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	IL6002315	A. BUILDING: _____ B. WING _____	C 06/03/2025

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S 000	Initial Comments Facility Reported Incident of May 9, 2025 IL192289 Facility Reported Incident of May 12, 2025 IL192292 Facility Reported Incident of May 7, 2025 IL192143 Facility Reported Incident of April 22, 2025 IL191146 Complaint Investigation 2584524/IL192876	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3210 t) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999		

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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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure four of ten residents (R2, R3, R7, and R9) were free from abuse. This failure affected R2, R3, R7, and R9 who were physically hit, pushed, and punched by peers. As a result of this failure, R3 was hit, pushed, and punched, and sustained a laceration to the forehead requiring 8 stitches.

Findings include:

1.R3's Admission Record documented date of admission to the facility as 02/01/2024, with diagnoses that includes but not limited to Schizophrenia unspecified, bipolar disorder unspecified, depression unspecified, insomnia, obstructive sleep apnea (adult) (pediatric), history of falling, muscle weakness (Generalized), unsteadiness on feet, and other abnormalities of gait and mobility.

R4's Admission Record documented R4 was admitted to the facility on 09/30/2023; diagnoses includes but not limited to Depression

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unspecified, insomnia unspecified, unspecified psychosis not due to a substance or known physiological condition and asthma.

R3 and R4 had a resident-resident physical attack that resulted into R3 being sent to the hospital due to fall injury from R4 hitting, slapping, and pushing R3. R3 fell on a transferring lifting device, causing a laceration to the forehead over the left eyebrow.

On 05/14/25 at 11:49 am, R4 was observed on the 1st floor of the facility in the room preparing to go out on planned consultation. R4 stated, "On 4/22/202, (R3) came to my room to steal my (snacks) and was going through my stuff. We (R3 and R4) were on the same floor. They (facility) moved me down here (1st floor) after I came back from the hospital. I pushed (R3) and hit her, because she was stealing from me; she came from her room to my room stealing." R4 stated when she pushed R3, R3 fell and hit her head on the (transfer lifting Device) in the hallway. "(R3) started bleeding from the head, and I think they (staff) said she had some stiches from the hospital. At the time of physical contact, there was no staff around; I did not know I pushed her so hard."

R3's medical record showed documentation R3 was sent to the hospital and returned to the facility with eight (8) stiches to the upper left eyebrow.

On 05/14/25 at 2:44pm, R3 was observed in the room eating with redness noted on the left side of the forehead over the eyebrow, healing well, with no open wound or drainage. R3 was not willing to talk about the incident of 4/22/2025. According to R3's electronic health record (EHR), R3 was sent

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to the hospital on 4/22/25, and received 8 stiches to the forehead.

On 05/14/25 at 12:49pm, V8, LPN (Licensed Practical Nurse/Wound care Nurse), stated, "I am familiar with (R3) and (R4). I was not on the floor when it happened, but I was on the 3rd floor. The staff on the 2nd floor called me. I saw (R3) laying on the floor, with blood coming from upper left eye eyelid. They had already called the ambulance to pick up (R3). I applied pressure to the site and cleaned it. (R3) came back to the facility with 8 stitches. Hitting, pushing, or slapping another resident either by staff or peers, is a form of physical abuse. (V1, Administrator) V2, (Director of Nursing), Social Services, and the physician should be notified."

On 05/14/25 at 2:58 pm, V1 (Administrator) stated, "There was no witness to what happened. (V6, LPN/Licensed Practical Nurse), who was in charge at the time of 04/22/25 incident, no longer works at the facility. (R3) and (R4) were sent to the hospital for evaluation. Upon (R4's) return to the facility, (R4) was moved to the 1st floor." V1 acknowledged hitting, slapping, pushing, and any physical contact, is a form of physical abuse. V1 stated that was why the incident was treated as abuse.

2. On 05/21/25 at 12:58 PM, R2 was observed on the 1st floor of the facility ambulating around. R2 stated, "(R1) came (wandered) into me room and hit me. I was in my room, and I did not do anything to (R1); he just came to my room and hit me. I have been in the hospital. Those hurt."

On 05/14 /25 at 12:04pm, V10, LPN (Licensed Practical Nurse) stated, "(R1) needs constant redirection, so (R1) has needs to be monitored.

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The last time I saw (R1), he was in the dining room, and I was at the nurse's station. We tend to monitor (R1) on a 1:1 (one to one staff monitoring). I did not see (R1) when he passed the nurse's station; I really don't know when (R1) passed by me. All I heard was some commotion down the east hallway. (R2) said (R1) came to his room and hit him. This behavior is part of why we monitor (R1) closely. (V11, Certified Nursing Assistant/ CNA) was assigned to both residents. At the time of incident, (V11) was on lunch break; I am not sure where she was, but I know (V11) was not on the floor. I was at the nurse's station, but I did not see the altercation. Both (R)1 and (R2) are in the hospital. The facility protocol for staff coverage when the staff assigned is not on the floor is we mainly monitor the dining room when the resident is in there. I helped in monitoring the floor, but I could not tell you how (R1) got past me. (R1) needs close monitoring. Yes, hitting, pushing, or slapping another resident either by staff or peers is a form of abuse, and it must be reported immediately to (V1, Administrator), who is the Abuse Coordinator".

On 05/14/25 at 12:21pm, V11 CNA (Certified Nurse's Aide) stated, "I am familiar with both (R1 and R2). I was not on the floor when they had the problem (Physical altercation). I was taking the lunch cart downstairs around 12ish (12:00pm or 1:00pm). When I was going off the floor, I did not know where the Nurse was, maybe in the nurse's medication room, so the nurse was not informed that I was going off the floor. When I left, there were other CNA's that can watch over my residents. When I got back to the floor, I saw management staff (V1 and V2) on the floor, and I was told both (R1 and R2) had a fight. Yes, hitting, pushing, or slapping another resident either by staff or peers is a form of physical

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abuse."

3.Facility Investigation Report of the incident of 05/09/25 documented R8 hit R7 in the back of the head while lining up to go for a smoke break with staff. V1 (Administrator) documented based on the known facts from medical record review and interviews the following conclusions have been determined about the original allegations, and checked abuse column. Police contacted event (#). Plan of care for R7 and R8 reviewed and updated.

R7's Admission Record showed admission date as 03/28/2022, with diagnoses that includes but not limited to Bipolar disorder, Paranoid schizophrenia and anxiety disorder.

R8's Admission Record showed admission date as 03/30/2025, with diagnoses that includes but not limited to Effusion right knee, Bacteremia, Cutaneous abscess of right upper limb, Type2 diabetes mellitus with foot ulcer, long term use of antibiotics and unsteady gait.

On 05/21/25 at 10:05am, V5 (Certified Nurse's Aide) stated, "On 05/09/25, we are getting ready for smoke break, and I was arranging the residents' wheelchairs against the wall in the hallway on the 1st floor. I heard a commotion behind, as I turned around and it was (R7) and (R8). (R7) said (R8) hit him in the back of his head. I immediately removed (R8) to other side in the hallway at the nurse's station. I told (V1, Administrator) about what happened. (R8) said (R7) was repositioning his wheelchair, and the wheelchair touched his foot. It is not appropriate for a resident to physically hit another resident. Yes, hitting, pushing, slapping, kicking, touching like pinching another resident is a form of

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physical abuse."

On 05/21/25 at 10:55am, R7 was in the room in a wheelchair. R7 stated what he can remember about the incident of 05/09/2025 is "(R8) hit me touching his head, I'm okay now. It hurts (referring to when it happened)."

On 05/21/25 at 11:16 am, R8 stated R7 wheeled the wheelchair into his leg, and it hurt him, and he felt pain on his leg. R8 stated he should not have hit R7, and let the facility staff handle it, but he reacted out of pain from the leg wound. V8 (Wound Care Nurse), who was present at the time of interview, stated R8 has a diabetic wound on the lower extremities.

On 05/21/25 at 12:37 pm, V17, NP (Nurse Practitioner), stated, "Many of these residents are confused and they have mental issues; they don't always know what they are doing, so it is difficult to say it is an abuse." When asked what abuse is and to give example of physical abuse and whether hitting, pushing, slapping another resident is a form of abuse, V17 did not answer.

4. R10's Progress note showed V9's, LPN (Licensed Practical nurse), documentation, dated 05/12/2025 timed 10:56am, indicating R10 was physically aggressive toward staff, throwing water on staff landing on other residents that was sitting by R10. R10 was screaming, yelling, and talking to self, and was not redirectable. Physician notified and gave order to send R9 to the hospital for psych (psychiatric) evaluation. While R10 was waiting to be sent out, R10 was placed on one-to-one monitoring. On the same day at 2:58pm, V9 documented R10 physically attacked R9, who was the roommate.

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S9999	Continued From page 7 On 05/15/25 at 1:43 pm, V16, PRSC (Psychiatrist Rehabilitation Service Coordinator), stated, "On the day of the incident on 05/12/25, (R9) was responding to internal stimuli (hearing voices, was noted pacing in the hallway and talking to himself). (R10) was placed on 1:1 for behavior monitoring for throwing water on peers in the dining room and staff, and was uncontrollable. While we were in his room, the roommate, (R9), came into the room to pick up his books from his bed, and as (R9) was bending over to pick up the books, (R10) jumped up and hit (R9) and shuffled (R9). (R9) fell and laid on his bed. This happened around 1:30 pm. (R9) did not know he was not to come into the room. I called for help, and (R9) was immediately removed from the room to the nurse's station. (R10) was then moved to the Social Services office until he was taken by ambulance to the hospital. (R9) did not know he was not to come to the room. (R10) has not returned to the facility." On 05/22/25 at 12:37 pm, V20, PRSD (Psychiatrist Rehabilitation Services Director), stated "Abuse is a harm toward resident, and it can be verbal, physical, mental, financial, misusing of resident property, and can also be isolating a resident. Physical abuse can be hitting, pushing, slapping, kicking, touching like pinching another resident is a form of physical abuse. A resident is assigned one to one supervision because the resident is having behavior problem, and by being on one to one, is to make sure the resident has no contact with anyone else (other resident) to cause them harm and to protect them from others harming them. In case of (R9) and (R10), (R10) was acting out; he should have been separated from the roommate, because there is a potential for harm. (R10) should have been in a separate space like the patio or another space	S9999		

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S9999	Continued From page 8 before been transported transporting to the hospital. The facility policy on Abuse Prevention Program documented residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Physical abuse is infliction of injury on a resident that occurs other than accidental means and that requires medical attention. Physical abuse includes but not limited to hitting, slapping pinching, and kicking. The policy under protection of residents documented that residents who allegedly mistreat another resident will be removed from contact with other resident during the cause of the investigation. The facility policy on Behavior Management for Agitated Behavior, presented with no date, documented targeted behavior includes agitated behavior, which represents danger to self and others, due to Alzheimer's disease with anxiety, dementia, mental illness or other illnesses. Interventions listed includes but not limited to removing the resident from problem area and separate from others when necessary. Approaches to use when encountering a potential violent resident includes but not limited to moving other residents out of the area. (B)	S9999		