STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004147	A. BUILDING: _____ B. WING _____	C 11/24/2021

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APERION CARE PEORIA HEIGHTS	1629 GARDNER LANE PEORIA HEIGHTS, IL 61616

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S 000	Initial Comments Complaint Investigation: 2127912/IL139595 2128043/IL139759 2128069/IL139793 2128079/IL139802	S 000		
S9999	Final Observations There are two Statements of Licensure Violations. I. of II. Statement of Licensure Violations: 300.625 a) 300.625b) 300.625 k) 300.625 n) 300.1210 a) 300.1210 b) 300.1210 d)6) Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks. b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 n) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents. 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. 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	S9999		

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S9999	Continued From page 2 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Noncompliance resulted in three deficient practice statements. A. Based on observation, interview and record review the facility failed to educate one resident (R16) about R16's diagnosis of HIV (Human Immunodeficiency Virus) and Hepatitis C who was known to proposition sex in exchange for money and/or cigarettes, known to have a criminal history of prostitution and known to have diagnoses of sexually transmitted disease. The facility also failed to develop interventions to protect residents from potentially having unprotected sex with R16. These failures resulted in R16 having access to all 82 residents in the facility from admission (9/14/21) to 10/29/21. B. Based on interview and record review the facility failed to immediately investigate and protect residents from sexual propositions by R16 for money and cigarettes. Prior to 9/30/21, R17 reported to V11 (Social Service Director) that R16 had offered sex in exchange for money and/or cigarettes. This allegation was not investigated until 10/29/21 allowing R16 to remain	S9999		

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S9999	Continued From page 3 unsupervised with full access to all residential areas within the facility. These failures resulted in R16 having access to all 82 residents in the facility from admission (9/14/21) to 10/29/21. C. Based on interview and record review the facility failed to incorporate the Identified Offender Report and Recommendation of 10/14/21 into the identified offender's care plan in a timely manner and evaluate the effectiveness of the care plan for 1 of 1 resident (R16). This failure has the potential to affect all 82 residents in the facility. Findings include: Resident Room Roster dated 10/29/21 indicates 82 residents in the facility. Current Physician Orders indicate R16 was admitted to the facility on 9/14/21 with diagnoses that include Bipolar Disorder, HIV (Human Immunodeficiency Virus), Viral Hepatitis C and PTSD (Post Traumatic Stress Disorder). Comprehensive Assessment dated 9/23/21 indicates R16 is cognitively intact, understands, is understood and is independently mobile. Per "(R16's guidelines)" implemented on 10/29/21, R16 had access to the entire facility including the smoking area prior to 10/29/21. Current Physician Orders indicate R17 was admitted to the facility on 9/2/21 with diagnoses that include Seizure Disorder, Schizophrenia and Anxiety Disorder. Current Comprehensive Assessment indicates R17 is mildly cognitively impaired. Progress Note dated 9/30/21 indicates R17 was transferred to the hospital on that date and did not return to the facility.	S9999		

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S9999	Continued From page 4 State Police Record dated 9/14/21 indicates R16 has criminal history of numerous prostitution convictions among other felony charges and convictions. State Criminal History Analysis Report/Identified Offender's Program dated 10/25/21 indicates the facility received the Report "Via Facsimile" on R16 on that date. Report indicates details whether and to what extent, the identified offender's criminal history necessitates the implementation of security measures within the long-term care facility. Report indicates R16 was identified as a "Moderate Risk - the resident requires closer supervision and more frequent observation than standard or may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient." Report indicates the following specific considerations were important in arriving at the above recommendations: (R16) criminal history consisted of convictions for possession of drug paraphernalia. prostitution - several times, criminal trespass to land, possession of stolen vehicles - twice, resisting arrest. Report indicates R16 is diagnosed with both psychiatric and medical disorders. Report further indicates "Nursing facility staff stated that R16 has inappropriately fondled a male resident and made several attempts to obtain sexual favors for money with him." In view of R16's inappropriate behavior with a male resident and psychiatric condition, R16 is a moderate risk and supervision status is recommended.	S9999		

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R17
Written Statement by V11 (SSD) dated 11/3/21 is documented as follows:
"(R17) talked to me about (R16) asking for (R17) cigarettes and that (R16) offered (R17) 'sex for cigarettes' I discussed how to decline/stay away from (R16). (R17) expressed (R17) was comfortable telling (R16) 'No.' I provided suggestions to let staff know if (R16) did not stop asking when (R17) said 'No.' (R17) stated R17 was not afraid of (R16) or anyone else."

On 11/4/21 at 9:45am V11 (SSD) stated that V26 (State Identified Offender Investigator) held a video meeting (on 9/30/21) regarding R16. V11 stated that V26 interviews her then interviews R16 and that no one else participated. V11 stated that she was aware of R16 propositioning other residents - sex for money and that's why she put it on R16's care plan (on 10/4/21). V11 stated - at that time - staff told her about R16's behavior and that it involved R17. V11 stated that she did report R16's behavior to V25 (previous Administrator).

On 11/4/21 at 12:51pm V19 (State Identified Offender Program Manager) stated V26 (Investigator) conducted the interview with V11 (SSD) and R16 via a video meeting on 9/30/21. V19 stated no other staff contributed to the meeting or the information - V11 was the only staff who provided information to V19. V19 stated that V11 (SSD) provided information to V26 (Investigator) that R16 had displayed inappropriate sexual behavior, including propositioning male residents with sex in exchange for money since admit to the facility on 9/14/21. V19 stated V26 requested the incident reports/investigations from the facility regarding R16's behavior and never received any reports or

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S9999	Continued From page 6 follow up from V11. Current Care Plan (date initiated 9/27/21) indicates R16 has a history of criminal behavior and has "demonstrated stability during the screening process and does not appear to be a present risk." Care Plan indicates R16 fits the criteria for an Identified Offender. R16's Care Plan was not updated to include the Criminal History Analysis Report Recommendations on 10/25/21. Care Plan (date initiated 10/4/21) indicates R16 has a history of the following: Socially inappropriate behavior related to offering peers sex for money. This is related to R16's history of being homeless and using prostitution as a means to earn money to survive. Care Plan did not include any specific supervision or specific interventions to address R16's behavior. Care Plan (date initiated 10/29/21) indicates R16 had a psychosocial wellbeing problem and that R16 reported feeling lonely which has led R16 to have episodes of socially inappropriate behavior, at times sexual in nature. On 11/8/21 at 9:30am V11 (SSD) stated that it was actually R17 who told her that R16 had been offering R17 sex for money and/or cigarettes - not staff. V11 acknowledged that she updated R17's care plan on 9/19/21 and it may have been due to R17's allegations regarding R16. V11 stated that she updated R16's care plan on 10/4/21 in response to R17's allegations and stated, "I just didn't get around to it until then." V11 stated that R17 was mildly cognitively impaired and at increased risk of abuse. V11 stated that R17 may not have an official diagnosis of being intellectually disabled, however "seemed like	S9999		

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S9999	Continued From page 7 (R17) was by the way (R17) acted and spoke." On 11/8/21 at 9:10 V22 (Licensed Practical Nurse/LPN) stated that she had been told by R17 that R17 had been offered sex by R16, but R17 said "No." On 11/4/21 R30 reported R16 would beg for food and cigarettes and offer sex for money to other residents. No investigation or prevention of further inappropriate sexual behavior by R16 was done until 10/29/21 involving R16 and R17. No documentation of any of the known behaviors by R16 were documented in R16 or R17's medical record. On 10/29/21 at 4:15pm V1 (Administrator) stated that she was unaware of R16's behaviors of propositioning residents with sex for money or any allegations made by R17 until (10/29/21) and that the allegations should have been investigated, including interventions to protect other residents - immediately. Current Medication Administration Record indicates R16 was not placed on hourly checks until 10/28/21 and was not placed on 15-minute checks until 10/29/21. Physician's Progress Note dated 10/27/21 at 1:17pm indicates "Reason for visit - (R16) has allegedly been making sexual advances toward other residents. Discussed the importance of not making any sexual advances toward other residents.	S9999		

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S9999	Continued From page 8 On 11/4/21 V1(Interim Administrator) acknowledged V11 (SSD) was aware of R16 propositioning R17 "sex for money." V1 stated that she asked other staff and they also were aware of R16's behavior. R4 On 11/4/21 at 3:45pm R4 stated that R4 had been in a consensual relationship with R16, however R16 did not have boundaries and wanted more of a sexual relationship than R4 wanted. R4 stated that R16 did not understand "No" and would still persist in initiating sex. R4 stated that eventually R16 moved on to R15. No additional monitoring or supervision was identified, implemented or documented related to R16's Identified Offender status, Criminal History Analysis Report or medical diagnoses. No attempts by the facility to counsel, educate or address R16's HIV or Hepatitis C diagnoses were found or presented. Adequate interventions to protect other residents were not implemented until 10/29/21. On 11/23/21 at 2:00pm V2 (Director of Nurses/DON) stated that the physician and V25 (previous Administrator) discussed R16's sexually transmitted disease status with R16 and stated, "I don't know if any of it is documented though." V2 stated that R16 was told to disclose R16's HIV/Hepatitis C diagnosis to R4 and any other potential partner. V2 stated that the facility was without a care plan coordinator for a while and "Corporate was doing the care plans." On 11/23/21 at 2:05pm V1 (Administrator) stated that R16's diagnoses (of HIV and Hepatitis C) were on R16's admission records, "Corporate"	S9999		

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could have initiated a care plan from that information and that the nurses were also aware of R16's diagnoses.

The facility was aware of R16's offering sex in exchange for money/cigarettes prior to 9/30/21, was aware of R16 fondling a male resident (R17) per State Criminal History Analysis Report dated 10/14/21 and aware of the consensual intimate relationship with R4 who stated that R16 wanted more of a sexual relationship than R4 wanted and that R16 "didn't understand No."

R15
Current Physician Orders indicates R15 was admitted to the facility on 1/6/20 with diagnoses that include Schizophrenia and age-related Osteoporosis. Current Comprehensive Assessment indicates R15 is cognitively intact and make needs known.

Abuse Investigation Report dated 10/27/21 indicates on 10/27/21 at approximately 9am, R7 reported to a nurse that R7 saw another resident (R16) in bed with R7's roommate (R15).

On 10/29/21 at 2:53pm R7 stated that R16 had been coming into their room for several days and (on 10/26/21) R16 was on top of R15 in R15's bed and R15 was saying "No." R7 stated that R7 also saw R16 hold R15 up against the wall, trying to kiss R15. R7 stated that R7 is afraid of R16 and doesn't want R16 in their room. R7 stated that R7 reported the concerns to V16 (Therapist) the next day.

On 11/3/21 at 3pm V16 (Therapist) stated that R7 told her early on 10/27/21 that R16 came into

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their room last night, got into R15's bed and was trying to "hump" R15 for 20 minutes while R15 was sleeping. V16 stated that R7 told her R7 was scared. V16 stated that she immediately told R15's nurse. V16 stated that later that day R16 was moved to the other side of the facility.
No interview of V16 was found in the investigation report.

On 11/4/21 at 4:15pm R30 stated R30 saw R15 and R16 out on the patio smoking. R30 stated that R30 told R16 to leave R15 alone because R16 would try to be inappropriate with R15 and wouldn't leave R15 alone.

On 11/4/21 at 10:00am V11 (SSD) stated that R15 is very private and very passive and doesn't want to get anyone into trouble.

On 11/8/21 at 9:20am V22 (LPN) stated that in the evening of (10/26/21), she received a phone call from R2 who stated that R7 told R2 that R16 said or did something inappropriate with R15 (R7's roommate). V22 stated she interviewed both R15 and R16 at that time - and both denied anything inappropriate - however did not interview R7 who made the allegation and was a witness.

V22 did not immediately report R7's concerns about R16 to a supervisor or to the administrator and an investigation was not initiated until the next day when R7 again reported R7's concerns to V16 (Therapist.) R16 was not moved to the other side of the building (away from R15) until the afternoon of 10/27/21.

On 11/5/21 at 10:00am V1 (Administrator) stated V22 (LPN) should have reported the allegations to V2 (Director of Nurses/DON) or to her (on

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S9999	Continued From page 11 10/26/21). On 10/29/21 R15 refused to answer any and all questions regarding R16. At that time V1 (Interim Administrator) stated that R15 also refused to speak to the police and insisted "nothing happened" and that R16 was her friend. Current Medication Administration Record indicates R16 was not placed on hourly checks until 10/28/21 and was not placed on 15-minute checks until 10/29/21. Facility Policy/Abuse prevention and Reporting dated/revised 1/22/19 documents: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. The facility will conduct an investigation and protect the resident from non-consensual sexual relations anytime the facility has reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator.	S9999		

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S9999	Continued From page 12 Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. Internal Investigation: All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or documents. External Reporting/Initial Reporting of Allegations: When an allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property has occurred, the resident's representative and the State Agency shall be informed by telephone or fax. All allegations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property are to be reported immediately, but not later than two hours after the allegation is made. Informing Law Enforcement: The facility shall also contact local law enforcement authorities in the following	S9999		

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S9999	Continued From page 13 situations: Sexual abuse of a resident by a staff member, another resident, or a visitor. "A" II. of II. Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210d)3) 300.1210d)6) 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. 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.	S9999		

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	IL6004147	A. BUILDING: _____ B. WING _____	C 11/24/2021

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S9999	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide behavioral health care, services, and develop individualized interventions documented in the Facility Assessment to address a resident's behavior associated with Schizophrenia, PTSD (Post Traumatic Stress Disorder), and Major Depressive Disorder for one of one resident (R1) reviewed for behavioral health services in a sample of 32. These failures resulted in R1 developing a sudden escalation in behaviors resulting in R1's emergent admission to the hospital. Findings include: R1's hospital physician's progress notes and recapitulation of R1's hospital stay dated 9/24/21, from prior to R1's admission to the facility and	S9999		

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S9999	Continued From page 15 obtained from R1's medical records at the facility, documents that R1 has diagnoses to include Anxiety, Bipolar 1 disorder, Depression, Insomnia, and PTSD (post-traumatic stress disorder). This progress note documents that R1 was homeless, not taking any medications for R1's psychiatric conditions, and would, "Need to establish Psych care after discharge." This note further documents R1, "Will only do what R1 wants to do. Can be argumentative," and had "Disorganized thought processes." A Facility assessment dated 10/15/21 documents that the facility can accept residents with diagnoses profiles including Psychiatric/Mood disorders. This same assessment documents under the heading of Psychiatric Mood/ Disorders, "We utilize a Psychiatric consultant which sends a (Social Worker) and NP (Nurse Practitioner) who assist the staff and medical director with resident's who have behavioral needs." In addition, the Facility Assessment states under section 1.9 that the facility's process to make admission or continuing care decisions for persons that have diagnoses or conditions that the facility is less familiar with or have not previously supported as, "Administrator and Director of Nursing would consult the (facility's) contracted vendors if needed. Pharmacy, (Medical Supply Resources), Medical Director, Lab resources. The Administrator and D.O.N. (Director of Nurses) would discuss what services or resources were needed to care for patient and how to come about those resources when needed. Work with Medical Director and VP (Vice President) of Clinical Services to determine facility is capable to meet needs. Equipment and in-services completed prior to admission." This assessment indicates there are at least eight other residents who have Behavioral Health	S9999		

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S9999	Continued From page 16 Needs residing in the facility. The assessment documents that specific care of practices provided for residents' Mental Health or Behavior includes, "Contract with social work services group, manage medical conditions and medication related issues causing symptoms and behavior. Identify and implement interventions to help support anxiety, cognitive impairment, depression." Further, this assessment documents a list of employed staff, contracted staff, consultants, and ancillary staff providing care or services to residents which includes a Psychiatric Rehabilitation Service Coordinator, Behavior aides, a Psychologist, and a Psychiatrist. On 10/27/21 V6 (Admissions) stated he evaluated R1 prior to accepting R1 as a resident at the facility. V6 stated that he did not assess R1 in person but rather read through R1's hospital records to determine if the facility could meet R1's needs. V6 stated he is not a licensed nurse or medical practitioner. V6 stated that R1's hospital record did not show that R1 had any behaviors. V6 stated that R1 did have some mental health diagnoses which did not warrant any concern. V6 stated he did not think R1's medical record documented that R1 had any mental instability. R1 said that after R1 had to be emergently admitted to the hospital on 10/13/21 for behaviors, the facility did not want R1 to return unless R1 had a "psych eval." R1's facility list of current diagnoses includes Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Post-Traumatic Stress Disorder, and Insomnia. R1's physicians' orders from the time of R1's admission until R1 was emergently discharged	S9999		

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S9999	Continued From page 17 dated 10/1/21 to 10/13/21 do not indicate R1 was prescribed any psychiatric care, treatments or medications to treat R1's psychiatric/mood disorders. R1's orders do not include any referrals for psychiatric or mood order specialists to address R1's diagnoses or lack of treatments. R1's Minimum Data Set (MDS) assessment dated 10/8/21 documents that R1 is cognitively intact but has verbal behavioral symptoms directed at others four to six days per week, displays behaviors that significantly disrupt care or living environment, rejects care four to six days per week. R1's MDS documents that R1 has a psychiatric history including psychotic symptoms and possible misinterpretation of events and the intentions of others, demonstrates denial and/or evasiveness: when discussing mental health issues, minimizing significance of mental health/psychosocial issues, has diagnosis of depression and/or history of depressive illness: Presents with signs and symptoms of depression/mood distress, low self-esteem, isolation and withdrawn behavior, and complains of chronic pain, illness, fatigue and/or persistent anger, fear and/ or anxiety. This MDS also documents that R1 has a history and presence of dysfunctional behavior such as provoking, aggressive, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention-seeking, and/or otherwise abrasive, /inappropriate behavior including wandering into peer's rooms/ personal space. This MDS concludes based on these indicators that R1 is at high risk for a history of previous/recent mistreatment and/or potential future problems/ symptoms related to mistreatment. R1's care plan does not address R1's behavioral symptoms or R1's diagnoses of PTSD,	S9999		

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S9999	Continued From page 18 Schizophrenia, and Major Depressive Disorder except for adding R1, "Is at risk for abuse/neglect (related to) delusional thinking." R1's medical record does not include documentation that R1 was receiving behavior monitoring. R1's Social Services notes documented by V11 (Social Services Director) dated 10/13/21 document that R1 was transferred emergently to the hospital on that date after exhibiting the behaviors of yelling, cursing, threatening, name calling, and delusions. On 11/1/21 at 11:00a.m. V11 stated that R1 had been displaying delusions of grandeur and talking continuously to no one in particular using vulgar or inappropriate language since the time of R1's admission. V11 stated the only interventions that were put into place were, "The usual things like redirection." V11 could not describe any interventions that were implemented to address R1's specific psychological and mood disorders or symptoms. V11 stated that on 10/13/21 R1 was yelling, cursing, and threatening. V11 stated that R1 was brought into her office to calm down. V11 stated that the more she talked to R1 the worse R1 became so she told R1 she would stop talking to R1 if that would help. V11 stated that when no attempt at calming R1 down worked. The facility called for an ambulance to take R1 to the hospital for a psychiatric evaluation. R1's facility progress notes from the time of admission to discharge dated 10/2/21 to 10/13/21 includes only two physician progress notes, one dated 10/6/21 and the other dated 10/9/21. Neither physician's progress notes indicate that R1 has resident needs that cannot be met at the	S9999		

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S9999	Continued From page 19	S9999		

facility or that the facility does not offer services to meet R1's needs. These two physician's progress notes do not address R1's psychiatric/mood disorders or recommend any treatments. There are no progress notes indicating R1 was referred to or evaluated by a Psychiatrist, a Psychologist, a Psychiatric Rehabilitation Service Coordinator, or Behavior aides.

R1's hospital Interdisciplinary Team (IDT) meeting notes dated 11/1/21 document that R1's principal problem is Psychosis in Elderly. These same notes document that on 10/25/21, " (R1) is ready for discharge; writer will contact (the Facility) as (R1) has not received an involuntary discharge from the facility." R1's IDT notes also document that on 10/28/21 R1 was still at the hospital because, "Discharge is pending placement." These same notes document as of 11/1/21, "(R1) will be discharged once placement is found."

On 10/27/21 at 9:30a.m., at 12:55p.m. and on 11/1/21 at 1:00p.m. V1 stated that R1 cannot return to the facility until R1's mental status is stabilized. V1 stated that the facility does not have the services R1 needs in R1's current condition. V1 stated that V6 (Admissions) sends her regular updates on R1's condition while R1 is admitted to the hospital. V1 stated that based on R1's hospital notes, R1 is not suitable to come back to the facility despite R1's hospital IDT notes recommending discharge back to the facility. V1 also stated that no facility physician including the Medical Director, any other facility physician or physician's surrogate has reviewed R1's circumstances for being emergently admitted to the hospital, R1's hospital treatment plan, or current condition/ behaviors to determine whether R1 is appropriate to return to the facility. V1

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S9999	Continued From page 20 verified that the Facility Assessment documents that the facility is supposed to be able to care for residents with behaviors and a psychiatric diagnosis, however, V1 stated she didn't accept R1 as a resident in the facility. V1 stated R1 was accepted by the previous Administrator who no longer works at the facility. V1 stated she does not know what type of behaviors R1 had prior to being admitted to the facility. On 11/1/21 at 9:11a.m. V13 (Hospital Social Worker) stated that R1 was involuntarily admitted to the hospital on 10/13/21 because of behavioral problems R1 had on that date. V13 stated that R1 was evaluated by psychiatric specialists who prescribed psychoactive medications and interventions to treat and address R1's symptoms after R1 was admitted to the hospital. V13 stated that R1's behaviors are now in stable condition and R1 is ready for discharge back to the facility, however, the facility is refusing to take R1 back. "B"	S9999		