see anything that addresses abuse incidents." V3 said that the care plan should be done for both because both residents (R1 and R2) are affected.

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R1's care plan does not address R2's aggressive behavior towards R1. V5's (Director of Social Services) psychosocial notes do not document any of R1's incidents with R2.

On 12/18/2024 at 12:06 PM, V5 (Director of Social Services) stated that all of his notes are under psychosocial and were written in general. V5 was asked about R1's psychosocial notes and why all the notes do not address any incidents from R1's encounter with R2. V5 stated that the last time he saw R1 was 11/7/2024 and there were no particular concerns for R1. V5 was asked about addressing the abuse incidents that R1 encountered in the care plan's intervention to prevent further abuse from occurring. V5 stated that since R1 is not at risk for doing abuse or does not participate back during a physical aggression, a general statement of at risk of abuse behavior was placed. V5 was asked if interventions were placed in R1's care plan would it help to prevent another incident of abuse from happening. V5 did not directly answer the question. V5 stated that if he only knew R1 felt unsafe or scared, he would go out of his way to transfer R1 into another facility. V5 was informed that the incidents of R1 and R1 expressing feelings of unsafety and fear were documented in the behavioral notes and were readily accessible. V5 did not comment. V5 was asked how he would feel if the same thing happened to him. V5 stated that he would be scared too, and added, "Next time I will do better."

Abuse Policy dated 01/04/2024, reads: This facility affirms the right of the residents to be free from abuse. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident

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S9999	Continued From page 7 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 mistreatment, neglect, or abuse of the residents. This will be done by establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. Identifying occurrences and patterns of potential mistreatment. Immediately protecting residents involved in identifying reports of possible abuse. (B)	S9999		