STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007231	A. BUILDING: _____ B. WING _____	C 12/04/2024

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S 000	Initial Comments Complaint Investigation 2419859/IL181892	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.3300c)1)C 300.3300d)2 300.3300e)1)2)3)4)5) Section 300.3300 Transfer or Discharge c) Reasons for Transfer or Discharge: 1) A facility may involuntarily transfer or discharge a resident only for one or more of the following reasons: C) for the physical safety of other residents, the facility staff or facility visitors. d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances: 2) When the transfer or discharge is mandated by the physical safety of other residents, the facility staff, or facility visitors, as documented in the clinical record. The Department and the State Long Term Care Ombudsman shall be notified prior to any such involuntary transfer or discharge. The Department will immediately offer transfer, or discharge and relocation assistance to residents transferred or discharged under this subsection (d)(2), and the Department may place	S9999		

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relocation teams as provided in Section 3-419 of the Act; or (Section 3-402(b) of the Act)

e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:

1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act);

2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act);

3) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10 days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health or the State Long Term Care Ombudsman at the telephone numbers listed below."; (Section 3-403(c) of the Act);

4) A hearing request form, together with a postage paid, preaddressed envelope to the

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Department; and (Section 3-403(d) of the Act);

5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act).

This requirement is not met as evidenced by:

Based on interview and record review the facility involuntarily transferred and discharged a resident with dementia and behaviors to the emergency room. The facility failed to notify IDPH (Illinois Department of Public Health) and the State Long Term Care Ombudsman of R1's involuntary transfer and discharge. The facility failed to provide notice of the involuntary transfer and/or discharge of the resident on a form prescribed by the state with the required documentation needed for 1 of 1 resident (R1) reviewed for transfer/discharge in the sample of 6.

The findings include:

The Face Sheet dated 12/5/24 for R1 showed medical diagnoses including dementia with other behavior disturbance, type 2 diabetes mellitus, hypomagnesemia, hypertension, bacterial pneumonia, asthma, gastro-esophageal reflux disease without esophagitis, urinary incontinence, and altered mental status.

The Behavior Note dated 11/26/24 at 12:36 PM for R1 showed she refused lunch and a supplement. R1 was going to toss her plate of food and the staff stopped this from happening. R1 was offered many different things to eat and drink which increased her agitation. R1 was pushed around in her wheelchair, and this did not

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help calm her. Staff tried to assist R1 into a recliner and she became more aggressive, cursing and swinging at staff. The nurse (V5 RN - Registered Nurse) from the west side took R1 over to the west side with him.

A Nurse's Note dated 11/26/24 at 2:19 PM (late entry) for R1 showed, this writer (V5 RN) observed resident being aggressive/disruptive with staff after lunch. Writer offered to take resident on 1:1 off unit. Writer asked resident if she wanted to go to the other side of the building; she said yes. We went to the health center west for a while. She (R1) was occasionally verbally profane; did accept assistance to stand without aggression. After an hour or so the resident did want to return upstairs. Writer toileted resident with 2 CNA (Certified Nursing Assistant) assist in her room. At that time the resident was not aggressive during pants change. The note showed the writer took R1 back to the health center CNA's at 1:15 PM.

The Nurse's Note dated 11/26/24 for R1 showed, at 2:03 PM, received a call from V2 DON (Director of Nursing) that resident (R1) was hitting another resident and V3 NP (Nurse Practitioner) gave a verbal order to send resident (R1) to the ER (emergency room). Writer attempted to call V4 (R1's POA - Power of Attorney) on both his home phone and cell phone with no answer. At 2:29 PM, POA still had not returned call and the ambulance was contacted by phone to arrange transport. At 2:47 PM - ambulance arrived to transfer R1 to the hospital. Transfer sheet, medication list and behavior notes sent with resident. At 2:50 PM spoke with RN (Registered Nurse) at the hospital ER to give report. Requested a referral for geriatric psychiatric hospital and that V2 be contacted before

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returning resident. At 8:36 PM, Called the hospital ER department. They relayed that the ER department had mental health crisis personnel/center evaluate her (R1). They reported that she (R1) had a UTI (urinary tract infection) and they will be sending her back to the facility. The ER department was directed to call V2 DON and the number was given. The ER department also relays that the resident was calm and cooperative with care.

On 12/5/24 at 8:22 AM, V1 (Administrator) stated R1 was sent out to the hospital because she hit another resident and her behaviors needed to be managed if they were going to keep her. V1 stated R1 went to the hospital ER and the ER wanted to send R1 right back. V1 stated the ER did not do anything for R1 to help with her behaviors. We needed something to be done for R1 before she could be safely taken back at the facility. V1 stated R1 was not taken back to the facility at that time. V1 stated V4 (R1's spouse) came to the facility and cleaned out R1's room because they were under the impression she was being discharged.

On 12/5/24 at 10:38 AM, V2 DON (Director of Nursing) stated the facility did not take R1 back when the ER tried to discharge her back to the facility because they felt she was a danger to herself, staff, and others. V2 stated R1 was a danger because she was impulsive, would throw herself out of bed, tried to ambulate when it was not safe to, was combative with care, and hit 2 other residents. At 11:27 AM, V2 stated the facility did not have a discharge policy.

On 12/5/24 at 12:15 PM, V7 LPN (Licensed Practical Nurse) stated she is not aware of the facility having any discharge policy. V7 stated if a

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resident is sent to the ER for evaluation, they will wait a few hours and then call the facility for an update. V7 stated the ER calls and lets the facility know when they are sending a resident back to the facility. V7 stated the resident is taken back to the facility unless something is stated before hand with the intention that they would not take a resident back. V7 stated the facility does not have many discharges.

On 12/5/24 at 12:49 PM, V8 (SASS - Screening, Assessment and Support Services counselor) stated she was called a few weeks ago to evaluate R1 in the hospital ER. V8 sated R1 has dementia and is from a nursing home. We decided R1 was not having mental health problems and it was safe for her to return to the facility. R1's behaviors were related to her acting out and her dementia. We were told by the hospital that the facility did not want R1 to come back to the facility.

On 12/5/24 at 1:07 PM, V3 NP (Nurse Practitioner) reviewed the ER documentation regarding R1 from her arrival and her stay in the ER. V3 stated R1 was seen by V8, the mental health crisis counselor from a contracted outside organization for evaluation. V3 stated V8 recommended R1 go back to the facility. The ER physician spoke with V9 (facility's Medical Director) and V9 spoke to the facility and the facility stated they would not take R1 back. On 11/28/24 R1 was still in the ER. R1's husband and spouse wanted her to go back to the nursing home but R1 was evicted. V3 stated the ER documentation showed V9 saw R1 in the ER on 11/28/24 and did not feel R1 needed to go to a psychiatric facility.

On 12/5/24 at 3:00 Pm, V2 DON stated the facility

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does not give any notices for discharge and/or transfers. V2 stated they have never done that since she has been at the facility. V2 confirmed no notice for R1 was given to anyone and the facility did not have written notices.

The Care Plan dated 10/4/24 for R1 showed, Behaviors. Staff will identify triggers for agitation and aggression and develop strategies to de-escalate situations. The care plan was revised on 11/22/24 and showed, staff will be able to identify factors/interventions that help to prevent/minimize inappropriate behaviors. R1 will not act out in a way that is harmful to self or others. Creating a comforting and quiet environment (secondary lounge area on Health Center). Monitor medications effectiveness and side effects. Offer R1 a snack, beverage, and/or activity. Staff will be patient and supportive. Staff will use simple language and clear instructions when communicating. R1 is resistant to care and will often curse, hit/bite or throw things at those attempting to assist her. R1 is unable to follow directions. Staff will provide frequent reminders, cueing and redirection. Requires staff to manage behavior episodes. R1 is often physically aggressive and/or combative with staff. R1 also becomes restless. Staff will provide 1:1 care when a resident becomes restless, combative or aggressive. Receives mental health services. Care staff will report any changes from baseline behaviors. The care plan did not show any behaviors of suicidal ideation, homicidal ideation, intentional harm to herself or other residents.

As of 12/5/24 the facility did not have a discharge policy or written notices for transfer/discharge.

(B)