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CITY VIEW MULTICARE CENTER	5825 WEST CERMAK ROAD CICERO, IL 60804

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S 000	Initial Comments Complaint Invesigations: 2194930/IL135944 2194663/IL135601 2195323/IL136420 2195167/IL136239 2195486/IL136609 Facility Reported Incident Investigations of: 07-13-21/IL136406 07-14-21/IL135995 07-30-21/IL136632 Annual Survey exited 08/25/2021 cites the same findings.	S 000		
S9999	Final Observations 1 of 3 Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 300.3240 Abuse and Neglect a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999		

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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 are not met as evidenced by:

Based on interview and record review, the facility failed to prevent a cognitively impaired resident (R2) from being coerced by another resident (R3) to perform an oral sexual act on him, failed to prevent a female resident (R11) from being inappropriately touched by a male resident (R12) and failed to prevent a resident (R6) from being physically and mentally abused by facility's security staff members (V38, V39), as outlined in the facility's abuse policy. This applies to 3 of 6 residents (R2, R6, R11) reviewed for abuse.

As a result, R2 was allowed to engage in a sexual act without knowing the consequence of her actions, R11 was forced to experience a violation of her personal space and body and R6 was pushed, threatened and subjected to the use of inappropriate language.

Findings include:

R2 had a diagnoses of Schizophrenia, Schizoaffective, and Psychosis. R2's Brief Interview for Mental Status (BIMS) dated 7/3/21 documents a score of five which indicates severe

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S9999	Continued From page 3 cognitive impairment. R2's Care plan dated 7/16/21 documents: R2 demonstrated cognitive impairment related to mental illness. Nursing note dated 7/3/21 documents: Approximately 9:45pm, R2 was observed in room with a co-resident. R2's face was toward R3's private area. On 8/4/21 at 1:15pm, R2 who was assessed to be confused and unable to report, or even answer questions about the incident dated 7/3/21. On 8/6/21 at 2:14pm: V4 (Social Service Assistant) stated, R2 is confused and cannot make her own decisions. On 8/10/21 at 12:13am, V1 (Administrator) said, V5 (Certified Nurse Aide/CNA) walked into R2's room, observed R2 looking at R3's private area. I spoke with R3 who stated, R2 performed oral sex on R3. We substantiated the allegation of abuse. On 8/13/21 at 1:31pm, V51 (PRSC) said, R2 is not able to make decision for herself. R2 is not able to give consent for sexual activities nor would I call R2's family for consent for R2 to have sex. A BIMS score determines the cognitive level of a resident. A BIMS score of 00 -07 requires full assistance with decision making. The decision making is done by the Power of Attorney (POA)/Guardian. Facility reportable incident sent to IDPH dated 7/3/21 documents: R2 was observed in the room with R3 with face towards R3's private area.	S9999		

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Hospital paperwork dated 7/3/21 document: R2 was discharged to the hospital for inappropriately touching a male resident.

R3 had a diagnosis of Schizophrenia and Bipolar. Brief Interview for Mental Status dated 6/8/21 documents a score of fifteen which indicates cognitively intact. Care plan dated 7/20/21 documents: R3 exhibits sexually inappropriate behaviors manifested by attempting to take advantage of peers who lack ability to consent. R3 who was observed and assessed to be alert to person, place and time during the investigation.

On 8/3/21 at 11:56am, R3 said, I put my penis in R2's mouth. It was consensual. R2 performed oral sex on me.

Transfer form dated 7/3/21 documents: Behavior- R3 touched co-resident inappropriately, placed on 1:1, R3 sent to hospital for evaluation.

Hospital paperwork dated 7/4/21 documents: R3 was sent to the hospital for inappropriately touching another female resident.

Police report dated 7/15/21 documents: R3 admitted to allegedly having sexual contact with a co-resident (R2) on 7/3/21.

Reportable Incident dated 7/3/21: Addendum 7/15/21: R3 reported that he had allegedly had a consensual sexual relationship with R2.

R11 was admitted to facility on 2/12/21 with a diagnosis of Schizoaffective Disorder, Bipolar Disorder, Hypertension, and Anemia.

R11's Brief Interview for Mental Status dated

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S9999	Continued From page 5 7/29/21 documents a score of 15/15 which indicates cognitively intact. R11's progress note dated 7/13/21 documents: R11 was in the dining area wiping off tables when she was touched inappropriately by a peer. On 8/3/21 at 11:10 am, R11 who was alert and oriented at time of interview said, a male resident touched her buttocks while she was in the dining room. R11 said anyone that touched her inappropriately without her consent is in violation of her personal space. On 8/4/21 at 2:40pm, V17 (Psych Tech) said, he witnessed R11 in common dining room and R12 touched her buttocks. V17 said he separated the residents and informed nurse. Facility's final abuse report dated 7/18/21 documents under conclusion: It was reported R12 allegedly touched R11 in an inappropriate manner. R12 stated he did not want to talk about it. R11 stated R12 tapped her on the behind as he was walking past. Staff that was present also stated that he tapped her as he was walking past R11 and R12 was redirected immediately. Under witness statement for R12 documents: R12 stated he doesn't know why he touched R11's behind when walking past her. R12 said he was very sorry. R12 was admitted to facility on 4/14/21 with a diagnosis of Schizophrenia, Hypertension, and Lack of Coordination. R12's Brief Interview for Mental Status dated 7/28/21 documents a score of 15/15 which indicates cognitively intact.	S9999		

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R12's progress note dated 7/13/21 documents: R12 was observed by staff touching female peer on buttocks in dining room. Per R12 "I need some p****." Resident separated for safety.

On 8/3/21 at 4:01pm, R12 who was alert and oriented to self, said he grabbed a resident's butt on the 4th floor, and she slapped him. R12 refused to give any further details.

On 8/4/21 at 2:40pm, V17 (Psych Tech) said he witnessed R11 in common dining room and R12 touched her buttocks. V17 said he separated the residents and informed nurse.

R12's local hospital record dated 7/13/21 documents under patient notes: When asked why R12 was sent to the hospital, R12 stated "I touched other patients butt and I regret what I did. I did not know why I did it."

Facility's final abuse report dated 7/18/21 documents under conclusion: It was reported R12 allegedly touched R11 in an appropriate manner. R12 stated he did not want to talk about it.

R11 stated R12 tapped her on the behind as he was walking past. Staff that was present also stated that he tapped her as he was walking past R11 and that R12 was redirected immediately. Under witness statement for R12 documents: R12 stated, he doesn't k now why he touched R11's behind when walking past her. R12 said, he was very sorry.

R6 was admitted to the facility with the diagnosis of Schizophrenia. Minimal Data Set (MDS) dated 5/24/21 Brief Interview for Mental Status documents a score of thirteen which indicated

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S9999	Continued From page 7 cognitively intact. Nursing note dated 7/27/21 documents: R6 alleged he was verbally abused in the elevator by staff. R6 reported staff used swear words at him. On 7/30/21 at 2:37pm, R6 who was assessed to be alert to person, place and time said, I was getting on the elevator, when V39 (Security) pushed me and said, get your as* off the elevator. V38 (Security) stepped off the elevator and said, Nigg** I'm going to beat your as*. We stood in a fighting stance face to face. On 8/10/21 at 12:13pm, V1 (Administrator) said, V38 was terminated for verbal abuse toward R6. On 8/17/21 at 2:26pm, V39 (Security) said, I did not speak inappropriately to R6. V38 (Security) got off the elevator and told, R6 he would whip his as*. V38 (Security) stood face to face with R6 in a fight stance. Final reportable incident dated 7/27/21 documents: V38 and V39 spoke inappropriately to R6. R6 was concerned with V38 who appeared to be aggressive. V39 said, V38 spoke inappropriately to R6. V39 was allowed to return to work and will be assigned to a different floor than R6. V38 will not be returning to the facility. Employee Disciplinary Action Form dated 8/3/21 documents: V38 (Security) failed to follow employee handbook category 1 number 1 stating resident abuse (verbal or physical) for incident that happened on 7/27/21. Employee will be terminated without any privileges to be rehired. Employee handbook documents: Category 1 offenses are most serious and subject to the employee's immediate discharge without rehire privileges. The following are category 1 offenses:	S9999		

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S9999	Continued From page 8 #1. Resident abuse (verbal or physical). V38 was unable to be reached during this survey. Facility policy titled "Abuse prevention program" revised 9/17/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. Abuse: The willful infliction of injury. Unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Verbal Abuse: any use of oral, written or gestured language that included disparaging and derogatory terms to resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. (B) 2 of 3 Statement of Licensure Violation: 300.610a) 300.1210d)6) 300.2210 a) 300.2210b)2)3) 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	S9999		

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S9999	Continued From page 9 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 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 300.2210 Maintenance a)Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. b) Each facility shall: 2)Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. 3)Maintain all electrical cords and appliances in a safe and functioning condition. These requirements were not met as evidenced	S9999		

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S9999	Continued From page 10 by: Based on observation, interview and record review, the facility failed to monitor and supervise residents to prevent unsupervised smoking in the building and to prevent contraband smoking materials from coming into the facility (R8, R23), failed to provide a safe environment by leaving electrical wires exposed and maintain safe electrical outlets in resident's room (R27, R28, R29, R30, R32, R33, R34, R35, R36, R37), and allowed residents to put foil into electrical outlets to ignite a spark to light smoking materials (R8, R23, R31). Findings include: R8 was admitted on 12/14/17 with a diagnosis of Schizophrenia. R8's progress note dated 7/12/21 documents: resident noted with broken electric cables attempting to ignite fire to light a cigarette butt. R8's progress note dated 7/26/21 documents: using improvised devices to light fire in the bedroom, danger to self and others. Transferred to hospital. R8's petition dated 7/26/21 documents: using electrical cables to set fire in the bedroom. R8's hospital record dated 7/26/21 documents: R8 stated," I was trying to use the electrical cords to light toilet paper so I can smoke weed and crack." Hospital record dated 7/27/21 documents positive finding of cannabis. On 7/26/21, R8 said he was trying to light a	S9999		

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cigarette by using the electrical wires from the over the bed light in his room. R8 said he removed the wires but was unable to describe how he removed the wires. R8 said he put the wires into the electrical outlet and had toilet paper near the outlet to catch fire to light his cigarette. R8 said he had a cigarette from a previous smoke break. R8 then demonstrated how he lit the cigarette, R8 sat on the floor near the electrical outlet and pulled the privacy curtain near the outlet. R8 put his face near the outlet to catch the flame. R8 said this time the privacy curtain was too close to the outlet and was set on fire. R8 had to put it out with his hands and wet towel.

On 8/10/21 at 3:21pm, R8 said he called a suppler (R8 refused to give name or description) who would meet him in the common outside patio, where he would receive marijuana. R8 said he would return into the building and was never searched or questioned.

On 8/3/21 at 3:30pm, R8's previous room was observed with black soot around one outlet. The electrical outlet was observed with an object sticking out which was confirmed by V11 (Maintenance Director) to be a piece of foil. V11 and V35(Maintenance) said they were unaware of any concerns related to the electrical outlets in R8's room but residents in the building will stick things in the outlets to ignite a spark so they can light a cigarette
R8's smoking assessment dated 4/18/21 documents: May not be capable of handling/carrying any smoking materials and requires supervision when smoking.

R23 was admitted on 8/18/10 with a diagnosis of Schizoaffective Disorder, Bipolar, and Asthma.

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R23's smoking assessment dated 4/18/21 documents: May not be capable of handling/carrying any smoking materials and requires supervision when smoking.

R23's care plan dated 12/24/20 documents: R23 as an identified offender with history of aggravated arson 1996 and considered high risk.

R23's progress notes dated 7/26/21 and 7/27/21 document had no unsafe use of electrical wire by V37(Nurse). R23's progress note dated 8/8/21: R23 using cables to light cigarettes in R29-30's room.

On 8/10/21 at 4:30pm, V37 said R23 was in the room when the incident with R8 happened on 7/26/21 but was unable to provide any other information related to incident. R23 was unable to provide any additional information about incidents and denied any involvement.

On 8/5/21 at 4:45pm, R23's room was observed with black soot around one outlet in the room. The hospital bed in the room was observed with cord that had been cut with exposed wires.

V11(Maintenance Director) said the outlet had black soot around it which indicates that something was placed in the outlet causing a spark. V36 (Maintenance) said that this behavior is happening all over the building and residents are using foil from food deliveries to stick in the outlets to light cigarettes.

On 8/6/21 at 12:34 pm, R27-28 room had two over the bed light frames on the wall. Within the frame of the lightening device there were two electrical outlet plugs that had black soot on

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S9999	Continued From page 13 them. At 12:44pm, R29-R30's room was observed with two exposed wires from the over the bed the light and one electrical outlet with black soot. At 12:51pm, R31's room had one outlet with black soot and small piece of foil, observed along with exposed wires from the over the bed light. At 1:06pm, V11 confirmed that it was a piece of foil in the outlet in R31's room. At 1:12pm, R35's room had exposed wires from one of the over the bed lights. At 1:14pm. R32-33's room had paper stuffed into the electrical outlet and exposed wires from one of the over the bed lights. At 1:15pm, R34's room was observed with four exposed wires from the over the bed light and one electrical outlet with black soot. At 1:20pm, R36-37 had two exposed wires from the over the bed lights. On 8/10/21 at 2:04pm, R29-30's room had an outlet blackened with soot with a small object within the outlet. On 8/19/21 10:50am, R27-R28's room was observed with soot covered outlets and two lightening fixtures over the bed which had been previously observed on 8/6/21. At 11:02am R29-R30's room had new observations of foil and an unknown object protruding from one ceiling outlet. On 8/5/21 at 1:47pm, V11 (Maintenance) said he	S9999		

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S9999	Continued From page 14 has been at facility for about 2 months. V11 said about a month ago residents removed fire lights in a bathroom on the 5th floor. V11 stated staff do not report when these incidents occur. Maintenance staff will find outlets burnt or cut electrical cords from televisions or over the bed lights randomly. V11 said they do not do any daily inspections because there is not enough staff. V11 said he has replaced about 20 outlet covers in 2 months but unable to provide any record of replacements or where they were replaced. On 8/10/21 at 10:00am, V11 said he was aware that there was a concern related to residents placing cords/foil in the outlets. V11 stated there is a possibility of fire if the breaker does not cut the power supply to the outlet. It is possible to get an electrical shock from the outlet if placing objects into the wall but V11 states he has not seen or heard of anyone getting hurt. V11 said they have not done any audits of the rooms but claimed to be placing wall plates over the outlets since June. When asked what rooms they were placed in, V11 was unable to recall specific rooms, unable to produce a log of replacements or receipts of purchases of items. V11 said he has replaced a cover on 8/6/21 on the seventh floor. On 8/10/21 at 10:25am, V35(Maintenance) said he has not placed any wall plates on outlets but replaced the outlet cover in R29's room on 8/3/21. On 8/10/21 at 10:34am, V36(Maintenance) said he has only placed one wall cover on 8th floor.	S9999		

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S9999	Continued From page 15 On 8/11/21 at 204PM, V55 (Electrician) said he has never heard of foil being placed in outlets not sure what will happen. If there are observations of blackened areas around the outlet, it indicates there was some kind of fire near the outlet. In most cases the circuit breaker will trigger which will turn off the power supply to prevent fires or electrocution but there is always a chance that someone could be injured. Facility policy titled: Physical plant weekly inspections undated documents under electrical inspections: All receptacles and switches shall be inspected for cracks, condition of cover plates and any signs of shorts. 8/6/21 at 2:14pm, V4(APRSD) said all smoking materials are held by staff and no resident is allowed to smoke independently. Facility policy titled smoking policy undated documents: There will be no smoking permitted inside the facility. All resident smoking material will be kept by the facility in a secure location. All smoking remnants will be discarded into approved receptacle by staff or under staff supervision. Residents will have no smoking materials in their possession. Facility policy titled Search and Confiscation Policy undated documents: The facility has right to search belongings and person if there is reasonable suspicion that contraband is being brought into the facility. Items that are considered harmful or unsafe for the resident will be destroyed. Prohibited items include but not restricted to the following list: cigarettes, cigars, loose tobacco, lighters, sharps, razors, scissors,	S9999		

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S9999	Continued From page 16 knifes or items considered a possible danger. (A) 3 of 3 Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999		

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S9999	Continued From page 17 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. 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 18 These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to have an effective 1:1 monitoring system in place, failed to implement their crisis prevention intervention protocol to de-escalate an incident of self-injurious behavior for 1 of 1 residents (R1) reviewed for supervision. This failure resulted in R1 being able to pry off a heating vent and stabbing herself in the abdomen while under 1:1 supervision by facility staff and R1 to being sent to the local hospital for treatment. Findings include: R1 admitted to facility on 5/12/21 with diagnoses of Schizoaffective Disorder, Major Depressive Disorder, Schizophrenia, Unspecified Psychosis, Paranoid Personality, Delusional Disorder, Auditory Hallucinations, and Post Traumatic Disorder. R1's plan of care dated 6/12/2021 shows R1 has a history of self-harmful & self-mutilation ideation (thoughts) and/or behavior. R1's interventions dated 6/7/21 include: As warranted, conduct, random room safety checks, personal wellness checks, and behavior monitoring of resident. Interventions dated 5/21/21 include conduct appropriate assessments upon admission. Review transfer record, including screening to determine any history of self-harm; encourage resident to seek help of staff when in distress. Facility incident report dated 5/21/2021 documents: An incident occurred in R1's room,	S9999		

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S9999	Continued From page 19 R1 admitted to stabbing herself with a pen. A complete body assessment revealed pen stuck in resident stomach. 911 called. No witnesses found. Facility incident report dated 6/4/2021 documents: An incident happened in R1's room. R1 observed with open area to abdomen and small amount of bleeding noted. R1 had broken pieces of pencil in her hand. R1 stated she stuck a pencil in her stomach. Facility incident report dated 6/17/2021 documents: An incident occurred in R1's room, call to room by CNA, R1 stated she swallowed a key. No witnesses. Facility incident report dated 6/30/2021 at 12:54 AM documents: An incident occurred in R1's room. R1 was noted with self-inflicted skin tears on left wrist and lower abdomen with plastic spoon. R1 stated, "I do not want to be here, just take me to the hospital."911 called. No witnesses found. Progress note dated 7/14/21 documents: R1 was readmitted to the facility from local hospital around 1:00PM. Progress notes dated 7/14/2021 at 17:32 documents: V8 Nurse was doing petition to send R1 to hospital. R1 stated she was giving V8 ten minutes to get R1 out of the building. I sent V5 (CNA) to closely monitor. V5 (CNA), yelled for (V8) to come to R1's room. V8 observed blood coming from R1's abdomen. R1 had a sharp object in her hand. V8 stated I tried to get R1 to give me the object, R1 tried to cut me with the object. I called security to get the object.	S9999		

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S9999	Continued From page 20 A facility incident report dated 7/14/2021 documents: At 4:45pm, V8 was preparing petition to send R1 to the hospital, V5 (CNA-Certified Nursing Assistant) placed at room to closely monitor R1. Witness statement from V5 documents: R1 grabbed a sharp object when I tried to take the object R1 started to cut at me with it. Then R1 took the object and cut her stomach. Witness statement from V8 documents: Observed R1 with blood coming from her stomach. R1 had a sharp object when I tried to take it from her, the resident tried to cut me with it and said she will cut my throat with it. On 7/20/21 at 5:04p.m. V5 said she was told by the nurse that R1 needed 1 to 1 monitoring, V5 said, she was in the room standing behind R1 when R1 pulled the vent off the radiator in the room, R1 then turned to V5 and began to wave the object in front of V5 face while saying I will cut you. V5 said, she yelled out for help and was asking R1 to put the object down and or give her the object. V5 said, R1 did not give her the object but then took the object and cut herself in the abdomen area. V5 said, R1 then dropped the object. V5 said, the nurse arrived and stayed with R1 while she went to call a code gray. V5 said, R1 needed 1 to 1 observation because R1 harmed herself in the past, by swallowing a key and cutting herself with a plastic spoon. On 7/21/2021 at 1:28PM, V5 said, when she was monitoring R1, R1 walked to the nurse station, R1 stated, to V8 "you have 10 minutes", V5 said, she did not know what R1 was talking about. V5 said, V8 told her to watch R1 closely and she continue to follow R1 to her room. V5 said, while in R1's room, V5 was sitting in a chair, she saw R1	S9999		

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standing at the window, R1 was leaning forward a bit. V5 said, she saw R1 hands moving near the radiator vent. V5 said, she stood up and walked toward R1's back, R1 continued to have hand movement while leaning toward the radiator vent. V5 said, she never asked R1 what she was doing, nor did she redirect R1 at that time. V5 said, she heard a click sound and that's when R1 turned around toward V5, R1 had the radiator vent in her hand and began to wave it at V5, while saying " I will cut you b####". V5 said, she then asked R1 to put the object down and give it to her (V5). V5 said, R1 then raised her shirt and cut herself in the stomach area. V5 said that's when she yelled for help. V5 said, she did not yell for help prior to R1 cutting herself and she did not call code gray when she saw R1 by the window "doing something with her hands" When asked if R1 was trying to remove the radiator vent when V5 observed R1 "moving her hands near the radiator vent" V5 would not respond.

On 7/20/21 at 1:20PM, V8 said, she arrived at the facility for her shift around 3:00pm on 7/14/2021, as she got on the elevator, V8, R1 and V5 got on with her. V8 said, she was informed by V5 that R1 needed 1 to 1 monitoring, V8 said, once on the 8th floor, she informed V5 to closely monitor R1 when they got off the elevator. V8 said, close monitoring and 1:1 observation is the same thing. V8 said, close monitoring and/ or 1 to 1 observation is when the staff keeps an eye on the resident, the staff can sit outside the room or the staff can go in the room as long as they watch the resident. V8 said, maybe 15 minutes after 3:00pm, R1 and V5 approached the nurses' station and R1 said " you have 10 minutes to get me out of here or I will hurt myself" V8 stated, she told R1 okay, I'm working on it and you don't have to do that. V8 said, R1 and V5 returned to R1's

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S9999	Continued From page 22 room. V8 said she does not know if V5 was inside the room with R1 or standing on the outside of the door of R1's room. V8 said, she placed a call to the physician and the physicians plan was to petition R1 for evaluation as she was preparing the involuntary petition. V8 said, about 15 minutes later she heard V5 yelling out for help. V8 said when she went to R1's room, she observed R1 bleeding from the stomach area. V8 said R1 was bleeding "bad there was a lot of blood", V8 said, she observed blood on R1's shirt, pants and the floor. V8 said, she saw a horizontal laceration to R1's stomach however she did not complete an assessment of the wound because R1 would not allow her to. V8 said, she then informed V5 to get help, and she heard V5 announce a code gray. V8 said, R1 would not put the sharp object down when she asked R1 to put the object down. V8 said, R1 waved the object in her face stating, "I will cut you". V8 said, R1 did not put the sharp object down until the two male staff arrived and that's when R1 handed the object to V12 (Security). V8 said, R1 would not allow anyone from the facility to assess her injuries or render first aide, R1 continued to say "do not touch me" V8 said, she left the room and called 911. V8 said, the paramedics arrived and put R1 on the stretcher. V8 said, she does not know if the paramedics rendered first aide to R1. On 7/20/21 at 1:20PM V8 said, she knew R1 required 1 to 1 monitoring because she was informed of this and also, she used her judgement to determine R1 needed 1 to 1 monitoring because R1 has harmed herself about 3 times when she worked with R1. V8 said, R1 does not want to be in the facility, and she hurts herself when she wants to go back to the hospital. V8 said, she did not call code gray when R1 said, she was going to hurt herself.	S9999		

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R1's local police report dated 7/14/2021 at 4:47p.m. documents: Police were dispatched to a call of psychological evaluation at the facility. Local police dispatch advised that a resident cut herself in her stomach with a razor and still had it in her hand. Upon arrival, along with the local paramedics went to the eighth floor where the resident was located standing near security. The resident was identified as R1. V5 devised that R1 had been discharged from hospital on the above date and was admitted to the facility. V5 related that R1 appeared to be distraught upon arrival and aggressive. While in her room, V5 advised that R1 began cutting herself with a razor. V5 provided the said razor, which in fact was an air vent from the room.

Officer was able to locate the A/C unit in the room with the missing vent. As V5 walked into R1's room, she observed her cutting her lower stomach area and yelled at V5 to leave her alone. The air vent was ultimately removed from R1's hand before the police arrival. V5 further added that R1 has an extensive history of harming herself, as she was said to have swallowed pills, keys, and cut herself in the past. Officer took eight digital photographs of R1's room, the observed blood, air vent used to self-harm and A/C unit with missing vent. The photographs have been attached to the incident report. R1 was transported to local hospital for further medical treatment.

On 7/20/21 at 5:50PM, the surveyor observed one picture in the police report of the object that R1 used to cut her abdomen. The picture showed a rectangular object which looked like the vent cover that was observed in the facility. The vent cover was noted to have coagulated blood near

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S9999	Continued From page 24 one corner of the surface which covered approximately a fourth of the vent cover. On 7/20/21 at 1:53 PM. while accompanied by V11 (Maintenance Director), the surveyor observed the radiator unit in R1's room listed on the incident report, there was a gray radiator /air conditioner unit noted in front of the window. The unit had 6 vents in place on top of the unit, there was an opening noted to the right of the unit (front facing). V11 said, there was a vent missing from the radiator/ air conditioner unit, V11 said, there's six vents and it should have seven vents on top, also there should be a door where the open area is on the unit. R1's Local hospital record dated 7/15/21 documents: R1 was admitted due to self-inflicted stab wound to abdomen with piece of furnace to a previous stab-wound site on abdomen. Under abdomen documents: 8cmx 2 cm x 3cm depth. On 7/20/21 at 4:34p.m V3 (Social Service Director) said 1 to 1 observation and close monitoring are two different types of observations. V3 said 1 to 1 observation (monitoring) is used when a resident threatens harm to self or others. V3 said, during 1 to 1 observations staff should be within arm's length of the resident. V3 said the staff should have visual control of the resident, they should be able to see what the resident is doing with their hands, staff must accompany the resident at all times and if the staff need a relief, the staff must wait for coverage, staff should never leave the resident alone. V3 said close monitoring are frequent rounds, staff does not have to stay with the resident at all times. V3 said he does not know how often staff should conduct rounds during close monitoring observations. V3 said	S9999		

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S9999	Continued From page 25 staff is trained in CPI (Crisis Prevention Intervention), CPI is a non-violent crisis intervention used to deescalate a situation with a resident. V3 said CPI is used when the resident is past the point of de-escalation, when the resident is physically acting out towards others, when residents try to harm themselves or others. V3 said when a resident says they will hurt themselves, staff should seek help from the Social Worker, the Social Worker will then counsel the resident, and the Social Worker would get the nurse involved to contact the physician for orders. V3 said R1 has known behavior of hurting herself. V3 said R1 required 1 to 1 observation because of her behaviors of self-harm. V3 said he was not there when the incident occurred but what he understands is that R1 was on 1:1 observation when R1 removed an object from the A/C unit in her room and cut her abdomen with the object. V3 said the facility failed R1 during this 1 to 1 observation because R1 cut herself while she was on a 1 to 1 observation. V3 said R1 should not have any sharp objects in her room or in her possession, nor can she have any objects that she can use to inflict harm to herself with. V3 said R1 is a danger to herself and others. On 7/21/21 at 11:19a.m V3 said it is difficult for the facility to conduct an assessment on R1's behaviors, triggers and manage her because R1 usually is discharged shortly after her admissions to the facility. V3 said the 8th floor where R1 resides has not had a social worker for 2 months, V3 said he just acquired that unit along with his assistant. V3 said R1 is managed with 1 to 1 observation. V3 said the facility has given R1 a 30-day notice. On 7/20/21 at 12:30PM V4 (Social Service Assistant) said he was informed that R1 cut herself with a sharp object that she removed from	S9999		

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	IL6009948	A. BUILDING: _____ B. WING _____	08/24/2021

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S9999	Continued From page 26 the air conditioning unit in her room. V4 said R1 has behaviors of self-harm. V4 said R1 requires 1 to 1 observation at all times because of her behavior of self-harm. On 7/20/21 at 3:15p.m V10 (ADON- Assistant Director of Nursing) said the facility does not have a policy for 1 to 1 observation. V10 said, 1 to 1 monitoring/observation are for residents that are at risk for self-harm or harm to others. V10 said when a resident is on 1 to 1 observation the staff should be within arm's length of the resident, the staff should be in eye view of the resident and be able to see what the resident is doing with their hands, V10 said the staff should be able to touch, grab and intervene if something happens. V10 said 1 to 1 observations are conducted to prevent the resident from harming themselves and others. V10 said when V5 saw R1 standing at the window and "moving her hands near the radiator vent" she would have expected V5 to redirect R1, ask R1 what she was doing and also to redirect/stop what she was doing, V10 said she would not have expected V5 to call a code gray unless R1's behavior was escalating. R1's hospital record dated 7/14/21 at 920AM documents under psychiatric progress note history: R1 more towards baseline. She does have 2 sitters because she's very impulsive. Under short term goals dated 7/13/21 documents: Self injury- R1 seems to be injuring herself for strategic purposes that are unrelated to any suicide attempts or gestures. R1 purposely injures herself to this extent. Under 1:1 (monitoring) sitters- R1 has two sitters for 1:1 (monitoring), the physician has allowed her to use paper cups. Under contracting for safety- R1 is cooperative and pleasant but continues to behave in this manner and will remain on 1:1(monitoring)	S9999		

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S9999	Continued From page 27 for safety precaution. R1's electronic records showed no documentation of a completed screening assessment for evaluating of self-harm/suicide risk and screening assessment for indicators of aggressive and/or harmful behavior from the initial date of admission on 5/12/21 to current admission of 7/14/21. On 7/21/2021 at 12:45p.m V3 (social service director) said upon admission and readmission residents have a screening assessment for evaluating self-harm/suicide risk and for indicators of aggressive and/or harmful behavior. V3 said he did not observe an assessment conducted for R1. Facility undated policy titled, Guidelines for Handling and Addressing Behavioral Emergencies noted, in part the first step involves recognizing and handling the behaviors in the earliest stages, assess whether the anger/acting out is related to mental illness, dementia or other probable and perhaps transient factors. The escalating resident, staff need to be aware of how likely a resident is to lose control and exhibit a behavior- especially a behavior that might escalate- this comes from knowledge obtained on resident assessment as well as the care plan. It will need to be clear which staff member will be in-charge of escalation of behavior- the staff will follow the lead of the designated staff member in charge. Residents displaying a behavior need to have a staff member with them from time of the onset of the behavior until it is resolved or managed. This supervision maybe able to be reduced to lesser supervision such as every 15 minutes checks, depending on the ability of those involved to provide successful care and	S9999		

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S9999	Continued From page 28 interventions to resolve the behavior. The duration of 1:1 supervision or every 15 minutes checks will be based on each individual resident/situation. Determine and define if there is history of aggressive and/ or unpredictable behavior. Attempts need to be made to quantify (measure) the resident level of upset or anger. Is the resident making threats or exhibiting motions that suggest they intend to inflict harm towards another person (s)? Immediately approaches, If the resident does not seem to start to calm down quickly call for assistance. If it appears that the resident is likely to harm themselves or others call a "Code Gray" This will alert available staff to come to assist as needed and also this notification lets staff know to deter residents from going to this area as well as alerting staff not to take any residents to that area. Remember there should be adequate staff dealing directly with the resident. Every resident behavior will be assessed and addressed individually. There is no standing program for behavior prevention. Be sure that the assessment and care planning and medication reviews as well as the individualized activity programs for residents with behavior issues are done accurately and timely. Facility policy titled "Standard Supervision and Monitoring" dated 6/10/20 noted in part these guidelines emphasize a proactive intervention promoting enhanced physical and psychological well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs. At any time that the resident is being supervised or redirected during, the direct care staff member may need to redirect the resident through verbal and physical guidance and or care. If the resident cannot be guided,	S9999		

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S9999	Continued From page 29 supervised, or redirected during intervals of rounds the resident may require 30-minute, 15-minute, or 1:1 supervision. The physician/psychiatrist will be notified for further evaluation and treatment to further assess and treat the resident if increased supervision and guidance is required. (A)	S9999		