STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009237	A. BUILDING: _____ B. WING _____	C 08/12/2021

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EASTVIEW TERRACE	100 EASTVIEW PLACE SULLIVAN, IL 61951

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S 000	Initial Comments Investigation of Facility Reported Incident of 7/3/21/IL136510	S 000		
S9999	Final Observations Facility Reported Incident of 7/3/21/IL136510 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 300.1220b)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.	S9999		

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S9999	Continued From page 2 Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These regulations were not met as evidenced by: Based on observation, record review and interview, the facility failed to develop and implement effective behavioral interventions for R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R12, each with a known cognitive impairment. These failures resulted in repetitive instances of resident to resident physical abuse to R1, R5, R6, R7, R10, R11 and R12. These failures put these residents at continued risk for engaging in ongoing behaviors resulting in physical violence to one another. Unmitigated behavioral interventions could result in residents sustaining severe, life-threatening, or fatal injuries. Findings include: The facility policy titled "Abuse Prevention Program" dated 11/16/16 documents the following:	S9999		

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S9999	Continued From page 3 "Procedures for Prevention" Establishing am environment that promotes resident sensitivity, resident security and prevention of mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property; including, prohibiting staff from using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to keep, or distribute photographs and recordings of residents that are demeaning or humiliating. Procedures for Prevention: Dementia management and resident abuse preventions; including, How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff;" Establishing a Resident Sensitive Environment: Resident Assessment: As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis. 1.) A facility Incident Report dated 6/5/21 documents the altercation between two residents (R9 and R10 as follows: V10, Certified Nursing Assistant witnessed R10 yell at R9 because R9 was standing next to R10. R9 then hit R10 with	S9999		

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S9999	Continued From page 4 an open hand on R10's back. The incident occurred in the front lobby of the facility. A facility Incident Report dated 6/8/21 documents an altercation between the above same residents (R9 and R10) as follows: V14, Speech Therapist witnessed R9 walk up behind R10 and push R10's wheelchair. R10 asked R9 to stop pushing R10's wheelchair. R9 then hit R10 in the back twice with R9's fist. This incident occurred in the front lobby of the facility. R9's Physician Order Sheet (POS) dated August 2021 documents R9 with the diagnosis of Dementia with Behavioral Disturbances. R9's Minimum Data Set (MDS) dated 6/30/21 documents R9 as severely cognitively impaired R9's Plan of Care (current) R9's Plan of Care (current) documents a problem area of disruptive/inappropriate behaviors towards staff and residents at times. Approaches are documented as "Determine if behavior is stimulated by dertain (sic) activities, noise levels, persons involved, time of day. Gain attention of Resident by using name. Talk with resident in calm manner. Redirect to area where others will not be distracted." The Care Plan does not address R9's physical aggression toward other residents. R9 does not have an Abuse Risk Assessment or a Social History Assessment in the Medical Record. R9's facility Behavior Tracking Forms dated for May 2021 document a targeted behavior of physical aggression and documents R9 with this behavior on 5/4, 5/5, 5/7, 5/10 and 5/13/21. June 2021 Behavior Tracking Form also documents a Targeted behavior of physical aggression and R9	S9999		

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S9999	Continued From page 5 exhibiting this behavior toward R10 on 6/8/21 only (there is no documentation of R9's physical aggression toward R10 on 6/5/21 per the facility Incident Report dated 6/5/21). July 2021 Behavior Tracking Form with the targeted behavior of physical aggression documents R9 exhibiting this behavior on 7/1, 7/3, 7/7, 7/9, 7/12 7/17/21. There is no documentation on this form correlating R9's physical aggression on 7/15/21 toward R12 per the facility Incident Report dated 7/15/21. R10's POS dated August 2021 includes a diagnosis of Dementia with Behavioral Disturbances. R10's MDS dated 5/24/21 documents R10 as severely cognitively impaired. R10's Plan of Care (current) includes Behaviors of physical abuse, refusal of care and manipulation. Approaches include "initiate behavior monitoring program, Use consistent calm approach, Maintain a Calm Environment." R10 does not have an Abuse Risk Assessment or Social History Assessment in the Medical Record. R10 had no Behavior Tracking Forms for review. 2.) A facility Incident Report dated 6/27/21 documents an unwitnessed altercation between R1 and R8. V15 Housekeeper found R1 on the floor of R8's room and reported it to V2 Assistant Director of Nursing. V2 responded and upon entrance to R8's room R1 was on the floor and R8 told V2 that R8 had pushed R1 down. Assessment of R1 showed some redness to R1's left upper back. R8's POS dated August 2021 includes a diagnoses of Dementia with psychosis.	S9999		

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S9999	Continued From page 6 R8's MDS dated 7/6/21 documents R8 as severely cognitively impaired. R8's Plan of Care (current) documents a care area of Behaviors that includes physical aggression and wandering. Approaches include "Resident will calmly accept redirection, Initiate Behavior Monitoring, Use consistent calm. firm approach, Maintain a calm environment, Review abnormal behaviors with Interdisciplinary Team." R8 does not have an Abuse Risk Assessment or a Social History Assessment in the Medical Chart. R8's Behavior Tracking Form dated for June does not document R8's physical aggression toward R1 on 6/27/21 (per the facility Incident Report of 6/27/21). There is documented wandering throughout May, June and July 2021. R1's Physician Order Sheet (POS) dated August 2021 documents R1 with Dementia and wandering behaviors. R1's MDS dated 7/13/21 documents R1 as severely cognitively impaired. R1's Plan of Care (current) documents a problem area of Wandering - Resident walks all day and will go into other resident's rooms (started 10/29/20). Approaches - Provide supervision, approach calmly, offer assistance and attempt to redirect, Provide opportunities to go outside with supervision, Walk with resident to accomplish a purpose such as greet others, Redirect when entering other rooms, Intervene as needed with others residents to prevent altercation, Post pictures of resident at other nursing stations to let them to provide supervision and assistance as needed, Ask all staff to notify nursing if resident found in other areas of the building and requires	S9999		

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S9999	Continued From page 7	S9999		

assistance to return, mark room with name, familiar object or picture, medication to improve cognition and manage anxiety. R1 does not have an Abuse Risk Assessment or a Social History Assessment in the Medical Record.

R1's Behavior Tracking Forms dated for June do not document R1 wandering into R8's room on 6/27/21. Behavior tracking for July does not document R1 wandering into R3's room on 7/17/21. Per the facility's Incident reports dated respectively.

3.) A facility Incident Report dated 7/1/21 documents witnessed abuse between R7 and R11. V18 Dietary Aide stated V18 heard R11 yell and went into the room and witnessed R7 kick R11 in the left foot. R11 stated that R7 had also kicked R11 in the knee. There were no injuries. 15 minute checks continued and for R7 and R7 was moved off the hall per the above report.

R7's POS dated August 2021 includes a diagnosis of Memory Loss.

R7's MDS dated 7/30/21 documents R7 as severely cognitively impaired.

R7's Plan of Care (current) documents a care area of behaviors with known wandering, but does not document R7 having physical aggression. Approaches include "redirect resident when wandering." R7 does not have an Abuse Risk Assessment or a Social History Assessment in the Medical Record.

R7's Behavior Tracking Forms do not document any physical aggression behaviors in May, June or July 2021 (7/22/21 incident is not

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S9999	Continued From page 8 documented). R11's POS dated August 2021 includes a diagnosis of Dementia with Behavioral Disturbances. R11's MDS dated 7/1/21 documents R11 as moderately impaired. R11's Plan of Care (current) documents R11 with Behaviors of wandering, resistive to care and may exhibit behaviors that are disruptive to others and may result in harm to resident from others as reprisal. R11 does not have an Abuse Risk Assessment or a Social History Assessment in the Medical Record. R11 had no Behavior Tracking Forms for review. 4.) A facility Incident Report dated 7/3/21 documents V16 Certified Nursing Assistant witnessing R1 attempting to pick up a cookie from another resident's (unknown) place and R2 reached across the table in the dining room and hit R1 on the arm, leaving a slight redness on the left forearm of R1. R2's POS dated August 2021 includes a diagnoses of Dementia. R2's MDS dated 6/14/21 documents R2 as cognitively intact. R2's Plan of Care (current) R2's Plan of Care (current) has no care area for physical aggression toward staff or other residents as exhibited on 7/3/21 (per facility Incident Report and on 6/6/21 toward a CNA per Nursing Notes). R2 does not have an Abuse Risk Assessment or a Social	S9999		

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S9999	Continued From page 9 History Assessment in the Medical Chart. R2's Nursing Notes dated 6/6/21 also document that R2 hit a staff member multiple times in the back because the staff member was blocking R2's television view while providing care to R2's roommate). R2's Behavior Tracking Form dated for June does not document R2's physical aggression toward staff on 6/6/21 per R2's Nursing Notes. R1's information as above. 5.) A facility Incident Report dated 7/5/21 documents V17 Licensed Practical Nurse witnessing R4 propelling down the hallway in R4's wheelchair and encountered R5 and reached out and smacked R5 on the arm. Before V17 could reach R4, R4 proceeded down the hall and encountered R1 wandering in the hall and smacked R1. R4 was placed on 15 minute checks. R4's POS dated August 2021 includes a diagnoses of Alzheimer's. R4's MDS dated 7/1/21 documents R4 as severely cognitively impaired. R4's Plan of Care (current) documents that R4 wanders and has frantic movements in R4's wheelchair. The Plan of Care does not address R4 having any physical aggression. Approaches for wandering include "redirect resident." R4 does not have an Abuse Risk Assessment or a Social History Assessment in the Medical Record. R4's Behavior Tracking form dated for May 2021 and June 2021 does not document any	S9999		

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S9999	Continued From page 10 aggressive behaviors. The July 2021 Behavior Tracking form documents on 7/1, 7/5/, 7/9, 7/15, 7/16 and 7/21 R4 having aggressive behaviors (there are no signatures on the form to identify who documented these entries). R5's POS dated August 2021 includes a diagnoses of Alzheimer's Dementia. R5's MDS dated 7/2/21 documents R5 as severely cognitively impaired. R5's Plan of Care (current) has no documented care areas for physical aggression. R5's Behavior Tracking Form dated May, June and July 2021 documents no physical aggressive behaviors. 6.) A facility Incident Report dated 7/15/21 documents V3, Social Service Director witnessing R9 picking something up off a table in the dining hall. R12 then yelled at R9 and R9 became agitated and pinched R12 on the right forearm. See R1's Information above. See R9's Information above. R12's POS dated for August 2021, includes a diagnosis of Dementia without Behaviors. R12's MDS dated 7/1/21 documents R12 as cognitively intact. R12's Plan of Care (current) documents that R12 is known to or has history of displaying inappropriate behavior and or resisting care. Specific behavior exhibited, arguing/fighting with husband and daughter, physical and verbal abuse	S9999		

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S9999	Continued From page 11 to others, self abuse, suicidal ideations, repetitive health complaints related to anxiety. R12 does not have an Abuse Risk Assessment or a Social History Assessment in the Medical Record. R12 had no Behavior Tracking Forms for review. 7.) A facility incident Report dated 7/17/21 documents V12 Certified Nursing Assistant reporting that R1 was in R3's room in R3's bed. R1 got out of the bed and was heading out of R3's room when R3 shoved R1 to the floor. V12 also stated V12 saw R3 use R3's feet to push R1 along the floor, trying to get R1 out of R3's room. R1 had slight redness to left hip and back. R1 was put on one to one supervision. R3's POS dated August 2021 includes a diagnosis of Dementia with Behavioral Disturbances. R3's MDS dated 7/2/21 documents R3 as severely cognitively impaired. R3's Plan of Care (current) documents on 8/5/21 a care area under Psychotropic Drugs: "exhibits signs of physical aggression as shown by swinging fists at staff." There are no interventions documented for this care area of physical aggression. R3 does not have an Abuse Risk Assessment and R3's Social History Assessment is incomplete. R3's Behavior Tracking Form dated for July documents physical aggression on 7/14/21 and wandering the facility on this same date, but does not document R3's physical aggression toward R1 on 7/17/21 (per facility Incident Report of 7/17/21). Behavior tracking for June documents	S9999		

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S9999	Continued From page 12 two instances of behaviors on 6/26 and 6/27/21. An entry dated 6/18/21 documents R3 hitting a staff member (unidentified) in the head. See R1's information above. 8.) A facility Incident Report dated 7/22/21 documents V19 Certified Nursing Assistant was walking down the hall and saw R7 grab R6 and push R6 up to the wall. R6 grabbed a wet floor sign and swung it at R7, hitting R7 on the left body side. No injuries were sustained. R6 was sent to the hospital for evaluation. This report does not document what intervention was implemented for R7. See R7's information above. R6's POS dated August 2021 includes a diagnoses of Dementia. R6's MDS dated 7/21/21 documents R6 as moderately cognitively impaired. R6's Baseline Plan of Care (current) does not document R6's aggressive behaviors as documented in the Incident of 7/22/21. R6 has no Behaviors Tracking Forms for physical aggression. On 8/3/21 at 9:45 am residents were congregated in the front lobby of the facility. Verbal bickering was heard between several residents. Residents in rooms were screaming through out the survey on 8/3, 8/4, 8/5 and 8/6/21. On 8/5/21 at 10:00 am V1, Administrator stated	S9999		

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S9999	Continued From page 13 the facility was aware that Care Plans and Behavior Tracking documentation was not up to date and they were working to get them updated. V1 also stated that Dementia training had been done only once since May 2021. 1.) In-servicing all staff in the facility on the Abuse Policy, along with Anger and Aggression in the facility's Dementia population. Completed by Administrator and Regional Clinical Director 8/12/21. 2.) The Interdisciplinary Team (IDT) has identified 20 residents within the facility that are at risk for abuse and aggressive behaviors to ensure person centered interventions are in place through their Care Plans and Behavior Tracking. This includes the residents that were identified in resident to resident physical abuse allegations, ensuring that targeted behaviors have the appropriate person centered interventions. Completed by Administrator, Social Service Director, Assistant Director of Nursing, Care Plan Coordinator 8/12/21. 3.) New interventions have and will continue to be communicated to staff in the facility by the Social Service Director through a Communication Book. Completed by the Social Service Director 8/12/21. 4.) All residents with aggressive behaviors or have potential for aggressive behaviors will be reviewed by the Behavior Quality Assurance meeting. Root Cause Analysis will be completed to determine potential triggers. Ongoing weekly. Completed by Administrator, Social Service Director, Assistant Director of Nursing and Care Plan Coordinator 8/12/21. 5.) Activities being performed at various times,	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	100 EASTVIEW PLACE SULLIVAN, IL 61951

(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 14 including evenings, for different cognition levels to prevent detrimental behaviors. Completed by Activities Director 8/12/21. (B)	S9999		