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S 000	Initial Comments Complaint: 2054273/IL123480 - F600 G cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b 300.1210c)3) 300.1210d)6) 300.3240a) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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.	S9999		

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S9999	Continued From page 2 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) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on interview, record review, and observations the facility failed to prevent resident to resident abuse for 6 of 6 residents (R2, R7, R8, R9, R10 and R11) reviewed for abuse investigations. This failure resulted in residents (R10) and (R11) falling, and as a result of the fall, R10 was hospitalized for a Displaced Intertrochanteric Fracture of the Right Femur. Findings include: 1.) The facility's Risk Management form dated 6/13/20 documents under Statement; V11 (Licensed Practical Nurse) stated R10 came into the dining room and was messing with the chairs and R8 moved one of the chairs back. R10 got mad and was yelling at R8 and he repeatedly hit	S9999		

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S9999	Continued From page 3 his walker against R8's chair. The facility's form titled, "Report of Illinois Department of Public Health" dated 6/13/20 documents under Summary: At 6:00 PM, R10 was being verbally and physically aggressive with R11 over some chairs in the dining room. (Referenced above) V20 (Housekeeper) yelled at V11 that R10 and R11 were fighting. The report documents that when V11 got to the two residents, they were both punching each other in the face and R11 fell on top of R10. When both residents fell, R10 fell on his right side and was screaming, "He broke my leg!" R11 had his vital signs taken and was helped up to a chair and both residents were taken to a local hospital emergency room for further evaluation. R10s' electronic medical record, under Medical Diagnosis documents R10 is an 85 year old with Cognitive Communication Deficit; History of falling; Parkinson's Disease; Major Depressive Disorder; Schizophrenia; Dementia with Behavioral Disturbance. R10's Progress Notes dated 6/13/20 documents under Note Text: R10 was in the dining room punching another resident, R11, in the face when V20 called out to V11. During the altercation, while R10 and R11 were swinging at each other R11 fell on top of R10. R10 fell onto his right hip and he started screaming "He broke my leg!" R10 and R11 were evaluated by V11 and both residents were sent to the local hospital. R10's Progress Notes also document R10 was transferred and admitted to a hospital in a neighboring state for a fracture of the right hip. R10's Minimum Data Set (MDS) dated 4/14/20, Section E documents behavior of verbal	S9999		

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symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked "behavior not exhibited." R10's MDS dated 6/13/20 documents verbal and physical behaviors not assessed.

R10's Care Plan dated 4/23/20, documents under, Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically aggressive behavior and verbally aggressive behavior.

R11's medical record under Medical Diagnosis documents R11 is a 75 year old with diagnosis of Major Depressive Disorder; Schizophrenia; Cognitive Communication Deficit; Alzheimer's Disease; Anxiety Disorder; Dementia without Behavioral Disturbance.

R11's MDS dated 7/2/20, Section E, documents physical behavior directed toward others occurs 1-3 times per week and verbal behavioral symptoms directed toward others occurs 1-3 days per week.

R11's Care Plan dated 6/4/20 documents under Focus; R11 has the potential to demonstrate episodes of agitation and has the potential to be physically aggressive. R11's Care Plan dated 3/5/19, documents under, Intervention; Intervene before agitation escalates; Guide away from source of distress to a quiet area; Engage calmly in conversation.

There is no documentation in R10's or R11's

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medical record on any of the interventions being initiated, and there is no documentation on the effectiveness of any of the interventions in R10's or R11's medical record or in their Care Plans. There is no documentation that R10 or R11's behaviors were being tracked.

On 7/29/20 at 6:00 PM via phone, V11 stated she had just got to work at 6:00 PM and was getting report from the day shift.V11 stated the residents had already had their evening meal and about 5 residents were in the dining room and staff were busy getting people ready for bed. V11 stated it's always busy at that time of the day and the C.N.A.'s were in and out of the dining room. V11 stated R10 was moving chairs and started knocking on R8's wheelchair with his walker and yelling at her and R8 asked him several times to stop. V11 stated R11 saw that R10 kept hitting R8's wheelchair and R11 asked R10 to stop, and when R10 wouldn't stop, R11 got up and went over to R10 and they started hitting each other in the face with their fists. V11 said, during the fist fight, they both lost their balance and R11 fell on top of R10, and when they hit the floor, R10 was screaming that his right leg hurt and that R11 broke his leg. V11 stated she called an ambulance for both residents and they were taken to the hospital and R10 ended up going to the hospital in Indiana for a fractured right hip and R11 came back to the facility after being checked out.

On 7/28/20 at 8:30 AM, V2 (Interim Director of Nursing) stated she didn't see the incident/resident altercation between R10 and R11. V2 stated she was told that R10 and R11 were fighting over chairs, and they got into a fist fight that resulted in R10 falling to the floor and fracturing his right hip. V2 stated she isn't sure

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who hit who first. V2 also stated when R10 started moving the dining room chairs, R8 was also in the dining room and moved one of the chairs back and R10 got really upset and hit her chair with his walker and that's when R10 and R11 got into it.

On 7/27/20 at 2:00 PM, V20 stated she was the only employee in the dining room and she saw R10 banging on R8's chair with his walker, then R10 and R11 got into it and started hitting each other in the face with their fists. V20 states she didn't know who hit who first, because she was getting the nurse to come to the dining room. V20 stated both residents were standing during the confrontation.

2.) The facility's form titled, "Report to Illinois Department of Public Health" dated 6/12/20 documents under, Summary: Resident to Resident altercation in their room. Male resident R10 had a broom handle and a pair of scissors and R10 attacked his roommate, R7 while in bed, hitting R7 in the head with the broom handle and scratching his chest with the scissors. Scratches were noted and EMS and local police were called. Resident (R10) was taken to the hospital and R7 was assessed by EMS. Neurological assessments being completed for the next 24 hours. No further distress is noted to R7.

R7's Progress Notes dated 6/12/20 document, R7 came up to nurses station without any clothes on. V10 (Certified Nurses Aide) went to R7's room to get his clothes, and found R10 sitting on the edge of bed with what appeared to be a large knife and a broom stick. V10 came back up to nurses station to report to V11 (Licensed Practical Nurse) what she saw. V11 went down to resident room with V10 and looked into the opened door

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to find R10 sitting on edge of bed with broom stick and large knife. V11 asked R10 if he was ok to which he replied "that man attacked me." V11 pulled the door closed and went back to the nurses station to call V1 (Administrator) and 911. V11 asked R7 what happened and he said "I got in a physical fight." "He hit me first." "He hit me with a broom in the head." "I'm not hurt." R7 had a scrape across his abdomen but did not appear to be in distress. V10 put R7's clothes on and took him to the dining room to eat while the police investigated further. R7 was evaluated by the Emergency Medical Service staff.

On 7/22/20 at 10:45 AM, V1 (Administrator) stated R7 and R10 were roommates and that R10 was "prejudiced against black people." V1 stated on 6/12/20, R7 came to the Nurse's Station without any clothing and V10 (Certified Nurses Aide) walked to R7's room to get him clothes and when V10 opened the door, R10 was sitting on his bed holding a broom handle and what V10 thought was a knife. V1 stated that when asked by the staff if R10 was alright, R10 responded that R7 came into his room through the window. V1 stated when the staff asked R7 what happened, R7 told them that he got into a fight and R10 hit him on the head with a broom. V1 stated R10 had a pair of scissors and a broom handle that he got out of the adjoining room. V1 stated they called the police about the resident to resident altercation immediately and R10 was sent out to the hospital for evaluation. V1 also stated R7 was assessed by the emergency medical staff and they continued to monitor R7 for 24 hours and he was fine. V1 stated she notified the doctor, R7 and R10's families, they did an investigation and sent a report in to IDPH. V1 stated R7 was moved to another hall and the incident was added to R7's Care Plan. V1 also

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stated the room next door to R7 and R10 was unoccupied because V19 (Maintenance) was doing some construction on that room. V1 stated V19 (Maintenance) failed to lock the door that was next to R7 and R10's room.

R10's Minimum Data Set (MDS) dated 4/14/20, Section E documents behavior of verbal symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked Behavior not exhibited. R10's MDS dated 6/13/20 documents verbal and physical behaviors not assessed.

R10's Care Plan dated 4/23/20, documents under, Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically aggressive behavior and verbally aggressive behavior.

R10's Progress Notes dated, 6/12/2020 at 2:50 pm; Transfer to Hospital Note Text: resident was transferred to (a local hospital) for psychiatric evaluation after incident with another resident (R7). There is no further documentation in R10's medical record/Care Plan to address his physical or verbal aggression regarding this incident or that R10 had prejudices against people of color. The facility has done no behavior tracking on R10.

3). a. A report titled 'Initial IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification' dated 12/4/19 includes information regarding a resident to resident

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altercation between R2 and R8 and lists the incident as alleged physical abuse, no injury to R8, and police notified.

The 'Final IDPH Incident and/or Abuse Notification' dated 12/4/19 documents the following: Another resident R8, was wheeling herself across the dining room. R2 got up from his wheelchair and struck R8 three times in the back and shoulder region. It was a witnessed incident by staff. Staff were unable to get between them to prevent the incident, R2 was unprovoked. R8 received a head to toe assessment, no injuries noted at this time. R2 was removed from the dining room and placed on 1 on 1 visual, R2 received a medication adjustment from the Behavioral Center.

R2's EMR Progress Note, dated 12/4/19, documents the following: This nurse and CNA (V12) heard yelling in the dining room. Upon looking from nurses' station to dining room CNA (V12) saw R2 strike R8 three times in the back and shoulder as R8 was wheeling herself to the dining room table. The residents were immediately separated and R2 was put on one-on-one supervision and 15-minute checks. POA's (Power of Attorney), MDs (Physician), Ombudsman, Police, DON V13, and Administrator V1 notified.

R8's EMR Progress Note, dated 12/4/19, documents the following: This nurse and CNA (V12) heard yelling in the dining room. Upon looking from nurses' station to dining room (V12) saw (R2) strike (R8) three times in the back and shoulder while R8 was wheeling herself to the dining room table. Residents were immediately separated and (R2) was placed on 15-minute checks with one-on-one supervision. (R8) was

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assessed head-to-toe with redness noted on her left rear shoulder and left front shoulder. DON, Admin, MDs, POAs, Ombudsman, and Police notified.

R2's MDS (Minimum Data Set), dated 1/31/20, Section C (Cognition) BIMS (Brief Interview Mental Status) score is 6, indicating R2 is severely impaired. Section E200 (Behaviors) of the MDS indicates resident exhibits physical behavior symptoms directed toward others such as hitting, kicking, pushing, scratching, and grabbing. R2's Electronic Medical Record's (EMR) Diagnoses are listed as Schizophrenia, Seizures, Major Depression, Disorder of Brain (Gunshot to the head).

R2's Care Plan includes the following focus: R2 has impaired cognitive function/dementia or impaired thought processes relate to disease Process or other specific disorders of the brain, R2 is considered at risk for abuse/neglect due to poor insight/poor judgement and difficulty communication, R2 has potential to demonstrate physical behaviors. The Care Plan does not include interventions related to these areas of focus.

R8's MDS, dated 4/3/20, Section C - BIMS is scored as a 6, indicating R8 is severely impaired. Section E (Behaviors) indicates "No Behaviors." R8's EMR diagnoses are listed as Chronic Kidney Disease, History of Falls, Schizophrenia, Major Depressive Disorder, Dementia, and Brief Psychotic Disorder.

On 7/27/20 at 9:45AM, V1 (Administrator) stated regarding the 12/4/19 incident concerning R2 and R8, that medications were increased for R2, R2 was placed on 1 on 1 supervision and 15 minutes

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checks to keep all residents safe. V1 did not think that this was abuse because this was R2 and R8's first altercation. V1 stated R2's actions toward R8 was out of the blue and was not provoked by R8.

On 7/22/20 and 7/27/20, R8 is noted sitting in a wheelchair and peddling with her feet. R8 is carrying 2 baby dolls and is peddling up and down the center hall, into her room, and into the dining room. R8 does not interact with staff or other residents.

b. A report titled 'Incident Report Form- IDPH Notification, dated 12/27/19, includes information regarding a resident to resident altercation between R2 and R8, and lists the incident as resident to resident, reddened area, alleged physical abuse, non-fatal, Physician, Family, and Police notified.

The 'Final IDPH and/or Abuse Notification' dated 12/27/19, documents the following: R8 was wheeling herself into dining room area. R2 stood up from his wheelchair and stumbled over to R8. R2 punched her in the chest without provocation. R2 was redirected to his room. R8 received head to toe assess. Reddened area found. R2 had med adjustment recently from prior incident. 15-minute checks were implemented.

R2's EMR Progress Note, dated 12/27/19, documents the following: Resident (R2) was witnessed getting up out of w/c (wheelchair), walked over to (R8) and made contact to her chest with a closed fist. Residents were separated. (R2) was removed from area. Resident is currently in his room. 1 to 1 is initiated only when he comes out of his room. Will continue to monitor.

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R8's EMR Progress Note, dated 12/27/19 at 2:19 PM, documents the following: Resident (R8) was in w/c in dining room. Wandered close to (R2). He got up out of w/c and hit resident (R8) in the center of her chest with his fist closed. R8 was removed from area immediately. On my examination I noted a large red area in the center of R8's chest. No bruising noted. No other red areas noted. Will continue to observe. Doctor and Power of Attorney notified of incident. Will continue to monitor.

On 7/27/20 at 9:55AM, V1 stated the following regarding R2 and R8's incident on 12/27/19: V1 thought R2 was doing better due to the recent medication adjustment on 12/4/19. V1 did not think it was abuse because it was a resident to resident altercation. V1 stated it was too random to be intentional. R2 was placed on 15-minute checks and one on one when out of his room. No behavior modifications were done due to R2's brain injury, no interventions were attempted at this time. Because of R2's brain injury the staff was only able to do one on one supervision. V1 also stated that R2 was frequently combative with staff.

c. A report titled 'Incident Report Form-IDPH Notification, dated 3/19/20, documents R2 smacked R8 in the back. They were separated with no injuries. R2 was placed on 15-minute checks.

The 'Final IDPH and/or Abuse Notification' dated 3/19/20, documents the following: R2 was in the dining room with other assisted residents. R2 reached across the table and slapped R8. Staff immediately separated them. R8 received head to toe check. No injuries noted. R2 was placed on

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	IL6007975	A. BUILDING: _____ B. WING _____	C 07/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN MANOR	900 WEST RACE STREET RIDGWAY, IL 62979

(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
S9999	Continued From page 13 15-minute checks. R2's medications were reviewed. R2's EMR Progress Note, dated 3/19/20, documents the following: Res (resident) was out in dining room this morning and it was reported by staff that he (R2) hit another resident (R8), separated residents, discussed with res about how it is not appropriate to hit others. R8's EMR Progress Note, dated 3/19/20, documents the following: Res was in dining room waiting for breakfast, it was reported to this staff that another res (R2) hit her, assessed her for injuries, no injuries noted, res denies c/o's, separated residents from each other, will mx (monitor). On 7/28/20 at 9:55AM, V21 (Registered Nurse) stated that R8 was very afraid of R2, as R2 targeted her. V21 stated she never knew why he was aggressive toward R8 and would hit her. The only interventions we put into place is the one on one supervision when he was in the dining room. R2 was very fast in his wheelchair and he could slip by the nurse's station and enter the dining room where R8 often stayed. V21 stated she was working the day of this altercation between R2 and R8 occurred. On 7/27/20 at 10:05AM, V1 stated that she did not think it was abuse as it was not witnessed. R2 and R8 were not at the same table. R2 went to R8's table and slapped her, this was not witnessed by staff. On 7/28/20 at 8:35AM, V1 stated the incident on 3/19/20 was witnessed by V24, (CNA) but she did not see what caused the incident.	S9999		

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S9999	Continued From page 14	S9999		

On 7/27/20, V14 (CNA/Certified Nurse Aide), V15 (Housekeeping/Laundry), V16 (CNA), V4 (Registered Nurse), and V17 (CNA) all stated R2 was frequently combative and often targeted R8 while in the dining room. V14 stated that R8 has dementia and cannot defend herself. V17 stated that R8 never provoked R2.

4). A report titled 'Incident Report Form-IDPH Notification', dated 4/19/20, documents the following: R2 was in the dining room. R9 was in the dining room. R9 started yelling that he had been hit by R2 on the right side of his head by R2's fist. Residents were separated and assessed for injuries. Residents were 1 on 1 with staff while dining. The Incident Report Form-IDPH Notification documents the incident as resident to resident, no apparent injury, and physical abuse.

The final IDPH Incident and/or Abuse Notification, dated 4/19/20, documents the following: R2 was in the dining room. R9 was in the dining room. R9 began yelling that he had been hit by R2 on the right side of his face by R2's fist. They were immediately separated and assessed for injuries. No injuries noted. R2 was sent to a behavior center for medication adjustment.

R9's EMR Progress Note, dated 4/19/20, documents the following: Was alerted to the dining room by staff after res (R9) was heard yelling that he had been hit by (R2), res (R9) states that res (R2) hit him with his fist on the right side of his head, right ear red, some bruising is starting to develop and right side of face is red, no swelling noted, res (R9) denies any other injures or complaints, no other injuries noted, Administrator notified, MD notified, (POA) notified, DON notified, will mx (Monitor). R9's Progress note dated 4/20/20 documents the

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S9999	Continued From page 15	S9999		

following: Awakens easily to verbal stimuli. Denies any pain. Cont. with Bruising to right ear and right side of face. Will monitor further.

R2's EMR Progress Note, dated 4/19/20, documents the following: Was alerted to the dining room by staff, res (R2) allegedly hit (R9) with fist in the head per (R9); for unknown reason. Staff responded to (R9) yelling, (R9) was noted to have redness to right ear and right side of face, no injuries noted to res (R2) allegedly initiated incident, residents separated and staff 1:1 monitoring dining room, Administrator notified, POA notified, DON notified, MD notified, res assessed for injuries, no injuries noted, denies c/o's, res (R2) ate meal in dining room supervised then went to his room where he does not have a roommate, will mx.

R9's EMR MDS, dated 4/6/20, Section C - BIMS is scored a 5, indicating severe cognitive impairment. Section E- Behavior is rejects care and wandering. R9's EMR Diagnoses are Dementia, Major Depressive Disorder, and Schizophrenia.

On 7/27/20 at 10:00AM, V1 stated that there were no witnesses, with R9 stating R2 hit him. R2 was placed on one on one, abuse was not known due to the fact that R9 can provoke other residents. No interventions were put into place since R2 was going to a Behavioral Center for an inpatient stay in just a few days. R2 was admitted to the Behavior Center on 4/21/20.

5). The facility's Policy and Procedure on Resident to Resident Incidents dated November 5, 2015 documents under the heading, "Purpose"; To prevent repeated incidents and ensure appropriate reporting. The facility's Policy

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S9999	Continued From page 16 and Procedure on Abuse Prevention and Reporting, dated November 5, 2019 documents under, Policy Statement; Residents must not be subjected to abuse by anyone. In the second paragraph of this same policy, documents; The facility shall implement programs and interventions individualized to the resident. A	S9999		