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S 000	Initial Comments Complaint investigations #2080249/IL119083 - F600 Facililty Reported Incident of 1/15/20/IL119206 - F600	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.
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:
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.

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 based on evidenced by:

Based on observation, interview, and record review, the facility staff failed to ensure that a resident was free of physical abuse when R3, who requires supervision due to exhibiting verbal aggression with threats of physical harm toward

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staff earlier in the day, got into physical altercation with fellow resident and staff. Facility failed to ensure that residents in the vicinity were safe when R3 picked up a chair and hit R2 in the forehead sustaining a laceration that required 7 stitches and 2 staples for one (R2) of three residents reviewed for physical abuse in the sample of 3 residents.

The findings include:

R2 is a 64-year-old, non-ambulatory male who was admitted to the facility on 12/28/13 with diagnoses that include Cerebral Vascular Accident with left hemiparesis and Schizophrenia. R2 has been assessed to be oriented with a brief interview mental score (BIMS) of 15 with periods of confusion and requires extensive assistance with his Activities of Daily Living (ADL) per the annual minimum data set (MDS) 12/27/19. R2 has been care planned for verbal and physical aggression due to his Schizophrenia and poor coping skills.

R3 is a 70-year-old, ambulatory male who was admitted to the facility on 12/20/19 with diagnosis of Schizophrenia. R3 came from a psychiatric hospital after residing in another nursing home. R3 was assessed to require limited assistance to supervision for his ADLs and has a brief interview mental score (BIMS) of 15 per the admission MDS 12/30/19. R3 has been care planned for adjustment to the facility and behavior management and assessed to be moderate risk per the admission (12/26/19) Screening Assessment for Indicator for Aggressive and/or Harmful Behavior.

On 1/28/20 at 2 PM, R2 stated he was talking with R4 in the 2nd floor alcove area adjacent to

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the dining area, the elevator and the nurses' station when this white guy (R3) came up to him and used the n-word which made R2 mad. R2 stated the next thing he knows is R3 hits him with leg of a chair. R2 stated that the staff were quick to the scene but did not stop R3 from hitting R2 with the chair. R2 stated he said nothing to R3 to provoke him but understands that the staff are saying he provoked R3. R2 then states he remembers saying "sit down and be quiet" after R3 used "the n-word". R2 stated he went to the emergency room and required 7 stitches and 2 staples to his forehead. R2 showed his scar on the forehead leading into the hair line. R2 stated that he does not know what the white guy looks like but knows he is new to the facility. R2 stated it is the first time he has been hurt in the facility. R2 stated that R3 was taken to jail and allowed to return to the facility which he thinks is not right.

On 1/28/20 at 1:08 PM, R3 stated he was coming off the elevator to go to his room. R3 stated R2 and himself exchanged expletive words when R2 started to come toward R3 in his wheelchair. R3 stated he thought that R2 was going to stand up out of the wheelchair and hit him. So, he grabbed a chair and hit R2 with the chair leg. R3 stated he thinks R2 needed stitches to the forehead. R3 stated that at a previous nursing home, a resident hit him with a chair. R3 stated that the staff were asking R3 if he knew that R2 had a bum arm but R3 stated he did not know this. R3 stated he was counseled and told not to start a fight or be in a fight and to report to his social worker. R3 asked if he is in trouble.

On 1/29/20 at 1:50 PM, R4 stated she was in the dining room talking with R2 when "out of the blue" R3 hits R2 with the chair leg. R4 stated "not to know where R3 came from" and stated " she did

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not see R3 until he hit R2 with the chair". R4 stated that the "staff say R2 provoked R3 but claims R2 said nothing to R3". R4 stated that "R4 was taken to jail but allowed to come back". R4 is an 80-year-old female and assessed to have a BIMS of "9" and has the diagnosis of Paranoid Schizophrenia per the MDS dated 12/2/19.

On 1/28/20 at 12:10 PM, V5 (Certified Nurse Aide/C.N.A.) stated she was present and talking with R2 and R4 when R3 came off the elevator and interrupted the conversation they were having to ask V5 a question. R2 was not happy and both R2 and R3 exchanged words but only was able to make out the word "coward". V5 stated before she knew it, R3 grabbed a chair and hit R2 in the forehead which required stitches. V5 stated that R2 is wheelchair bound and R3 is ambulatory and new to the facility. V5 stated that R2 likes to provoke and R3 is easily set off. V5 stated that both residents reside on the same floor but at opposite ends of the floor. V5 stated neither have had any altercations since and have exhibited acceptable behaviors since the incident. V5 stated that the rest of the staff were busy but came running to the scene when they heard the commotion.

On 1/30/20 at 4:30 PM, V9 (C.N.A.) stated she was in resident room 201 when she heard the commotion outside the room, V9 stated she came out of room and saw R3 holding the chair over R2's head. V9 stated that R3 was agitated earlier in the day and was sent down to the social service office due to being agitated and threatening physical harm toward staff. When R3 came off the elevator, he was still very agitated. V9 stated she saw R3 holding the chair over R2's head and came behind R3 and removed the chair from him. At this time, the rest of the staff came

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to the scene. V9 stated that V5 was present but that everything happened so quickly, and no one expected R3 to be physical. V9 stated that R2 had blood gushing from his forehead and staff applied pressure then a gauze bandage was wrapped around his head.

On 2/6/20 at 10:50 AM, V1 (administrator) stated he was doing morning rounds on 1/7/20 when he heard R3 being verbally aggressive toward the nurse and the nurse was telling R3 that she needed to call the physician for an order. R3 continued to be verbally aggressive saying he needed cough medicine now. V1 stated R3 can be very impulsive. V1 stated he was able to calm R3 down. V1 stated that the hospital informed this facility that R3 was sent to hospital due his behavior and that initially R3 wanted to return to his previous nursing home. V4 (Social Service Director) reached out to the previous nursing home but they said "no". This was confirmed per social service note. V1 stated that they never received the previous nursing home documentation only the hospital documentation on R3's aggressive behavior.

On 2/6/20 at 11:25 AM, V4, Social Service Director/Psychiatric Rehabilitation Service Director (SSD/PRSD) stated she was on the phone 1/7/20 when R3 came to her office. V4 asked R3 to come back later to talk. V4 stated R3 was very anxious, moving his hands about, voicing repetitive concerns about his possible need for dialysis due to his recent kidney diagnoses, and talking real fast making his mouth dry. V4 stated R3 left her office being anxious. V4 stated she heard "All staff to 2nd floor" and possibly code "Green" (behavior/emergency) when R3 hit R2 with the chair. V4 stated she took R3 to his room for 1:1 where R3 continued

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to pace the room, excessive repetitive talking and asking if he was going to jail and requesting water to drink for his dry mouth. V4 stated the facility staff are not trained in CPI (Crisis Prevention Institute). CPI is a non-violent crisis intervention training designed to teach best practice for managing difficult situations and disruptive behaviors. V4 stated the staff are instructed to ask resident what is bothering them as they talk in a calm voice and try to de-escalate and re-direct the resident.

V4's description of anxiousness sounds more like symptoms of agitation per the definition of agitation.

The facility's incident report documents the rest of the staff V7 and V8 (both Licensed Practical Nurses) and V9 and V10 (both CNA) were not present but came running to the scene when hearing the noise and saw R3 with the chair in his hands. The report documents that R2 told R3 to "shut up" which resulted in R3 picking up a chair and hitting R2 in the head and causing a laceration requiring emergency services. The incident report lacked information on the staples and stitches. Later, R2 recanted and stated he said nothing to cause the incident. Per nurses' notes, both were separated and R2 was sent to the emergency room for 2 staples and several stitches and R3 was monitored 1:1 until he was sent to the psychiatric hospital where he stayed for 7 days.

On 1/29/20 at 11:40 AM in the 2nd floor dining room, R3 was exhibiting verbal aggression about the meal he received and saying he "was given the wrong food, did not want it, F... can't eat it, wants PBJ sandwich, and it is not his fault" as his voice escalated. V5 and V11 (C.N.A.) were able

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to re-direct R3 and he calmed down. Other residents present did not respond to R3's verbal aggression.

Nurses' note 12/30/19 documents R3 being restless and agitated during breakfast. R3 attempts to fight co-residents. Staff intervene and redirect R3 back to his room. R3 is given Haldol injection which was effective. Nurses' note 1/4/19 at 10:34 PM, R3 is repetitive with his questions and staff are constantly re-directing R3. R3 exhibits restlessness, pacing and talking to himself. R3 was asked if he had a problem and R3 responded he is fine. R3 did calm down and went to bed.

Nurses' note 1/7/20 at 8:50 AM, R3 is cursing and threatening to hit staff. Staff intervene and re-direct R3. R3 is counseled about acceptable behaviors and is educated that if he hits anyone there will be consequences. At 10:30 AM on the 2nd floor, R3 hits R2 with a chair leg saying, "he verbally abused me". R3 was placed on 1:1 (one on one) with V4 in his room until R3 was sent to the psychiatric hospital and admitted with diagnosis of Aggressive Behavior.

R3's care plan (12/23/19) addresses his behavior of physical aggression due to his diagnoses of Schizoaffective/Schizophrenia disorder, history of substance abuse, poor and ineffective coping skills which is manifested by pacing, agitation, verbal/physical abuse/aggression and socially, disruptive behavior. The interventions are to provide 1:1, re-direct, support groups and to remind resident he/she is in safe and secure environment.

The facility's policy labeled ABUSE PREVENTION POLICY documents residents

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S9999	Continued From page 8 have the right to be free from physical abuse. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than accidental means. Abuse is also the willful infliction of injury. Facility's policy labeled MANAGING RESIDENTS WITH AGGRESSIVE BEHAVIORS IN LONG TERM CARE documents potential injury to resident and staff must be minimized. By understanding extrinsic and intrinsic factors and triggers which may contribute to the resident's escalation in behaviors, caregivers can implement strategies that will address the resident's predisposition to certain triggers which in turn can potentially minimize the risk of injury. (B)	S9999		