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| | IL6008312 | A. BUILDING: _____ B. WING _____ | C 02/14/2025 |

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| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident of January 28, 2025/IL185829 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.1210b)<br>300.3210t)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br><br>Section 300.3210 General | S9999 | | |

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t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents were free from physical abuse. This applies to 1 of 4 residents (R1) reviewed for abuse in the sample of 4. This failure resulted in R1 being bitten by R2, causing bleeding, hospital transfer, and antibiotic therapy for injury.

The findings include:

R2 is a 71-year-old male admitted with moderate cognitive impairment as per the MDS dated 1/8/25. R2 was
admitted with an admitting diagnosis including anxiety, dementia with behavior disturbance, cognitive
communication deficit, and schizophrenia.

R1's diagnosis includes moderately impaired cognition, as per the Minimum Data Set (MDS) dated 11/22/24. R1 had an admitting diagnosis, including alcohol-induced persisting dementia, anxiety, depression, and Alzheimer's disease.

1/28/25 3:21 PM nurse's note for R1 from V3 (Agency Licensed Practical Nurse/LPN) documents in part "930am Resident noted large bite mark on left arm. CNA (Certified Nursing Assistant) report a resident on unit caused the bite mark. This patient was very aggressive

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going into patient's room on unit. Open closed door ambulate(s) really fast around other patient on unit. DON/ADON (Director of Nursing/Assistant Director of Nursing) made aware visit patient/unit. Treatment nurse here rendering care for bite on left arm. Patient was sent to hospital for cares to bite mark. POA (Power of Attorney) was called notified of incident. Left facility at 10:44 AM for (local hospital)."

R1's Order Summary Report dated 2/11/25 documents an order dated 1/28/25 "Send to ER for further evaluation." Another order dated 1/28/25 "Cleanse left forearm bite mark daily with NSS (normal saline solution) and keep area to air dry until healed. Continue treatment of Amoxicillin-Pot Clavulanate tablet 875-125 mg. Give 1 tablet by mouth every 12 hours for bacterial infection for 7 days." Order dated 1/30/25 "Monitor injury to left forearm q (every) shift report any s/s (signs and symptoms) of infection to physician every shift for wound care."

On 2/11/25 at 9:50 AM, R1 was observed wandering and coming out of another resident room. On 2/11/25 at 9:50 AM, V10 (R1's certified nursing assistant/CNA) pulled up R1's arm sleeves and showed two-bit marks on both forearms one inch apart, along with a one-centimeter-round scab with bite marks.

On 2/11/25 at 9:40 AM, V10 stated that V10 works with R1 almost every day, but I wasn't working on 1/28/25 when R2 bit R1. R1 is nonverbal and cannot understand a lot. He has early-onset frontal lobe dementia and wanders to other residents' rooms. Both R1 and R2 reside in a locked dementia unit. According to V10, on 1/28/24, when R1 entered R2's room for the first time, R2 bit R1 on his left wrist. R1 was not

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bleeding from the injury. V10 than added that R1 returned to R2's room again about 10 minutes later and tried to move R2's wheelchair. R2 got upset, and a bit on both R1's forearms caused bleeding from the left forearm. R1 was sent out to the hospital, and he returned with oral antibiotics. V10 added that R1 must be monitored as, "he wanders around to keep him safe."

On 2/11/25 at 10:00 AM, V5 (Certified Nursing Assistant/CNA) stated, "I was in the nurse's station when the incident happened when R1 entered R2's room. We heard shouting from R2 to R1. There was no staff in the resident's room, and nobody witnessed the incident. R2 bit R1 two times 5 minutes apart. For the first time, R2 bit on R1's lateral side of his left hand. When R1 came out of R2's room, we noticed no bite on his left wrist. Then, R1 was bleeding a decent amount the second time and turned into purple discoloration with the bite site. R1 was assigned to V6 (CNA) as V7 (CNA) called off. I believe V6 is suspended, and I don't know why."

On 2/11/25 at 11:20 AM, V13 (Restorative Aide/CNA) stated, "I heard commotions between R1 and R2, and R1 had a bit mark on his left wrist from the first bit and was bleeding, but not that much. When R2 bit on R1 a second time after 30 minutes, I went into the hallway and saw R1 was bleeding from the left arm. R1 always wanders around and is hard to redirect. Somebody must monitor the hallway to see the dementia resident's activities and prevent them from going to other resident rooms/isolation rooms."

On 2/11/25 at 11:35 AM, V6 (CNA) stated, "I was assigned to another group of residents. R1 was assigned to V12 (CNA), and R1 is a resident who wanders around and triggers other residents to

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get upset."

On 2/11/25 at 10:15 AM, V4 (CNA) stated, "I heard about the issue between R1 and R2 on 1/28/25. R1 wanders to R2's room, and R2 gets irritated by R1, and R2 gets on R1's arm and bites him. I was in the hallway just outside of the dementia unit. R2's room was very close to the nurse's station, and we could hear when R2 was shouting and screaming at R1. I went to the dementia hall and checked on R1, and he was bleeding."

On 2/11/25 at 11:20 AM, V2 (Director of Nursing/DON) stated, "We were short by one CNA on the dementia unit on 1/28/25 due to call off (V7). V7's residents were not assigned to any specific CNA. The other four CNAs were supposed to chip in to cover for V7's residents, including R1. R1 was bit two times by R2. The first bit wasn't as bad as the second bite. The second bite was bleeding. Somebody must have followed him to redirect him to prevent injury from other residents entering their room. He has the right to be free from abuse/harm."

On 2/11/25 at 11:35 AM, V6 (CNA) added, "Almost a month ago, when R1 entered R3's room and lay on R3's bed, R3 got upset, put his hands on R1's neck, and threw him to the door. They are not doing anything to prevent R1's trigger to other residents."

On 2/11/25 at 12:40 PM, V3 (Agency Licensed Practical Nurse/LPN) stated, "I didn't witness the incident. V12 said that R1 went to R2's room, and R2 bit on R1's forearms. R1 always goes to other resident's room. R1 needs to be closely monitored to make him safe. There were a lot of conversations regarding who should take care of

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the resident group, including R1, as the originally assigned CNA (V7) called off. Overall, all the CNAs are responsible for monitoring the residents in the dementia unit."

On 2/11/25 at 3:21 PM, V16 (Nurse Practitioner) stated, "It was reported to me that R1 was bit by another resident (R2). The injury was assessed, and we sent him to the hospital for further evaluation, and he returned with an oral antibiotic. There was blood on his left forearm. To keep him safe in the unit, they should closely monitor and redirect him when he attempts to enter another resident's room."

On 2/11/25 at 3:35 PM, V1 (Administrator) stated, "I know residents have the right to be free from harm. We had a call-off on 1/28/25 and were short by one CNA. R1 is a resident who wanders to other residents' rooms and needs to be monitored."

On 2/14/25 at 10:00 AM, V17 (Staffing Scheduler/CNA Supervisor) stated, "Since V7 called off on 1/28/25, we split her residents among the other four CNAs in the dementia unit. V6 was assigned to care for R1. She (V6) refused to care for R1, so we suspended her for not caring for R1."

Behavior Management Team Review Meeting Note dated 11/4/24 document: R3 became agitated when R1 entered his room and lay on his bed. R3 attempted to maneuver R1 to the bedroom door, and R1 tripped and fell over.

R3 is a 58-year-old male admitted with moderate cognitive impairment as per the MDS dated 12/13/24. R3 was

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| S9999 | Continued From page 6<br>admitted with an admitting diagnosis, including anxiety, hallucination, dementia, depression, and schizophrenia.<br><br>Behavior Management Team Review Meeting Note dated 12/22/24 documented that R1 had entered R4's bedroom, and residents were observed pushing each other.<br><br>Behavior Management Team Review Meeting Note dated 12/29/24 documented that R4 struck R1 on his chest and arms.<br><br>The facility presented the Abuse Prevention and Reporting Guidelines document: The facility affirms the right of the resident to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment.<br><br>"A" | S9999 | | |