STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003073	A. BUILDING: _____ B. WING _____	C 10/27/2021

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PARK PLACE OF BELVIDERE	1701 5TH AVENUE BELVIDERE, IL 61008

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S9999	Final Observations Complaint #2117739/IL139367 Statement of Licensure Violations 300.625i) 300.625k) 300.625l) Section 300.625 Identified Offenders i) For current residents who are identified offenders, the facility shall review the security measures listed in the Identified Offender Report and Recommendation provided by the Department of the State Police. k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act) l) If the identified offender is a convicted (see 730 ILCS 150/2) or registered (see 730 ILCS 150/3) sex offender or if the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-201.6(d) of the Act). This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a private room for an identified sex offender. This applies to 16 of 20 residents reviewed for	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 identified offenders in the sample of 20. The findings include: The facility's resident roster given to the surveyor on 10/20/21 showed R10 and R11 both reside in rooms with another resident. The facility's document given to the surveyor on 10/26/21 showed R10 and R11 listed as identified offenders. Both R10 and R11's roommates are not listed as identified offenders. R10's Criminal History Analysis Security Recommendation Report (CHAR) dated 10/15/18 showed R10 is a convicted and/or registered sex offender. The resident must be placed in a single resident room with a private bathroom facility. R11's CHAR report dated 11/17/15 showed R11 is a convicted and/or registered sex offender. The resident must be placed in a single resident room with a private bathroom facility. On 10/27/21 at 1:05PM, V1 (Administrator) stated, "(R10) and (R11) are in rooms with other residents. I didn't have anywhere else to put them. I didn't see on their CHAR report that they had to have private rooms but I guess now I know that. All of my other identified offenders are in private rooms except those 2 so I thought it would be ok for a while. Neither of their roommates are identified offenders." The facility's undated policy titled, "Identified Offender Facility Policy and Procedure" showed, "Private Bed Rooms: The following residents shall have their own room: Convicted or registered sex offenders ...There shall be no waivers and no alternatives to the above requirement except for	S9999		

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S9999	Continued From page 2 an identified offender sharing a room with a spouse if it has been determined there is no risk or danger to the spouse." (B) 300.1210b) 300.1620c) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 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 300.1620 Compliance with Licensed Prescriber's Orders c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be documented in the clinical record. Portions of this	S9999		

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S9999	Continued From page 3 review may be done outside the facility. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Requirements were not met as evidenced by: 1). Based on observation, interview, and record review, the facility failed to ensure a resident (R1) was free from mental abuse, failed to ensure a	S9999		

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resident (R2) was not denied goods to maintain comfort. These failures resulted in R1 experiencing increased emotional lability and R2 experiencing increased anxiety and anger. These failures apply to 2 of 3 residents (R1 and R2) reviewed for abuse in the sample of 3.

The findings include:

1) R1's electronic face sheet printed on 10/21/21 showed R1 has diagnosis including but not limited to Schizophrenia, major depressive disorder, and insomnia.

R1's care plan dated 9/25/20 showed, "(R1) demonstrates significant mood distress related to schizophrenia, major depressive disorder, and social isolation."

R1's care plan dated 9/25/20 showed, "(R1) demonstrates a pattern of situational and/or coping problems in areas such as: psychosocial well-being, mood state and/or behavioral symptoms. Intervene on an incidental or episodic basis to re-direct behavior symptoms that impact others."

On 10/20/21 at 8:58AM, V1 (Administrator) stated, "V3 (Registered Nurse-RN) told me that (R1) got up out of his chair and she thought he was going to hit her so she closed the door and held it so he could calm down. (R1) said that (V3) came in his room and grabbed his arm and shook it and he called her a bitch and then she called him a bastard. I have started my interviews and am basically done with my investigation. (R1) has a history of telling people he is mentally retarded and that we hold it against him that he's a sex offender."

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On 10/20/21 at 9:04AM, R1 stated, "On Saturday night (10/16/21) I had my door cracked open and (V3) came and shut my door. I went and opened it and then she kept closing it so I told her I was going to knock the shit out of her if she didn't leave it open. After that, she closed the door and held it closed so I couldn't get it open. I tried like hell several times to open that door and I almost fell trying so hard. I was starting to panic because I just wanted my door open like it always is. I wasn't going to do anything to her. She finally let go of the door and I was able to open it. I went to bed because I was scared of what she would do to me. She came in my room awhile later and grabbed my arm and shook it and I called her a bitch and she called me a rotten bastard. I don't have any marks on me where she grabbed my arm but it hurt like hell. My stomach hurt when I saw her come into work last night and I was so scared of her this morning when she gave me my medication that I didn't talk to her at all. I don't know why they would let her work when she just did this to me a few days ago. I should have stayed calm the other night but I was so upset with her that I said those bad things to her and now I feel bad." Throughout interview with R1, he was anxious and tearful and kept repeating that he did not want to be kicked out of the facility and he never should have told anyone about it because now the staff are all going to be upset with him and be mean to him.

On 10/20/21 at 9:42AM, V6 (Certified Nursing Assistant-CNA) and V7 (RN) stated, "It is never appropriate to hold a residents door closed. This would be isolation and entrapment which are both forms of abuse. If we are ever fearful of a resident we assure the resident is safe, and call for help. You never close a resident in their room and prevent them from getting out. That could

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lead to increased behaviors and have long-term effects on a resident such as anxiety and fear. We have both worked with (V3-RN). Residents don't necessarily say she is abusive but they all call her a bitch and say she is very gruff with them and doesn't care about them. She has zero compassion for these residents."

On 10/20/21 at 10:40AM, V8 (RN) stated, "At no time is it acceptable to hold a resident's door shut as this is considered isolation. If a resident becomes agitated you are to try and deescalate the situation and re-approach later if necessary."

On 10/20/21 at 11:09AM, V5 (CNA) stated, "(R1) is pretty independent and very rarely does he get angry. He get obsessed over things but I wouldn't call him aggressive at all. I was working the night (10/16/21) that (V3) and (R1) got into an argument over his door being open. I heard them arguing while I was at the other nurses station. I got up to see what was going on, saw (V3) holding (R1's) door closed and asked if everything was ok and (V3) let go of the door and said everything was fine. (V3) told me that they were arguing because she told him he had to go to bed because it was late and she was trying to shut his door to make him go to bed. In my opinion she is not appropriate with the residents. She is not nice to them and I wouldn't want her taking care of my family after seeing how she talks to some of the residents."

On 10/20/21 at 12:10PM, V3 (RN) stated, "On Saturday night (10/16/21), I was asking (R1) why he didn't go to bed. He got mad and I thought he was coming after me so I held the door shut until I heard him sit back down. He tried to open the door a few times but I wouldn't let him until I heard him sitting down. This was a reaction to

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protect myself. The CNA working at the other end of the building (V5) heard what was going on and asked if everything was ok and I told her it was fine. What I did wasn't abuse, it was self-defense. It didn't last long, maybe 30 seconds or so. The next time I went into his room was for his morning medications on Sunday morning (10/17/21) and he didn't say anything to me, just took his medicine. I was suspended Monday night (10/18/21) but then came back to work on Tuesday night (10/19/21) because the investigation was over. I worked on (R1's) hall and gave him his morning medication this morning. He didn't talk to me at all and just took his medicine and turned away from me."

On 10/21/21 at 8:46AM, V1 (Administrator) stated, "I think this might just be how (V3) acts. It's just the way she is and that's just the attitude she always has. I guess I don't really consider this abuse but I definitely need to look into it if she is going to continue working here. A lot of times she is the only nurse in the building at night so that might be a problem."

On 10/21/21 at 9:40AM, V9 (Licensed Practical Nurse-LPN) stated, "(R1) has obsessive behaviors, he obsesses over medications and treatments. He does get loud and follows staff around sometimes but he has never tried to hurt anyone. He just doesn't understand his boundaries. (V3) and (R1) have always butted heads. (V3) is short and to the point and is not a warm person. She doesn't tolerate resident behaviors and doesn't take the time to try and calm them down. I received nursing report from (V3) on Sunday morning after the incident (10/17/21). (V3) told me the argument started because she wanted his door shut because his rocking chair was making noise. She said he got

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S9999	Continued From page 8 up quickly from his chair so she held the door shut until she heard him sit back down." On 10/21/21 at 10:26AM, V10 (psychiatrist) stated, "I do not see (R1) being an aggressive person at all. When his name comes to mind the last thing I think of is aggression. 10/19/21 was my first visit with him although we have seen him before in my hospital. None of the staff reported any aggressive or angry behaviors to me. They all stated his behaviors are obsessive and sexual so that's what I am focused on with him. If anything negative happens with him he becomes very emotionally labile and is fearful that something bad will happen to him. He is a very high acuity and complex patient that requires a lot of patience and care as far as emotions go." On 10/21/21 at 11:03AM, V2 (Director of Nursing) stated, "When an allegation of abuse is made, the perpetrator and victim are separated immediately. If it is a staff to resident abuse allegation I think the staff member might not be allowed to work with the resident but I'm not sure for how long. I think it depends on what the allegation is." On 10/21/21 at 12:50PM, V1 stated, "I was first notified about the incident between (R1) and (V3) on Monday (10/18/21). I began my investigation and suspended (V3). I thought I was done with my investigation because nobody was telling me anything so I brought (V3) back to work on Tuesday night. I had her statement and I told her that if another issue came up with (R1) that another staff member should take care of him. There isn't always another nurse available so (V3) may have access to (R1) at times but not very often. I did continue to interview staff on 10/20/21 but for the most part my investigation is done."	S9999		

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The facility's in-service titled, "Abuse" dated 4/7/21 showed V3 did not attend the annual in-service on abuse for 2021.

The facility's policy titled, "Abuse Prevention Program" dated 2/7/17 showed, "This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property, and mistreatment by anyone including but not limited to facility staff, other residents ...unreasonable confinement or involuntary seclusion means the separation of a resident from other residents or from their room or confinement to their room against the resident's will ...VI. Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Employees of this facility who have been accused of abuse will be removed from resident contact immediately. The employee shall not be permitted to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse is unsubstantiated."

2) R2's electronic face sheet printed on 10/21/21 showed R2 has diagnosis including but not limited to alcohol abuse, chronic viral hepatitis, atherosclerotic heart disease, and chronic obstructive pulmonary disease.

R2's care plan dated 10/20/21 showed, "(R2) has a behavior problem. He can be very argumentative and demanding. Anticipate and meet needs. Caregivers to provide opportunity for positive interactions."

On 10/20/21 at 9:25AM, R2 stated, "The nurse last night came into my room and I told her to get me a blanket. She said that I had to say please

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and again I said get me a blanket. She said I had to say pretty please so I did and then she left the room and never got me one. I was freezing for the rest of the night."

On 10/20/21 at 9:28AM, V7 (Registered Nurse) stated, "(V3-RN) was the nurse working this side last night and took care of (R2)."

On 10/20/21 at 9:35AM, V1 was informed by surveyor of R2's allegations of the incident involving R2 and (V3). V1 stated, "(R2) is really on a kick today. He complains about everyone and everything all the time. I don't even know if this even happened. For all we know he made it up. I guess I will have to suspend (V3) again. I don't even know if I need to investigate this or report it. This is just how (V3) is with the residents."

The facility's nursing schedule showed V3 worked on 10/19/21 from 10:00PM-6:00AM. V3 was allowed access to R2 at this time.

R2's behavior tracking for 10/19/21 showed no behaviors exhibited on 10/19/21.

On 10/20/21 at 12:10PM, V3 stated, "I went into (R2's) room around 5:30AM on 10/20/21 to give him his morning medicine and check his blood sugar. He asked me for a blanket and was snooty with me and said "Get me a blanket" in a mean tone. I said to him "Do you know how to say please?" Then he said pretty please and told me to do what I was told. I left the room and continued passing medications for other residents. I didn't get him a blanket because they were all the way down on the other end of the hall and I must have forgot to get it for him. He's always demanding things and it's ridiculous."

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R2's nursing progress notes for 10/19/21-10/21/21 were reviewed and no documentation was present regarding the alleged incident between V3 and R2.

2). Based on observation, interview, and record review, the facility failed to protect a resident (R1) from further potential abuse during an abuse investigation after an allegation was made regarding potential abuse from a nurse. The facility failed to remove a staff member alleged of abuse from working prior to the completion of an abuse investigation. The nurse witheld care to R2 by not providing a blanket. These failures contributed to a nurse having access and withholding care to R1 and R2. R1 was experiencing crying episodes, increased anxiety, increased obsessions, fear of being discharged from the facility, and fear of V3 (Registered Nurse) taking care of him. R2 experienced increased anxiety and anger.

This applies to 2 of 3 residents (R1 and R2) reviewed for abuse in the sample of 3.

The findings include:

1) R1's electronic face sheet printed on 10/21/21 showed R1 has diagnosis including but not limited to Schizophrenia, major depressive disorder, and insomnia.

R1's care plan dated 9/25/20 showed, "(R1) demonstrates significant mood distress related to schizophrenia, major depressive disorder, and social isolation."

R1's care plan dated 9/25/20 showed, "(R1) demonstrates a pattern of situational and/or

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coping problems in areas such as: psychosocial well-being, mood state and/or behavioral symptoms. Intervene on an incidental or episodic basis to re-direct behavior symptoms that impact others."

On 10/20/21 at 8:58AM, V1 (Administrator) stated, "V3 (Registered Nurse-RN) told me that (R1) got up out of his chair and she thought he was going to hit her so she closed the door and held it so he could calm down. (R1) said that (V3) came in his room and grabbed his arm and shook it and he called her a bitch and then she called him a bastard. I have started my interviews and am basically done with my investigation. (R1) has a history of telling people he is mentally retarded and that we hold it against him that he's a sex offender."

On 10/20/21 at 9:04AM, R1 stated, "On Saturday night I had my door cracked open and (V3) came and shut my door. I went and opened it and then she kept closing it so I told her I was going to knock the shit out of her if she didn't leave it open. After that, she closed the door and held it closed so I couldn't get it open. I tried like hell several times to open that door and I almost fell trying so hard. I was starting to panic because I just wanted my door open like it always is. I wasn't going to do anything to her. She finally let go of the door and I was able to open it. I went to bed because I was scared of what she would do to me. She came in my room awhile later and grabbed my arm and shook it and I called her a bitch and she called me a rotten bastard. I don't have any marks on me where she grabbed my arm but it hurt like hell. My stomach hurt when I saw her come into work last night and I was so scared of her this morning when she gave me my medication that I didn't talk to her at all. I don't

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know why they would let her work when she just did this to me a few days ago. I should have stayed calm the other night but I was so upset with her that I said those bad things to her and now I feel bad." Throughout interview with R1, he was anxious and tearful and kept repeating that he did not want to be kicked out of the facility and he never should have told anyone about it because now the staff are all going to be upset with him and be mean to him.

On 10/20/21 at 10:04AM, V12 (R1's guardian) stated, "On 10/19/21 I was visiting (R1) at the facility when he reported to me that on 10/16/21 he had his door partially open and the nurse (V3) came and shut the door. He stated they were arguing and she held the door shut so he couldn't open it. When she finally let go he opened the door and then laid down in his bed and she came back into his room and he called her a bitch and she called him a bastard and grabbed his arm and shook it. He said he is scared of (V3). I reported this to (V1) during my visit on 10/19/21 and she said she knew about it but hadn't reported it yet because she had not spoken with (V3) yet. (V1) stated she knew (R1) was lying but would report it anyway. It is very unusual for (R1) to complain and he usually minimizes things. In the past he has reported to me that (V3) is passive aggressive with him and does things like turn the ice machine off so he can't get ice at night."

On 10/20/21 at 12:10PM, V3 (RN) stated, "On Saturday night around 1:30-2:00AM, I was asking (R1) why he didn't go to bed. He got mad and I thought he was coming after me so I held the door shut until I heard him sit back down. He tried to open the door a few times but I wouldn't let him until I heard him sitting down. This was a reaction

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to protect myself. The CNA working at the other end of the building (V5) heard what was going on and asked if everything was ok and I told her it was fine. What I did wasn't abuse, it was self-defense. It didn't last long, maybe 30 seconds or so. The next time I went into his room was for his morning medications on Sunday morning and he didn't say anything to me, just took his medicine. I was suspended Monday night but then came back to work on Tuesday night because the investigation was over. I worked on (R1's) hall and gave him his morning medication this morning. He didn't talk to me at all and just took his medicine and turned away from me."

On 10/20/21 at 1:15PM, R1 stated, "Why would they let (V3) come back to work and take care of me? Please don't let her come back, she's going to do something to me now that I told you guys what happened. I just know it. Please help me." R1 began obsessing over V3 returning to work, began shaking his legs uncontrollably and he began to cry.

On 10/21/21 at 8:46AM, V1 (Administrator) stated, "I think this might just be how (V3) acts. It's just the way she is and that's just the attitude she always has. I guess I don't really consider this abuse but I definitely need to look into it if she is going to continue working here. A lot of times she is the only nurse in the building at night so that might be a problem."

On 10/21/21 at 11:03AM, V2 (Director of Nursing) stated, "When an allegation of abuse is made, the perpetrator and victim are separated immediately. If it is a staff to resident abuse allegation I think the staff member might not be allowed to work with the resident but I'm not sure for how long. I think it depends on what the allegation is."

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On 10/21/21 at 12:50PM, V1 stated, "I was first notified about the incident between (R1) and (V3) on Monday. I began my investigation and suspended (V3). I thought I was done with my investigation because nobody was telling me anything so I brought (V3) back to work on Tuesday night (10/19/21). I had her statement and I told her that if another issue came up with (R1) that another staff member should take care of him. There isn't always another nurse available so (V3) may have access to (R1) at times but not very often. I did continue to interview staff on 10/20/21 (after V3 had been cleared to work on 10/19/21) but for the most part my investigation was done. In my opinion these instances constitute abuse and never should have happened. I don't know what (V3) was thinking. These should have been reported to me right away and they weren't."

The facility's nursing schedule for 10/19/21 showed V3 worked from 10:00pm-6:00am and was the only nurse in the facility during these hours.

R1's medication administration record was reviewed for 10/19/21 and 10/20/21 and showed V3's initials as the person administering his medications between the hours of 10:00pm-6:00am.

The facility's final investigation report dated 10/22/21 showed, "Based on the resident's behavior triggering an emergency response to provide a barrier for a brief period, the facility could not substantiate that abuse occurred; however, the nurse (V3) was terminated for failure to meet facility expectations."

The facility's policy titled, "Abuse Prevention

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S9999	Continued From page 16 Program" dated 2/7/17 showed, "This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property, and mistreatment by anyone including but not limited to facility staff, other residents ...unreasonable confinement or involuntary seclusion means the separation of a resident from other residents or from their room or confinement to their room against the resident's will ...VI. Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Employees of this facility who have been accused of abuse will be removed from resident contact immediately. The employee shall not be permitted to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse is unsubstantiated." 2) R2's electronic face sheet printed on 10/21/21 showed R2 has diagnoses including but not limited to alcohol abuse, chronic viral hepatitis, atherosclerotic heart disease, and chronic obstructive pulmonary disease. R2's facility assessment dated 9/8/21 showed R2 has mild cognitive impairment. R2's care plan dated 10/20/21 showed, "(R2) has a behavior problem. He can be very argumentative and demanding. Anticipate and meet needs. Caregivers to provide opportunity for positive interactions." On 10/20/21 at 9:25AM, R2 stated, "The nurse last night came into my room and I told her to get me a blanket. She said that I had to say please and again I said get me a blanket. She said I had to say pretty please so I did and then she left the room and never got me one. I was freezing for	S9999		

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the rest of the night."

On 10/20/21 at 9:28AM, V7 (Registered Nurse) stated, "(V3-RN) was the nurse working this side last night and took care of (R2)."

On 10/20/21 at 9:35AM, V1 was informed by surveyor of R2's allegations of the incident involving R2 and (V3). V1 stated, "(R2) is really on a kick today. He complains about everyone and everything all the time. I don't even know if this even happened. For all we know he made it up. I guess I will have to suspend (V3) again. I don't even know if I need to investigate this or report it. This is just how (V3) is with the residents."

The facility's nursing schedule showed V3 worked on 10/19/21 from 10:00PM-6:00AM. V3 was allowed access to R2 at this time while the investigation was still ongoing for R1. V3 was allowed access to all residents in the facility before the abuse investigation involving her was completed.

R2's behavior tracking for 10/19/21 showed no behaviors exhibited on 10/19/21.

On 10/20/21 at 12:10PM, V3 stated, "I went into (R2's) room around 5:30AM on 10/20/21 to give him his morning medicine and check his blood sugar. He asked me for a blanket and was snooty with me and said "Get me a blanket" in a mean tone. I said to him "Do you know how to say please?" Then he said pretty please and told me to do what I was told. I left the room and continued passing medications for other residents. I didn't get him a blanket because they were all the way down on the other end of the hall and I must have forgot to get it for him. He's

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S9999	Continued From page 18 always demanding things and it's ridiculous." R2's nursing progress notes for 10/19/21-10/21/21 were reviewed and no documentation was present regarding the alleged incident between V3 and R2. 3). Based on interview and record review, the facility failed to provide a resident (R1) with an antipsychotic medication for 19 days after returning to the facility from an inpatient psychiatric stay at a local mental health facility. This failure resulted in R1 continuing to experience sexual and obsessive behaviors. This failure applies to 1 of 3 residents (R1) reviewed for medications in the sample of 3. The findings include: R1's electronic face sheet printed on 10/21/21 showed R1 has diagnosis including but not limited to Schizophrenia, major depressive disorder, and insomnia. R1's care plan dated 9/25/20 showed, "(R1) demonstrates significant mood distress related to schizophrenia and major depressive disorder." R1's care plan dated 9/30/20 showed, "(R1) has a behavior problem he masturbates on a pink stuffed animal and also makes inappropriate comments to staff r/t major depressive disorder, recurrent, unspecified." R1's care plan dated 9/25/20 showed, "(R1) demonstrates a pattern of situational and/or coping problems in areas such as: psychosocial well-being, mood state and/or behavioral symptoms. This appears related to schizophrenia	S9999		

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and major depressive disorder, recurrent, unspecified. Symptoms are manifested by: Cognitive deficits (poor reasoning, poor judgement) Lack of self-confidence, self-esteem, and self-worth. Mood distress/anger/anxiety/sadness/insomnia. Conflictual relationships with staff and peers. Distress over lost/changing roles, status."

R1's psychiatric note from R1's nurse practitioner dated 9/14/21 showed, "Patient had inpatient psychiatric hospitalization on 8/19/21 for increased bizarre behavior and sexually acting out behaviors in addition to mania. Patient was stabilized and discharged back to facility on 8/27/21 with prescription for Olanzapine 7.5mg ...In the last 2 weeks the patient has gotten progressively more behavioral including increased sexual thoughts, obsessing over sexual thoughts and medications as well as religious preoccupation. Medications were reconciled from discharge from inpatient psyche and Olanzapine had been decreased upon readmission to the facility to 5mg ....will increase Olanzapine back to 7.5mg every evening starting 9/14/21."

R1's local hospital discharge medication orders dated 8/27/21 showed, "Olanzapine 7.5mg every night for 30 days. Next dose due this evening."

R1's medication administration record (MAR) for August 2021 and September 2021 showed R1 received Olanzapine 5mg at bedtime from 8/27/21 thru 9/14/21. R1 did not receive any Olanzapine on 9/15/21.

R1's MAR for September 2021 showed R1 did not begin receiving the Olanzapine 7.5mg dose until 9/15/21.

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S9999	Continued From page 20 On 10/21/21 at 9:40AM, V9 (Licensed Practical Nurse) stated, "When a resident returns from the hospital, the admitting nurse goes through the medication list, calls the physician to verify orders, and transcribes any new orders onto the resident's MAR. If a physician does not agree with a medication ordered from the hospital then the nurse will enter that information into a progress note. If there is no progress note then the assumption is that the orders were all agreed upon by the physician. If a resident is not given the correct dose of their antipsychotic medications that can lead to increased behaviors and possibly mental status changes. If a resident receives the incorrect dose of this class of medications for weeks that would be considered a significant medication error." On 10/21/21 at 10:26AM, V10 (R1's psychiatrist) stated, "(R1) is on Olanzapine for Schizophrenia. He has chronic psychotic disorders dating back to his childhood. He was hospitalized at my hospital in August 2021 for psychiatric behaviors and medication management. I was not aware that he had not received the full dose of his Olanzapine that was prescribed to him during the August hospitalization. He very likely would have had an exacerbation of symptoms. He is probably one of the most intense residents I have at the facility as far as complexity and his medications should be given exactly as ordered. Negative situations will make him emotionally labile and he will be fearful that something bad will happen to him. It takes a great deal of patience and care for someone to take care of a resident as complex as he is and it just makes things worse for him when his medications are not given as ordered. I just increased his Olanzapine again and if he would have been given the full dose when he returned from the hospital, there is a good change we	S9999		

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would be ahead of the game with (R1) and his behaviors."

On 10/21/21 at 11:03AM, V2 (Director of Nursing) stated, "Medication reconciliation is performed when a resident is new or a readmission to the facility. All medications should be confirmed with the resident's physician and if it is approved then the medications are put onto the MAR. If they are not approved, then the nurse enters a progress note into the resident's chart indicating why a medication was not continued. All medications should be given as ordered. Antipsychotics should be given at the ordered dosage. Failure to do so could result in increased behaviors."

R1's nursing progress notes dated 8/28/21 showed, "Educated repeatedly today that he cannot sit nude in his chair. He stated he showered and was drying and then he would get dressed. Hours later still nude. Door kept closed although he reopens at times and tries to sit with a blanket barely covering himself."

The facility's undated policy titled, "Admission/Readmission" showed, "12. The admitting nurse completes the nursing assessment and obtains admitting orders. Once the admitting orders are verified, the orders are transcribed onto the physician's order sheet, medication administration record, and treatment administration record. The medication orders are then transferred to the pharmacy."

(B)