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S 000	Initial Comments Complaint Investigations: 1924936/IL113733 Facility-reported Incident (FRI) to Incident date of 7/8/19/IL114060	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 300.3300d)2) 300.300de)1)2)3)4)5) 300.300g)j)k)l) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3300 Transfer or Discharge

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 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), and the Department may place 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)

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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 10days 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 at the telephone number listed below."; (Section 3-403(c) of the Act)
4) A hearing request form, together with a postage paid, preaddressed envelope to the 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)
g) A copy of the notice required by subsection (d) (1) of this Section and Section 3-402 of the Act shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the resident, the resident's representative, and, if the resident's care is paid for in whole or part through Title XIX, to the Department of Healthcare and Family Services. (Section 3-405 of the Act)
j) The planned involuntary transfer or discharge shall be discussed with the resident, the

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resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Section 3-408 of the Act)
k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 of the Act)
l) A resident subject to involuntary transfer or discharge from a facility, the resident's guardian or if the resident is a minor, his or her parent shall have the opportunity to file a request for a hearing with the Department within 10 days following receipt of the written notice of the involuntary transfer or discharge by the facility. (Section 3-410 of the Act)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on observation, interview, and record review the facility failed to attempt to manage resident behavior within the facility prior to issuing an emergent involuntary discharge, failed to

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assist family with finding appropriate alternate living arrangements, failed to ensure that an involuntary discharge was not based on the resident's condition at the time of transfer, and failed to ensure that the resident was being transferred to an appropriate environment for one of five residents (R15) reviewed for involuntary discharge in the sample of 29. This failure resulted in R15 being discharged to an unsafe environment, experiencing severe emotional distress and increased confusion.

Findings include:

The facility's Admission Criteria policy, dated 3/2019, documents "Our facility admits only residents whose medical and nursing care needs can be met."

The Facility Assessment dated 6/20/19 documents "List the common diagnosis, conditions, physical and cognitive disabilities of the residents the facility cares for to determine the types of human and physical resources needed. Common diagnoses: Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions, Parkinson's Disease, Hemiplegia, Paraplegia, Quadriplegia, Multiple Sclerosis, Alzheimer's Disease, Non-Alzheimer's Dementia, Seizure Disorders, Cerebral Vascular Accidents, Stroke, Traumatic Brain Injuries, Neuropathy, Down's Syndrome, Autism, Huntington's Disease, Tourette's Syndrome, Aphasia, Cerebral Palsy."

This Assessment documents "Each resident is evaluated by the Director of Nursing and nursing

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staff to ensure the potential residents can be properly cared for and the resources necessary are on site or can be acquired externally. If it is developed in house the resident is evaluated for the need and we acquire the necessary equipment and/or resources to properly care for the resident." This Assessment also documents, "Services and Care we offer based on our residents' needs: Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities."

The facility's (undated) Abuse, Neglect, Exploitation Prevention, Investigation, reporting policy documents "Residents who allegedly mistreated another resident will be removed from contact with that resident during the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of other resident and employees of the facility. A room change or staffing change may be indicated but should not be interpreted as a restriction of rights or liberties. Residents will be protected from service interruptions, restrictions, and any other form of retaliation."

R15's Admission Record face sheet dated 7/30/19, documents R15 was admitted to the facility on 9/12/16. This sheet documents R15 has diagnoses of Anxiety, Alzheimer's Disease, Dementia with Behavioral Disturbance, and Major

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Depressive Mood Disorder.

R15's physician order sheet, dated 7/8/19, documents R15 had active orders for Alprazolam (Xanax) 0.25 milligrams (anti-anxiety medication) give one tablet every morning, and two tablets in the afternoon every day for anxiety.

R15's Minimum Data Set assessment (MDS), dated 5/2/19, documents R15's cognitive skills for daily decision making are severely impaired. This assessment also documents R15 has fluctuating behaviors of inattention and altered level of consciousness and has continuous behaviors of disorganized thinking.

R15's current (undated) care plan documents "I wander with no rational purpose, seemingly oblivious to my needs or safety throughout the (facility). When I begin to wander, attempt to engage me in activity or something that will hold my interest." This care plan also documents "I (R15) have behavioral symptoms present as evidence by yelling/ screaming/ hitting/ kicking/ scratching/ biting and throwing things. Monitor me for wandering as I will go in other residents' rooms and take their personal items and yell at them to get out of my house." The same care plan also documents "The resident (R15) is/has potential to be physically and verbally aggressive related to dementia with behavioral disturbance and anxiety. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away and approach later."

R15's progress note, dated 4/30/19 at 2:17 PM, documents "(R15) became agitated with another resident in the multi-purpose room. This writer

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(V4 Social Service Director) was able to redirect (R15) to the common area. With no further incident."

R15's final abuse investigation, dated 5/6/19, documents "At approximately 1:30 PM on 4/30/19 (R15) and (R12) were in the resident dining room, (R15) became agitated and slapped (R12) on the chin." This investigation also documents "(R12) was assessed and had no injuries and did not express any pain or injury. Upon investigation, (R15) has dementia and was upset because she believed (R12) to be in her house and could not understand why she was not leaving when she asked her to. (R15) was maintained on a one to one visual contact the remainder of the evening as well as monitored for agitation and behaviors with none other noted that evening."

R15's final abuse investigation, dated 6/12/19, documents at 5:00 PM on 6/12/19 "(R15) became agitated with staff and other residents while sitting in the main living room of the facility. (R15) was upset that other residents were "In her house". (R15) went around staff and pushed (R29), causing (R29) to lose her balance and fall to the floor." This investigation also documents R15 was maintained on one to one visualization for the remainder of the night and that V27 (R15's Physician) "Reviewed (R15's) medications and ordered to change the timing of the administration of (R15's) antianxiety medication to earlier in the afternoon, to minimize behaviors in the late afternoon and evening."

R15's progress note, dated 7/8/19 at 4:28 PM, documents "Attempted to take (R15) to the bathroom, (R15) agitated at each attempt." R15's progress note, dated 7/8/19 at 5:16 PM, documents "(R15) ambulated down the hallway

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agitated but not aggressive just talking. (R15) ambulated into another resident's room and without cause walked up to (R9) and slapped her across the face. (R9) had not even spoke to (R15) and she did it." Both progress notes were documented by V10 (Registered Nurse)

On 7/31/19 at 11:15 AM, R9 was sitting in a wheelchair in her room. R9 stated "On the evening of 7/8/19, (R15) came in my room through the bathroom and started yelling at me that I was keeping her baby awake and then she slapped me and hit my face. One other time she came flying through the bathroom door and started yelling at me while I was watching television. I don't use the bathroom at all. I have told staff to lock it, but they don't. I always would yell for staff whenever (R15) was in my room. They (staff) were always aware. I just never knew when (R15) may come in here and start on me."

On 7/30/19 at 1:30 PM, V10 (Registered Nurse) confirmed working on the evening shift of 7/8/19. V10 stated "(R15) has dementia, Alzheimer's and has had agitation. She could go from being pleasant to picking stuff up and throwing it or shoving you. She had her bad times of the day. When she first admitted I noticed a pattern that by 1:30-2:00 PM, she would get more agitated. Some of it would do with the change of shift. The incident on 7/8/19 is one that (R15) has done in the past. (R15) went into (R9's) room. She would do that sometimes, if she could hear that someone was in the room on the other side of the bathroom door, (R15) would go in the other room and try to kick them out, thinking it was her house to do so. She had done that several times. I didn't see the actual incident. (V25, Certified Nursing Assistant (CNA)) and (V26, CNA)

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reported it to me and I'm not sure how much they saw of it. When I went down, (R9) said (R15) had slapped her across the head. We got (R15) out of the room and I got on the phone with (V2, Director of Nursing (DON)) and (V1, Administrator). We had to do one on one monitoring with (R15) after that. When she was admitted she was confused from the get go. She was on Xanax since admission. My next step that day was that I was instructed by (V2) to contact (V27, R15's physician) and get an order for a psychiatric evaluation and an involuntary discharge. (V27) wouldn't give that due to it being normal for Alzheimer's and dementia. (V27) offered to get (R15) more Xanax. But I explained that I was told by the (V2) and (V1) that we need to involuntarily discharge (R15). (V27) said "What am I supposed to do? Throw her out on the street?" We didn't leave her side. We took turns walking with her."

On 7/30/19 at 1:50 PM, V25 (CNA) and V26 (CNA) both confirmed working the night that R15 was discharged. V25 stated "We were both coming out of a room across the hall when (R15) was leaving (R9's) room. We could hear (R9) screaming. (R9) was yelling and saying (R15) hit her and she was calling the police. (R15) has hit other residents in the past. She has knocked (R29) down before and she smacked (R12) across the face. Those were recent episodes. In the beginning when (R15) was admitted she was confused but not aggressive. (R15) has become more physical in the last 6-8 months. (R15) would often yell out "this is my house, get out." Normally (R15) liked seeing us and we could re-direct her. She felt bad that night (7/8/19) but didn't know why. We took her out to the lobby area and she calmed down a lot. When (V23/R15's family member) got here (R15) was

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calm. (R15) used to have a pattern of behaviors like typical "sundowners" (worsened confusion in the evening hours). They were getting more frequent lately. Interventions for (R15) would be distraction. This event occurred before supper in the evening time."

On 7/31/19 at 10:10 AM, V28 (CNA) stated "(R15) mood would just depend on the day. Sometimes she could be cooperative and other times she'd put up a fight. Sometimes (R15) would go into other resident's rooms and be physical and yell or be mad. (R15's) Alzheimer's and dementia has just progressed and it made her have more aggressive behaviors, you'll have that with that disease."

On 7/30/19 at 12:00 PM, V23 (R15's family member) stated "On July eighth at 7:45 PM, I received a phone call that there was an incident and (R15) needed to be removed from the facility. I met with the (V1, Administrator), (V2, DON), and had (V27, R15's physician) on speaker phone. I was told that (R15) went into another room and hit another resident and they were unable to care for her anymore. When we asked for more time to figure things out, the administrator said that this has already been done right now and they could give us no time and that (V15, the facility's medical director) had signed off on it. So, at 9:00 PM they made me wake up my sleeping mother and take (R15) to my home which was in no way equipped to handle her and put her in great danger. (R15) had lived almost three years in the facility. She had had other altercations with residents and they never spoke about something like this. At every care plan meeting they always told me she is so re-directable. I was told this incident happened between 5-5:30, the nurse saw her walking down the hall and she never stopped

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her or tried to re-direct her. When we got (R15) to my house she was extremely difficult to manage. She didn't want to get out of the car. She was upset and tearful and did not know where she was or what we were trying to do for her. We had to do everything we could to get her into the house and ready for bed. The bed is high off the floor and we have stairs. (R15) was not safe in my home. The facility never contacted me to help me find another placement. I have not heard anything from them since she left on July eighth. There was no witness to the incident itself. No one saw it or was in there besides (R15) and the other resident (R9). When (R15) was admitted to the facility she had no idea that she was being admitted to a facility. She thought she was in her mother's house. We had to bring her to the facility in the first place because she was so confused. (R15) believed that from the day she was admitted until the day I took her home. They (the facility) did injustice to (R15) and it's not ok."

On 7/31/19 at 2:15 PM, V4 (Social Service Director) stated "A lot of (R15's) behaviors were in the evening so I wasn't in there for those times. (R15) had a lot of" sundowner" symptom. I don't recall any talk of getting (R15) out of the facility prior to her discharge on July eighth. I know we never said that she would need to find alternate placement. We talked some about her medications in care plan meetings with her family but we (the facility) never said we can't handle her here."

On 7/31/19 at 9:40 AM, V2 (DON) stated "The night she was discharged I got a call from staff telling me what had happened, and I came back in a little after 5:00 PM. The police officer talked with (R15), but she was fine and calmed down by

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then and of course made no sense. When (V1, Administrator) got here we both sat down and talked. When we talked to (V27, R15's physician), she wouldn't send (R15) to the emergency room for a psychiatric evaluation. (V27) said (R15) didn't need it and she wouldn't give us an order. (V1) and I decided that evening that we need to involuntary discharge on (R15). (V15, medical director) is our medical director and he gave us the order for (R15) to be involuntarily discharged. (R15) was aggressive hit or miss at times. She's had about three incidents since October. When we called both (V27 and V15) we asked for an order for involuntary discharge."

On 7/31/19 at 9:50 AM, V1 (Administrator) stated "The reason (for involuntary discharge) was for safety of other residents. It was a matter of us trying several different things and at that point we had exhausted all other options. (V27) told us "This is just (R15), this is the way she is, and this is what she does." So, a psychiatric evaluation wasn't an option. We do have other residents here with Alzheimer's and dementia. Aggression and agitation do go with dementia and Alzheimer's and it is a part of the disease process. We talked to (V23) that night about locked units and other facilities. After the last incident (prior to 7/8/19) we had made some changes to (R15's) medications and she was doing OK, then out of nowhere (R15) walked into another residents room and hit her. No-one was in the room to witness the incident. No staff saw what happened between the two residents. I gave the family and (V23) the involuntary discharge notice within hours of the incident. We have not talked with the resident's family since they left that night, aside from (V23) calling us to get medical records."

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	IL6005722	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

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On 7/31/19 at 11:00 AM, V15 (Facility's Medical Director) stated "(R15) is not my patient but she physically assaulted another resident and that resident is my patient. I did give (the facility) an order to discharge (R15). I am not her primary physician. Aggression and agitation are part of Alzheimer's and dementia. I do feel like the staff are more than capable of taking care of residents with Alzheimer's, dementia and aggressive behaviors related to the Alzheimer's disease process. The staff are very careful and capable, and they are capable of handling residents with behaviors, agitation and aggression."

On 7/31/19 at 12:45 PM, V27 (R15's physician) stated "(R15) has severe dementia. When (R15) comes in with (V23) to her appointments. She can't answer you when you ask her who (V23) is. (R15's) clarity and confusion is severe. So, when they (the facility) called me with this episode of her hitting another resident, to me obviously (R15) is confused and lashed out because she was scared or whatever. (The facility) wanted me to give an order to immediately discharge (R15) and release her. If you're a facility that deals with dementia and residents like this then why can't you handle this? If it was a problem with another resident maybe move (R15's) room or maybe eventually move (R15) to another facility. I didn't feel the immediacy of the discharge or putting (R15) in a hospital where her symptoms would get worse. If (R15) had violence with other residents, they didn't make me aware. I don't recall ever being told (R15) had a pattern of violence. They (the facility) never reached out and said she might need a higher level of care or a special unit until this night (7/8/19). Taking (R15) to (V23's) home which is unfamiliar, that could make her confusion related to dementia

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even worse and possibly make her have more behaviors, without trained staff there to help. (R15) didn't need to be thrown out that night. (The facility) certainly wanted to get the resident out that night. (V23) offered to come in and pay for someone else to come in and stay with (R15) and give her time to find placement, even a day or two longer to let (V23) find another facility. (V23) was actually being very reasonable with (the facility) and they wouldn't have it."

On 8/1/19 at 11:20 AM, V2 (DON) stated "We were always to redirect (R15). After she pushed (R29) down in June, we did some medication changes with (R15's) Xanax. It helped for a while but even (V27), the night we sent her out, said this is how (R15) is. I get that, and I understand it's part of (R15's) disease process. If (staff) saw (R15) walking down a hall and looking agitated they should re-direct her, offer her a coffee or just get her mind distracted. (R15) would go in (R9's) room here and there, she would go through the adjoining bathroom sometimes. (R9) did tell me that (R15) had went in during the night at times and would yell at her. (R9) does not use that bathroom, she uses a bed pan. We (the facility) never thought about locking the bathroom door on (R9's) side. When we changed her Xanax in June (V27) said we could go up with medication if needed, but since the actual event was more than just agitation, that wasn't what we (the facility) wanted. If we had the amount of staff to give her one to one attention that possibly could have helped, but we're not equipped to provide one on one care. (R15's) behaviors were that of sundowners and events happened on second shift usually. We don't have enough Certified Nursing Assistants or staff to provide more in (R15's) area." V2 confirmed that in the past a room change for R15 with a private bathroom

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was mentioned, but never happened. V2 also confirmed the facility did not try any further interventions on the night of 7/8/19 before making the decision to involuntarily discharge R15.

(B)