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S 000	Initial Comments Investigation of Facility Reported Incident of September 15, 2024/IL179129 Investigation of Facility Reported Incident of September 27, 2024/IL179131	S 000		
S9999	Final Observations Statement of Licensure Violaions I of II: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 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 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	S9999		

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meet the resident's medical, nursing, and mental 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.

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:

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.

Section 300.3210 General
t) The facility shall ensure that residents are not

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subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

This REQUIREMENT is not met as evidenced by:

Based on interviews and record reviews, the facility failed to protect a residents' (R2, R11, and R12) right to be free from verbal and physical abuse form another resident (R1) for three out of 13 residents reviewed for abuse. This failure resulted in staff not providing needed supervision for an aggressive resident causing R1 to get into a verbal altercation with R12, R11 having to physically stop R1 from striking R11 with a cane and R1 punching R2 in the face.

Findings include:

R1's Admission Record, Order Summary Report, and care plan documents in part diagnoses including but not limited to schizophrenia and bipolar disorder.

R1's Brief Interview for Mental Status (BIMS) dated 9/09/2024 documents in part that R1 was moderately cognitively impaired.

R1's care plan documents in part that R1 displays impaired decision-making ability as evidence of inattention, disorganized thought content, and hallucinations (date initiated 3/12/2024). Care plan does not contain a focus for potential/risk for abuse.

R1's progress notes document in part that on 9/26/2024, R1 experienced aggressive and noncompliant behaviors. V21's (Former Licensed Practical Nurse/LPN) progress note dated 9/26/2024 2:55 AM documents in part: "Resident

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is displaying aggressive and abusive behavior. Resident continues to walk the floor, not easily directed. Resident refused to go to [R1's] room. Resident is trying to fight another resident and stated, 'somebody is going to get hurt.' [R1] continues to verbally abuse [R1's] roommate." Noncompliant behavior continued throughout the day and needed multiple re-direction from staff. Facility sent R1 to the hospital for psychiatric evaluation and returned on 9/27/2024. V10's (Nurse) progress note dated 9/27/2024 2:25 AM documents in part that R1 returned to the unit argumentative and noncompliant. V22's (Nurse) progress note dated 9/27/2024 7:36 AM documents in part: "Resident at nurses' station verbally aggressive unable to redirect. Verbally threatening staff and peers."

On 10/23/2024 at 11:25 AM, V27 (Medical Records Director) stated during that Friday morning, facility assigned V27 to work as receptionist at the front lobby. R12 ran out the front door in the lobby with shirt off like R12 was getting ready to fight. V27 stated R1 and R12 were having a verbal altercation. R12 was inviting R1 to join R12 outside for a physical altercation. Social services stood outside with R12 to settle R12 down. V27 stated staff directed R1 back to the first-floor nurses' station. V27 described R12 as a resident that 'gets into moods where [R12] can be confrontational.' V27 stated "I guess that morning, [R1] was feeling confrontational as well and it spear headed the whole thing. Both showed signs of agitation and when those personalities met, it wasn't good."

On 10/23/2024 at 12:25 PM, R12 stated a resident put their fists up to R12 so R12 put their fist up in response. R12 stated "(R1) did it first." "I was outside. (R1) didn't follow me outside cause

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(R1) was scared. I said come outside and fight me but (R1) didn't. (R1) was too scared." "I had to protect myself then."

R12's Admission Record, Order Summary Report, and care plan documents in part diagnoses including but not limited to unspecified psychosis not due to a substance or known physiological condition; schizoaffective disorder, bipolar type; anxiety disorder; unspecified symptoms and signs involving cognitive functions and awareness; and unspecified intellectual disabilities.

R12's BIMS dated 8/25/2024 documents in part that R12 was moderately cognitively impaired.

R12's care plan documents in part that R12 has impaired cognitive function or impaired thought processes related to comorbidities (initiated 5/14/2024). It does not contain a focus for potential/risk for abuse.

During same interview with V27 on 10/23/2024 at 11:25 AM, V27 continued with the morning's events. After staff separated R1 and R12, V27 looked outside towards R12 and social services to make sure R12 was doing okay. When V27 turned around towards the first-floor nurses' station, V27 saw R1 having another altercation with R11 fighting over a cane. V27 stated "[R1] was trying to attack R11 with the cane." V27 stated R11 had two hands on the cane stopping R1 from striking R11 with it. V27 took the cane, headed back to the front lobby, and staff separated R1 and R11.

R11's Admission Record, Order Summary Report, and care plan documents in part diagnoses including but not limited to abnormal posture;

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chronic angle-closure glaucoma, bilateral; blindness, one eye, low vision other eye; abnormalities of gait and mobility; muscle wasting and atrophy; and lack of coordination.

R11's BIMS dated 8/25/2024 documents in part that R11 was cognitively intact.

R11's care plan documents in part that R11 has history of aggressive behavior towards others. R11 has displayed physical aggression toward staff and peers (initiated 11/21/2023). It does not contain a focus for potential/risk for abuse.

During a telephone interview with V21 (Former LPN) on 10/23/2024 at 10:22 AM, V21 stated when V21 arrived for work that morning, R1 was "already irate and fighting another resident at first." V21 saw R1 and R11 "tussling back and forth" over a cane. V21 stated R11 struck R1 twice in the face with a closed fist. V21 stated facility called a code to have additional staff assist with the incident. R11 went back to the bedroom and R1 went into the Parlor. V21 stated leaving the facility afterwards and when V21 returned, staff informed V21 that R1 hit R2 across the face.

V21's progress note for R2 dated 9/27/2024 9:30 AM documents in part: "Upon arrival nurse was told by the nurse that resident was struck in the face by (R1) peer. The resident noted with facial redness and slight swelling to the left eye. No cuts or scrapes noted. Asked resident was (R2) in pain, resident pointed to [R2's] nose. Resident face was red, and the nose is slightly swollen. Patient was given Tylenol for the pain, and ice pack for the swelling."

During a telephone interview with V22 on 10/23/2024 at 1:03 PM, V22 (LPN) stated seeing

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V21 walk out of the facility. When V22 made it to the front desk, V22 heard staff say, 'Hey they are trying to fight.' V22 went to the first-floor nurses' station where staff informed V22 that R1 got into two altercations. V22 stated separating R1 and R1 went into the Parlor by self. Staff later informed V22 that R1 punched another resident in the face (R2). V22 did not witness it but was told by staff because they saw it through the Parlor's window. V22 stated a Certified Nurse Aide (CNA) was looking at the Parlor and said 'hey [R1] just hit [R2].' Staff went to the Parlor and separated the residents. V22 stated R2 was crying and saying that R1 had hit R2 in the eye. R1 was cursing a lot and stated R1 got hit with the cane and that R1's finger was hurting. When V22 interviewed R2, R2 repeatedly stated getting hit in the eye. V22 contacted the provider and received orders for an x-ray of R1's face, which showed no fractures. V22 stated "I do believe that [R1] hit [R2]." V22 stated ever since R1 returned from the hospital, R1 has been aggressive and purposely getting into it with other residents.

V22's (Nurse) progress note for R1 dated 9/27/2024 8:14 AM documents in part: "Resident pacing back fourth throughout unit attempting to go in other peers' room. Resident shouting and pointing finger in staff face. Resident unable to redirect [Social Service] call and administrator [psychiatric service company] made aware PRN (as needed) offer but decline." V22's following progress note (time stamp 8:34 AM) documents in part: "Writer made aware by staff resident was walking pass and struck another resident in the face."

On 10/22/2024 at 1:11 PM, V9 (CNA) described R1 as being loud and bossy during last days at the facility. R1 would get upset if staff and

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residents didn't do what R1 told them to do. V9 stated sometimes R1 would get confrontational and exchange words with other residents. V9 stated working during R1 and R2's incident. R1 and R2 were in the Parlor room. V9 stated R1 was already loud and then V9 heard R2 yell '(pronoun/R1) hit me.' When V9 turned to look, R1 was bent over in front of R2 picking something off the floor and R2 was screaming. V9 stated facility assigned V9 to watch the Parlor room but V9 went out to get coffee and did not see the incident. When V9 returned and asked R2 what happened, R2 stated '[pronoun/R1] hit me.'

V9's typed and signed statement dated 9/27/2024 documents in part that V9 was at the nurses' station and did not observe the incident.

State Report documents in part a reportable incident on 9/27/2024 at 9:00 AM involving R1 and R2 for an alleged peer-to-peer altercation. Under "Analysis and Conclusion", it documents in part "When [R1] was asked what happened, all [R1] would say is 'I got [pronoun].' [R1] would not elaborate. [R2] was rubbing [R2's] right eye and cursing, not able to be redirected to the questions at hand."

R2's Admission Record, Order Summary Report, and care plan documents in part diagnoses including but not limited to bipolar disorder; difficulty walking; hemiplegia and hemiparesis affecting the left non-dominant side; muscle weakness; traumatic brain injury; muscle wasting and atrophy; weakness; lack of coordination; and disorder of bone density and structure.

R2's BIMS dated 3/17/2024 documents in part that R2 has severe cognitive impairment.

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R2's care plan documents in part that R2 may be at risk for potential abuse related to physical and/or communication challenge as evidenced by unable to propel wheelchair safely, severely limited range of motion and severe frailty/weakness (initiated 6/06/2023). Goal was for R2 to be free from harm through the next review. Additional focus documents in part that R2 may be at risk for potential abuse related to mental/emotional challenges (initiated 6/06/2023). Goal was for R2 to be free from harm through the next review. Intervention included to assure R2 that they are in a safe and secure environment with caring professionals (initiated 6/06/2023). R2's care plan also documents in part that R2 demonstrates behavioral distress related to ineffective coping mechanisms; poor verbal skills and inability to express self in a more appropriate language; poor self-esteem; feelings of inadequacy; and feeling powerless (initiated 6/06/2023).

On 10/23/2024 at 11:00 AM, surveyor interviewed V3 (Assistant Director of Nursing) who was in charge during R1's altercations between R2 and R11 per V2 (Director of Nursing) and V21 (Former Nurse). V3 stated [V3] was not involved in the incidents and found out about it during morning meeting. V3 instructed survey team to refer questions to the morning staff and to V1 (Administrator).

On 10/23/2024 at 1:52 PM, V2, stated the facility tries to ensure that the environment and residents are safe and free from abuse. If staff can identify early on and be proactive, the facility can get appropriate parties involved to prevent any incident from occurring. If a resident is irate and aggressive, the facility must make sure there is

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no immediate threat or anything to cause to escalate the situation. Staff must make sure the resident is free from other residents and there is no potential for harm to self and others. Facility will try to give the resident an opportunity for them to voice any concerns and work through it. V2 stated during R1 and R12's incident, after the staff separated the two residents, one staff should have stayed with R1 and another staff with R12. V2 stated staff should have directed R1 to another location such as to the bedroom or the office. V2 stated after R1 and R11's incident, staff should have put R1 on one-to-one monitoring. V2 stated facility has social services or psychiatric services aide to monitor one-to-one while the nurses handle the clinical portion. V2 stated if a resident is experiencing behaviors, then the staff must try the least invasive interventions first. If that doesn't work, then staff must notify the provider to get orders either for an as needed anti-psychotic medication or hospital evaluation. If the resident declines the medication, then staff are to follow-up with the ordering provider to retrieve further instruction.

On 10/23/2024 at 2:40 PM, V1 (Administrator) stated staff should have informed V1 regarding R1 and R11's incident and documented it. Staff should have de-escalated the situation and kept R1 under close supervision and monitoring. They should have had the nurse evaluate and the nurse should have documented what they done. V1 stated if a resident is irate, staff needs to try to speak with the resident to try to get them to focus on the issue at hand. Staff need to call social service and nursing to speak with the resident to get clinical perspective. If needed, nursing will then call psychiatrist or primary provider to get further instructions.

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Facility's "Policy & Procedure Supervision Policy" (01/24) documents in part: additional supervision may be required in order to meet the specialized needs of residents. Additional supervision may be but not limited to 1:1 supervision, 15-minute checks, 30 minute and so forth. Purpose: to ensure resident safety. Responsibility: All staff.

Facility's "Abuse Prevention Program Facility Policy and Procedure" (1/04/2018) documents in part: "Abuse is the defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." "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 and mental abuse including abuse facilitated or enabled through the use of technology." "This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment." "As part of the resident social history evaluation and MDS [Minimum Data Set] assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment or misappropriation of resident property or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents." "Supervisors will monitor the ability of the staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs. Situations such as inappropriate language, insensitive handling or

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S9999	Continued From page 11 impersonal care will be corrected as they occur." (B) Statement of Licensure Violations II of II: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)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. 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 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	S9999		

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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.

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:

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.

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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record

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review the facility failed to follow their care plan policy to develop, implement, and supervise a newly admitted resident with self- injurious and suicidal behavioral concerns. These failures resulted in a resident (R3) gaining access to a shaving blade/razor and cutting his right arm; in a separate incident R3 found a spoon in which R3 was able to break in 2 places and use the pieces to cut his arm; and another incident in which R3 punched a picture with a glass frame which resulted in R3 sustaining an injury that required R3 to be sent to the ER (Emergency Room) and receiving 7 sutures to the left hand.

Findings Include:

R3 has diagnosis not limited to Schizophrenia, Borderline Personality Disorder, Intellectual Disabilities, Schizoaffective Disorder, Bipolar Type, Major Depressive Disorder, Suicidal Ideations, Generalized Anxiety Disorder, Epilepsy, Anemia, Essential (Primary) Hypertension, Type 2 Diabetes Mellitus, Dysphagia, Oropharyngeal Phase, Unsteadiness on Feet, Personal History of Diabetic Foot Ulcer, Morbid (Severe) Obesity due to Excess Calories, Constipation, Shortness of Breath, Disorder of Urea Cycle Metabolism, Gastro-Esophageal Reflux Disease with Esophagitis, Hyperlipidemia, Insomnia and Calculus of Kidney. R3's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 12 indicating moderate cognitive impairment.

R3's hospital records provided by the facility dated 03/06/24 document in part: patient admitted for psych. R3 reports plan to cut his wrists and states he had attempted to cut his wrists as a suicide attempt. Admitted to hospital for hearing voices, suicidal gestures, and self-inflicted

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laceration to right arm. (R3 had self-harming history prior to facility admission)

R3's Preadmission Screen and Resident Review (PASARR) provided by the facility dated 03/14/24 document in part: On 02/24 for having thoughts of harming yourself, and verbal and physical anger towards staff and peers at the nursing facility you (R3) were in along with destroying property, during this hospitalization, you (R3) needed regular monitoring and redirection due to self-harming behaviors of punching walls and scratching your arms with forks and spoons.(R3 had self-harming history prior to facility admission)

Hospital Record dated 05/31/24 document in part: Reason for Admission: Danger to self.

R3 was admitted to the facility on 05/31/24 with a history of self-harm from cutting himself.

On 06/01/24 the facility failed to prevent R3 from gaining access to a shaving blade/razor. This failure resulted in R3 cutting his right arm with the shaving blade/razor. This incident was not care planned and no interventions in place.

On 07/03/24, R3 found a spoon, breaking it in-two and started cutting himself across the arm. This incident was not care planned and no interventions in place.

On 09/15/24 R3 sustained an injury to R3's left hand requiring 7 sutures after punching a picture with a glass frame on the facilities wall. This incident was not care planned an no interventions in place.

R3 was hospitalized on 06/01/24, 07/03/24,

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07/23/24, 09/15/24, 10/01/24 and 10/15/24 for self-harm/suicidal behaviors that was not care planned and no interventions in place.

On 06/01/24 documentation indicates R3 said that he is hearing voices telling him to cut and kill himself. R3 used a shaving stick blade/razor and cut his right arm multiple times. R3 was hospitalized from 06/01/24 - 06/06/24 with an admitting diagnosis of Schizophrenia. Petition for Involuntary/Judicial Admission dated 06/01/24 document in part: R3 cut his arm and states that he is hearing voices to cut himself and killing himself. Cut right forearm with shaving blade.

Screening Assessment for Evaluation Self Harm/Suicide Risk dated 06/12/24 document in part: 2. Past History of suicidal ideations. 3. History of psychiatric/mental health problems, major depression and/or personality disorder diagnosis, significant/severe problems. 7. Chronic behavioral symptoms, control problems, behavior management issues, moderate problem. 11. Category score 6. 6-15 = moderate risk. Resident has history of self-harm.

R3's progress notes dated 07/03/24, indicates writer made aware by floor staff that R3 is in parlor using spoon R3 had broken to cut his arm. R3 noted with several superficial cuts to right arm. R3 was hospitalized from 07/03/24 - 07/22/24. Petition for Involuntary/Judicial Admission dated 07/03/24 document in part: R3 broke a metal spoon in half and took the broken handle and attempted to cut his throat with it. R3 is continuing to verbalize that he would like to "cut my throat." R3 cannot be redirected and is a grave danger to himself.

R3's progress notes dated, 07/23/24, indicates

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R3 became agitated with staff members due to running out of cigarettes, which led to an incident where R3 smashed a glass picture in the hallway near the nursing station. R3 was hospitalized from 07/23/24 - 08/02/24. Petition for Involuntary/Judicial Admission dated 07/23/24 document in part: (R3) intentionally punched the glass mirror in an attempt to get glass to cut himself. (R3) cannot be redirected and has become increasingly aggressive towards staff.

R3's progress notes dated 09/15/24 indicates R3 was redirected to leave nurses station and eat lunch. R3 became agitated proceeded to parlor and punched glass picture on wall resulted in open area to left hand. Hand Clean with normal saline, pressure applied, hand wrap tight to decrease bleeding. R3 was sent to the hospital and returned to the facility with 7 sutures to the left hand.

State Report incident date 09/15/24 incident time: 1320 (1:20 PM) documented part: brief description of incident: On 09/15/24 assigned nurse observed (R3) punching picture glass on the wall in the parlor that resulted with an open area to left hand. Resident was redirected and the site was cleaned with normal saline, and bleeding controlled at this time. When asked why the behavior, resident stated" I'm upset." On call NP (Nurse Practitioner) called, an order given for transfer to hospital emergency room for evaluation and treatment. Resident from hospital with 7 sutures.

State Report document in part: Initial date 09/16/24, Final date 09/23/24. (R3) has a BIM's 12 (moderate cognitive impairment). (R3) is A/O (alert and oriented) x2-3 and can verbalize needs. On 9/15/24, (R3) was displaying poor impulse

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control with suicidal ideation (SI) with a plan to harm self by punching at a painting when redirected during dinner time. (R3) remains hospitalized for SI with a plan and schizoaffective disorder. Resident was treated for injury to left hand and observe with 7 sutures. Upon (R3)'s return from hospital (R3) was still noted with active SI with a plan, unpredictable behavior, aggressiveness, and poor impulse control. On call MD (medical doctor) was called and made aware, an order was given to be sent out for psych evaluation.

V4 (1st Floor Unit Manager/Licensed Practical Nurse) Statement Dated 09/15/24 document in part: I nurse (V4) did not witness (R3) punch the wall. I heard a noise. I and my supervisor provided care after incident. Patient hospitalized.

V5 (Certified Nurse Assistant) Statement dated 09/15/24 document in part: I did not witness (R3) punch into the wall, but I came present when (R3) was getting attention from the nurse.

V6 (Certified Nurse Assistant) Statement dated 09/15/24 document in part: V6 wrote (R3) was pacing back and forth through the hallway stating that if he does not smoke, he is going to walk out or go crazy on his way towards double doors (R3) then punched glass picture.

On 09/15/24 2155 resident was sent out for SI with plan-smashing his hand on glass picture again and strangulate himself. Resident was admitted to hospital for schizophrenia.

On 09/15/24 documentation indicates R3 demanding to smoke, when R3 was told he couldn't smoke R3 began to punch window, and when he was redirected, he began to run out the

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front door, resident continued to punch wall and place sheet around his neck. Writer was called to floor for a resident that was hard to redirect smashing his (R3) hand into the wall that he had previously went to hospital for causing it to bleed, then talking about SI (Suicidal Ideations) if he could not smoke. Attempted to place a sheet around his neck. R3 was hospitalized from 09/15/24 - 09/23/24 with a diagnosis of Schizophrenia. Petition for Involuntary/Judicial Admission dated 09/15/24 document in part: smashing wall with fist. attempted to place sheet around his neck. Hard to redirect. Talking about SI (suicidal ideations), noncompliant.

On 10/01/24 documentation indicates R3 noted with aggressive behavior, punching walls with his fists, punching pictures on the wall breaking glass frames and threatening staff with physical violence. Being a danger to himself and others. Disruptive behavior threat to self and others slamming throwing hitting caregivers and staff. R3 was hospitalized from 10/01/24 - 10/07/24 with a diagnosis of Suicidal Ideations. Petition for Involuntary/Judicial Admission dated 10/01/24 document in part: (R3) is noncompliant, unable to be redirected. Punching wall, attempting to ram his head into wall. Swinging objects at caregivers and other residents.

On 10/14/24 documentation indicates R3 approached nursing station asking for cigarettes. R3 then proceeded to start displaying aggressive behavior, punching walls repeatedly, in the hallway disturbing peers, yelling, screaming, and threatening staff. Resident started walking behind staff member and stated, "I will kill that b****." Resident is noncompliant and unable to be redirected at this time. (R3) is attempting to exit the facility, punching walls, and displaying

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homicidal ideations towards nursing staff threatening to kill us. (R3) attempted to have a physical altercation with nurse, lunging at her clenching his fist. (R3) is disrupting the milieu and unable to be redirected. (R3) is in need of immediate hospitalization as (R3) presents as a threat of harm to himself and others. R3 was hospitalized from 10/15/24 - 10/21/24 with a diagnosis of Aggressive Behavior. Petition for Involuntary/Judicial Admission dated 10/14/24 document in part: (R3) is attempting to exit the facility, punching walls, and displaying homicidal ideations towards nursing staff threatening to kill us. (R3) attempted to have a physical altercation with nurse, lunging at her clinching his fist. (R3) is disrupting the milieu and unable to be redirected. (R3) is in need of immediate hospitalization as he presents as a threat of harm to himself and others.

During the facility tour on 10/23/24 twenty-four pictures with glass coverings were observed hanging on the walls throughout the first-floor nursing unit.

R3's Care Plan document in part: Focus: (R3) has a history of self-harmful ideation (thoughts) and/or behavior. Date initiated 05/31/24. Interventions: Conduct the appropriate interdisciplinary assessments upon admission. Review transfer records, including screening material to determine any history of self-harm. Date Initiated: 05/31/24. Conduct an initial psychiatric evaluation. Review the person's risk for harm. Date Initiated: 05/31/24. If there is a history of self-harmful behavior assess: what occurred, where it occurred, circumstances surrounding the event(s), precipitants, and any current plan to harm. Establish a safety contract (verbal and/or written) with the resident. Date

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Initiated: 05/31/24.

R3's Care Plan Focus: Safety General. Interventions: Perform safety risk evaluation(s) on admission, as needed and upon changes in condition. Date initiated 07/24/24.

R3's Care Plan Focus: The resident demonstrates cognitive impairment related to: Diagnosis of mental illness., Symptoms are manifested by: Poor impulse control., Symptoms are manifested by: Poor ability to control anger and frustration. Date Initiated: 07/24/24. Interventions: If the resident is agitated or becomes agitated during care, "back off" and try to calm the resident with soothing words. If the resident remains agitated tell him or her that you'll come back when he/she is feeling better. If the resident has a psychiatric disorder verbalize that you will help him/her "stay in control." Assure the resident that he/she is safe and protected. Date Initiated: 07/24/24. Focus: (R3) demonstrates behavioral distress related to: Being challenged by mental illness., Problems are manifested by: Verbally abusive behavior when agitated., Problems are manifested by: Physically abusive behavior when agitated. Date Initiated: 07/24/24. Intervention: Ask (R3) to calmly explain what is causing this upsetting behavior. Date Initiated: 07/24/24.

R3's Care Plan Focus: The resident expresses maladaptive behavioral symptoms related to: A diagnosis of chronic mental illness. Date Initiated: 07/24/24. Interventions: Review rules/behavior expectations to help the resident improve judgment & self-control. Date Initiated: 07/24/24. Use behavior management techniques to promote & "shape" the desired behavior such as: Look pro-actively at the behavior. Identify causal

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factors & work to reduce, minimize and/or treat the causal factors. This stresses prevention. Date Initiated: 07/24/24. Use behavior management techniques to promote & "shape" the desired behavior such as: Controlling the environment to the degree possible to moderate stress. Date Initiated: 07/24/24.

R3's Care Plan Focus: (R3) has a history of self-harmful ideation (thoughts) and/or behavior. This appears related to: Evidence of severe mental illness (i.e., active psychosis, major depression, lack of sound judgment, poor contact w/ reality)., Additional risk factors include Previous self-harmful behavior. Date Initiated: 07/24/24. Interventions: Conduct an initial psychiatric evaluation. Review the person's risk for harm. Date Initiated: 07/24/24 Revision on: 10/22/24. As warranted conduct/carry out: Daily monitoring & supervision of the resident. Date Initiated: 10/22/2024. As warranted conduct a room check/search & remove: Any other objects that (in the opinion of the health care professionals) may pose a threat to safety. Date Initiated: 10/22/24.

R3's Care Plan Focus: The resident displays manipulative behavior which is disruptive, insensitive and/or disrespectful to staff and peers. This behavior is related to: Feelings of powerlessness, helplessness, inadequacy, and loss of control., Strengths and Abilities: Date Initiated: 08/06/24. Interventions: Educate the staff on manipulative behavior (what it looks like, why it occurs, what needs the person is communicating), especially as it manifests with this particular individual. Date Initiated: 10/22/24. Focus: Resident has a surgical wound to the left hand. Left 5th Finger Date Initiated: 09/24/24.

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On 11/12/24 at 08:52 AM Surveyor asked R3 where he got the razor from and if it was given to him at this facility. R3 responded, "I asked for the razor to shave myself. A certified nurse assistant gave the razor to me, but I don't remember her name. I gave the razor to the nurse." When asked was the razor given to the nurse after he had cut his arm R3 responded, "yes."

On 10/22/24 at 02:07 PM V17 (Wound Care Nurse) stated "(R3) had some sutures to the left hand from an incident that (R3) punched a picture. Based on (R3) behavior's, I don't think that this is an appropriate setting for him. I think sometimes if (R3) gets upset about certain things and start to raise his voice it is startling to other residents."

On 10/22/24 at 02:45 PM R3 stated "I got mad at the nurse station and got sent out. I had sutures in the left hand." Two scabbed areas were observed to R3's left hand knuckles. "I feel like I am angry. I cut my right arm because I couldn't smoke. I didn't want to wait till the smoke break."

On 10/22/24 at 02:53 PM V5 (Certified Nurse Assistant) stated "I was here when (R3) punched the picture, but I did not witness it. (R3) has a behavior if he does not get his way, he throws tantrums. (R3) is known for harming himself when he is angry. It is just when (R3) acts out its a danger to himself because (R3) starts to hit the pictures on the wall, when he is mad."

On 10/22/24 at 03:01 PM V6 (Certified Nurse Assistant) stated "If (R3) wants to smoke after smoke break time, (R3) gets agitated. (R3) is self-harming and (R3) just get to punching stuff trying to hurt himself. Maybe (R3) need to be somewhere where he can smoke all day. On

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09/15/24 (R3) wanted to smoke a cigarette and he started punching the walls. (R3) said "if I don't get a cigarette now, I am going to get upset." (R3) was pacing back and forth. (R3) was in the parlor and that is when (R3) punched the glass picture on the east wall of the parlor and broke the glass. The glass shattered, (R3) sat in the chair and the nurse attended to (R3)'s hand. (R3) punches walls but that was the first time (R3) punched a picture."

On 10/22/24 03:19 PM V4 (1st Floor Unit Manager/Licensed Practical Nurse) stated "when (R3) first got here (R3) made scratches to his right arm. It was not bleeding, (R3)'s arm was cleaned, I notified psych and (R3) was put on 1:1 supervision until transport came. On 09/15/24 (R3) was redirected to leave the nurse station. (R3) proceeded to the parlor and punched the glass picture. (R3) gets upset at times when he gets redirected. I did not see (R3) pacing. We wrapped (R3)'s hand because it was bleeding. On 09/15/24 (R3) was able to be redirected but on the 11-7 shift on 09/15/24 (R3) was not able to be redirected. The incident with the sheet around (R3)'s neck happened on the 11-7 shift. I feel that (R3)'s behaviors are escalating."

On 10/22/24 at 03:58 PM V23 (Supervisor/Registered Nurse) stated "(R3) scratch, pinch self and hit the wall. (R3) hit the glass picture on the north wall in the parlor. There is a risk if (R3) punches those pictures, (R3) will hurt himself. (R3) punches the walls and is attention seeking. Behavior wise, I don't feel (R3) is appropriate for this facility. (R3) hurt himself. (R3) used a broken spoon to cut himself. (R3) will pinch himself then come and show the nurse if we ask (R3) to move from the nurse station."

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On 10/22/24 at 04:19 PM V18 (Registered Nurse) stated "on 09/15/24 they called me, so I ran down to see (R3). I saw (R3) with the sheet around his neck and (R3) said that he was going to kill himself. (R3) was smashing in things, and (R3) had just popped a loose the sutures because he had just gotten back from the hospital. (R3) started running toward the door, banging on the glass in the parlor, the pictures on the wall it was like (R3) was incoherent and could not be redirected."

On 10/22/24 at 04:47 PM V15 (Registered Nurse) stated "(R3) has behaviors and does this so often because (R3) always want to smoke. (R3) started punching on the window in the parlor. (R3) hit walls, pictures and want to go out the front door. I do not feel this facility is appropriate for (R3). (R3) need more supervision and almost need 1:1 when (R3) gets into that behavior. (R3) strikes out at the walls and windows."

On 10/22/24 at 05:00 PM V19 (Registered Nurse) stated "at first, (R3) was okay then I noticed (R3) would hit walls, doors a door frames. (R3) already had sutures in his hand, and nothing could stop him. I think that we probably should come up with a better solution because injury on top of injury, it may become harmful and (R3) may hit his hand and not be able to use it. The hitting has not deterred (R3) from hitting the wall. (R3) hit the picture by the elevator, and it tore up."

On 10/23/24 at 09:57 AM V20 (Wound Care Nurse) stated "(R3) had 4 sutures in his left hand. (R3) is alert and walks around. (R3) came in on readmission and I tried to take the 4 sutures out of his hand. (R3) allowed me to take 2 of the sutures out because (R3) said it was sore. When I did (R3)'s initial admission, I saw old scares on

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(R3)'s forearm. (R3) was implying that he did it and it was old scaring on (R3)'s arm."

On 10/23/24 at 10:07 AM V6 (Certified Nurse Assistant) stated "(R3) was asking for a cigarette, I did not see the sheet that was around (R3)'s neck. (R3) did punch the wall. We let the nurse know about (R3)'s behaviors. (R3) is self-harming if punching the walls is considered self-harming, yes, it is. Honestly when (R3) start up with his behaviors, I just report it to the nurse and that's it."

On 10/23/24 10:34 AM Per telephone interview V21 (Former Licensed Practical Nurse) stated "(R3) is very aggressive, violent, and likes to smoke cigarettes. The first time (R3) put his hand through the vending machine, picture on wall and wondered through the hallway. There were no interventions in place. I only saw them call the doctor and send (R3) out to be evaluated. (R3) was a ticking time bomb. (R3) broke a metal spoon in half, and he was scratching his wrist. (R3)'s wrist wasn't bleeding but there were noticeable scars. I believe the doctor should have been notified if I can't write what actually happened. The picture painting with glass that (R3) punched was located near the nurse station. (R3) was bleeding when he punched the glass, so (R3) got scratched. I didn't do anything with (R3)'s hand, the unit manager and social service treated (R3) once they took over, it is a protocol."

On 10/23/24 at 10:49 am V3 (Assistant Director of Nursing) stated "A lot of things trigger (R3) based on my opinion. Based on (R3)'s diagnosis if (R3) wants something and does not get it when he wants it (R3) gets upset. As a facility it is about safety. (R3) had 5-7 stitches to his hand. Right now, we have not gotten to the point of taking the

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pictures off the wall. When (R3) returned to the facility after getting the sutures to his hand (R3) was hitting his head on a glass picture and stated self-strangulation. (R3) was admitted to the hospital, and I never had a chance to interview (R3) when he came back because (R3) did not want to talk about it. (R3) was sent out for suicidal ideations and self-harm."

On 10/23/24 at 11:34 AM V27 (Medical Records Director) stated "(R3) like to punch things when he gets upset."

On 10/23/24 11:38 AM V10 (Registered Nurse) stated "(R3) said that he is going to commit suicide, so we sent (R3) out. (R3) was upset, hit the picture and (R3) still has stitches to his left hand. It may be 2 sutures on the knuckles because it has not healed completely. Sometimes it can be hard to deal with (R3). One-time (R3) took and hit the picture on the wall and injured himself, (R3) picked up a chair and threw a chair in the parlor. (R3) displays these behaviors most of the time. (R3) came out and showed his arm, (R3) said he want to kill himself; we sent (R3) out. I can't remember if I saw this shaving stick blade. I think we collected it, but I don't remember."

On 10/23/24 11:56 AM Per telephone interview V25 (Former Social Worker) stated "if (R3) is unable to smoke (R3) has aggressive behaviors and hit a glass picture in the parlor. I don't think (R3) is appropriate for a skilled nursing facility. (R3) gets angry and aggressive. (R3) had cuts on his hands, need a lot of tender loving care and 1 on 1 supervision. (R3) needs to be monitored at all times if (R3) is angry."

On 10/23/24 at 12:46 PM V12 (Social Service Director) stated "(R3) tries to cut himself, seek

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attention most of the time and tries to cut himself with anything he can get his hands on. We do an inventory when the residents are admitted to the facility. I don't think the shaving blade was with (R3) when (R3) came in. (R3) has a history of self-harm. Every staff is responsible to talk to (R3) and come tell us. The glass pictures on the walls are a hazard that (R3) can potentially harm himself again. They could replace or take the glass out of the pictures to prevent (R3) from harming himself by being cut with the glass if (R3) punches the pictures again. If (R3) keeps doing the same thing over and over again maybe there is something that we are not doing. You can tell when (R3) is starting to get in the mood and sometime, we indulge him."

On 10/23/24 01:12 PM V29 (Registered Nurse/MDS Coordinator) stated "(R3) has a behavioral diagnosis that can escalate where it is hard to redirect him. (R3) has suicidal ideations and when a resident goes out to the hospital, they may not come back with any changes but sometime there will be alterations in the plan of care. The goal for everyone is to have the residents safe in the facility."

On 10/23/24 at 01:29 PM V26 (Psychiatrist) stated "I saw (R3) a couple of times and (R3) had a recent hospitalization. (R3) has a temper that can't be controlled, has outburst and punching the wall. It was a little unclear what was setting (R3) off and the focus on impulsivity. (R3) has been hospitalized 7 times. No one knows how (R3) got from 0 - 100."

On 10/23/24 at 01:56 PM V2 (Director of Nursing) stated "Inventory of belongings is done on admission and (R3) had no belongings. (R3) was unable to tell where he got the shaving blade

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from. I did not see it and I believe it was discarded. (R3) had another incident shortly after that." (R3 was admitted to the facility without any belongings). V2 (Director of Nursing) also stated "We try to ensure the environment and residents are free from abuse. Typically, (R3) behaviors are based on if (R3) can't get his way. (R3) has a history of self-harm. (R3) harmed himself and there was one incident that caused injury. It is hard to put something in place for instant gratification. (R3) punches the walls as you see we have pictures on the wall. (R3) got an injury related to punching the picture and breaking the glass. I understand there are not any interventions addressing (R3) not self-harming himself dated prior to 10/22/24, no ma'am. There is a possibility it could have been something that was not done that we could have done. As we see the behavior is escalating and ongoing. We may have to look for different placement. In general, the behavior (R3) was displaying was so different for the safety of himself and the residents. I was being proactive when (R3) was upset, threatening bodily harm. The main goal is to keep the residents safe and the resident safe from harming themselves."

On 10/23/24 at 02:28 PM V14 (Social Worker) stated "(R3) is attention seeking, suicidal and (R3) harms himself."

On 10/23/24 02:54 PM V1 (Administrator) stated "(R3) has attention seeking behaviors and most of them are centered around smoking. If (R3) does not get his way and get a cigarette (R3) will act out, be verbally aggressive with staff, self-injurious, with behaviors of pinching, hitting himself, punch the wall and pictures. (R3) injured himself when he hit the picture and needed sutures. (R3) has the potential to harm himself if

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(R3) hits the pictures and break the glass and harm himself if he hits the walls as well."

On 10/24/24 at 12:34 PM Per telephone interview V30 (Former Psychiatric Rehab Services Coordinator) stated "(R3) is the one that was suicidal. The risk assessment is done, it depends quarterly or annually and when they come back from the hospital, they give you a new admission. It is like a return back and social service will do a full assessment. I met (R3) when he returned from the hospital. (R3) is very suicidal, and I think (R3) need to be in a higher level of care. There should be a suicide care plan and it should be updated. The updates would be to redirect and 1:1. (R3) would say I am about to cut myself. (R3) does the same thing over and over seeking attention. (R3) would hit the walls with his fist and break plastic spoons to cut himself. We don't have a 1:1. Since (R3) did that, (R3) had to go to the hospital and should not have come back. (R3) requires one on one and someone to monitor (R3) to eat. They could have changed the picture frames. From (R3)'s admission packet if they knew (R3) was suicidal like that R3 should not have had a shaver blade."

On 11/06/24 at 10:43 AM upon V2 (Director of Nursing) reviewing R3's care plan V2 stated "it does not appear that the care plan was updated each time (R3) went out to the hospital."

On 11/06/24 at 12:47 PM V4 (1st Floor Unit Manager/Licensed Practical Nurse) stated "(R3) cuts were superficial, and it looked more like scratches. I was not aware of the shaving stick blade and don't know where (R3) got it from. The issue with the spoon was addressed. It was a metal spoon from the kitchen and somehow (R3) got the top of the spoon off. When (R3) cut

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himself, I would think something should have been updated. There is no preventative measure in place."

On 11/06/24 02:24 PM Per telephone interview V10 (Registered Nurse) stated "(R3) came to the nursing station and showed me his arm. I asked what happen and (R3) said that he was hearing voices to tell him to kill himself. I took the blade from (R3). I don't know where (R3) got it from, it was shaving blade, a shaving razor that has 3 blades that the facility supplies. There was no active bleeding, but the skin was broken. (R3) has been trying to hurt himself and we send (R3) to the hospital. I was not aware that (R3) had a history of self-harm when he cut himself with the razor. I don't know where (R3) was when he cut himself, but he came to the nurse station. If a resident has a history of self-harm, I will say no, (R3) should not have a razor."

On 11/06/24 03:00 PM V12 (Social Service Director) stated "I do not know why (R3) is in this facility besides the fact that (R3) has psych issues. There should have been self-harm preventative measure in place upon admission and care planned. After each incident (R3)'s care plan should have been updated related to the specific behavior that (R3) had. Somebody probably dropped the ball somewhere along the line. We are working short." At 03:48 PM V12 stated "R3 should not have had a razor."

On 11/06/ 24 at 04:01 PM V2 (Director of Nursing) stated "the razor is typically standard, and the color is blue. Since (R3) has a history of self-harm (R3) should not have had a razor. As far as (R3)'s self-harm it should have been care planned and should have included some preventive measures for self-harm."

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On 11/06/24 at 04:23 PM V34 (Certified Nurse Assistant) stated "I remember (R3) seem like he can make a weapon out of anything. (R3) has a lot of outbursts and had taken a piece of wood from the overbed table. I was standing in front of the desk, and I asked (R3) what he has. (R3) whispered "I am going to burn this place down." (R3) paces in front of you. The nurse took the broken spoon away from (R3) and threw it in the garbage behind the desk. I remember (R3) holding the broken spoon trying to hide it. (R3) has done that with other things. (R3) will try to harm himself if he wants to go outside and smoke at night. I saw the marks on (R3)'s arm and reported it to the nurse. I see (R3)'s body language shift, pacing back with an angry face, then punching the wall by the elevator and (R3) knocked a picture down before. (R3) will say verbal threats, "I'll kill her, I'll kill you b***h when (R3) does not get his way. Sometimes there is not much of a warning."

On 11/06/24 at 04:35 PM V1 (Administrator) stated "I was aware that (R3) had a history of self-harm. I believe it was cutting of his arms. The care plan should have an intervention for the self-harm of cutting his arms. I am not aware of where (R3) got the razor that (R3) cut his arm. A resident with a history of self-harm should not have a razor in their possession. The care plan should have addressed the punching of the walls and scratching of the arms with spoons and forks that was identified prior to (R3)'s admission."

On 11/07/24 at 03:49 PM Per telephone interview V26 (Psychiatrist) stated "(R3) has a diagnosis of schizophrenia spectrum with the inability to take care of himself." When asked why is R3 in a skilled nursing facility. V26 responded "as far as I

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know the psychiatry reason is the primary reason, to my understanding. Essentially, since we talked about (R3) last month, we do not want to take a chance and in the hospital, we can be more aggressive without worrying about decompensation or reemergent of symptoms that were under control and see if we can get (R3) stable. The plan is to stabilize (R3) quicker to make more aggressive changes and once stable determine the appropriate placement for (R3). We don't want anything to happen to (R3) and the hospital is a better place to stabilize him." When asked if R3 is a resident that should have a razor since R3 has a history of self-harm, got possession of a razor at the facility, cut his arm and no one knows how R3 gained access to the razor. V26 responded, "(R3) should not have had a razor and they should figure out how (R3) got access to it." When asked if (V26) made aware of the spoon that R3 had broken and cut his arm. V26 responded "I was not made aware of the spoon." When V26 was made aware that after R3 had punched and broken two glass pictures on the unit resulting in cuts to his hand, the facility still has 24 glass pictures hanging on the unit. V26 responded "I think the environment, some adjustments can be made. If it is not working (R3) need to be in a facility where (R3)'s needs can be met."

On 11/12/24 at 09:17 AM V36 (Certified Nurse Assistant) stated "the new admission's admission kit is a basin, soap, deodorant, gown, towels, toothbrush, and toothpaste. If a new admission is coming it is wrapped up like a gift and place on the resident's bed."

On 11/12/24 at 09:22 AM V5 (Certified Nurse Assistant) stated "when a resident is admitted we get a basin." (Pink basins were observed located

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in the locked supply room in the left lower cabinet, urinals were in the right upper cabinet and mouth wash, toothbrush, toothpaste, shaving cream, blue razors, body wash, lotion, brush, and combs were in the left upper cabinet). V5 stated "I take everything that I need. I don't do the razors as much until I find out from the nurse if the razor can be given. The razors are for one time use. We take the razors to the soiled utility room and put them it in the sharp's container. (R3) is a harm to himself. You need a key to enter the clean utility room and a code to enter the soiled utility room."

On 11/12/24 at 09:37 AM V10 (Registered Nurse) stated "the admission kit is given to the residents by the aides. They give the resident the pitcher, basin, toothpaste, toothbrush, soap, and towels."

On 11/12/24 at 09:40 AM V4 (1st Floor Unit Manager/Licensed practical Nurse) stated "the resident's admission kit has a wash basin, towels, deodorant, and body wash. We don't give razors in the admission kit. When we give razors, we have to get it right back. The certified nurse assistants make up the admission basins. If the resident, ask for a razor to shave themselves the certified nurse assistant give them the razor. It depends on who the resident is, the razors are to be monitored then taken and put the razors in the sharp's container."

On 11/12/24 at 10:17 AM V1 (Administrator) stated "we are capable of caring for (R3). According to this (documentation) (R3) is at baseline since February. Any intervention put in place will not prevent that. (R3) was cleared by hospital staff. In-services for staff were done after the exit (dated 10/25/24).

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Document titled "Residents' Rights for People in Long-Term Care Facilities" undated document in part: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your rights to safety: Your facility must provide services to keep your physical and mental health, at their highest practical levels.

The Facility's "Policy & Procedure Supervision Policy" dated 01/24 document in part: additional supervision may be required in order to meet the specialized needs of residents. Additional supervision may be but not limited to 1:1 supervision, 15-minute checks, 30 minute and so forth. Purpose: to ensure resident safety. Responsibility: All staff. Procedure: 3. Additional supervision is followed per the plan of care in accordance with and individualized resident focused approach.

The Facility's "Suicide Observation and Prevention" policy dated 05/14 document in part: Purpose: To protect resident from self-injury or death. To increase resident's control of self-destructive impulse. To provide opportunity to talk about problems. Policy: It is the policy of the facility to implement interventions for residents who exhibit suicidal tendencies. 1. Pre-admission assessments should be sufficiently thorough to identify care needs or need for active treatment which the facility may or may not be able to provide. 2. Continuous monitoring includes mental and psychosocial status as well as physical. 3. Confer with Social Service and Interdisciplinary Team to assess mental status behavior and appropriate interventions. 6. Conduct a search of resident room, clothing, etc. for any harmful objects, and remove. 11. Discuss with team members daily the continuance of

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close observation with direction by physician or mental health professional. Staff to provide ongoing recording and reporting of behavioral observations and verbalizations. C Suicidal: 1. Threatened - verbalization of wish to die. 2. Attempted - recent injury to body (cutting, burning, hitting).

The Facility's "Behavioral Management Communication Guidelines" policy dated 04/14 document in part: 10. Successful interventions require the use of problem-solving process. Different interventions work for different individuals.

The Facility's "Care Plan" policy dated 04/14 document in part: All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. 8. Care conferences for review and revision of resident's care plan are scheduled at a conducive time for residents and their families. b. When a change occurs in a resident's condition the Care Plan Coordinator is notified by a member of the Interdisciplinary Team. The care plan is then reviewed and updated. 10. All interdisciplinary Team departments are responsible for charting that reflects the care plan concerns, problems, needs and/or strengths, approaches, progress, or lack of progress with possible reasons for and any new problems.

The Facility's "Change in Resident's Condition" policy dated 02/01/22 document in part: 2. Appropriate assessment and documentation will be completed based on the resident's change in condition or indication. 5. The Care Plan for the resident will be updated as indicated.
(A)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001333	A. BUILDING: _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA TERRACE	2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608

(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