STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009948	A. BUILDING: _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITY VIEW MULTICARE CENTER	5825 WEST CERMAK ROAD CICERO, IL 60804

(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
S 000	Initial Comments Complaint Investigations: 2295788/IL149352 2296743/IL150477 2296706/IL150432 Investigation of Facility Reported Incident of 06-21-2022/IL148187 Investigation of Facility Reported Incident of 07-28-2022/IL149664 Investigation of Facility Reported Incident of 08-21-2022/IL150621	S 000		
S9999	Final Observations Statement of Licensure Violation 1 of 2: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)3) 300.3240e) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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

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S9999	Continued From page 2 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. 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. 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	S9999		

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S9999	Continued From page 3 e) 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 interviews, and record reviews, the facility failed to follow their abuse policy and prevent incidents of sexual assault and resident to resident physical assault. This failure affected 6 residents (R11, R33, R4, R36, R23, R28) of 8 reviewed for abuse. These failures resulted in R11 making an allegation of rape being sent to the local hospital to be assessed and diagnosed with multiple external rectal tears and dark redness with impending bruising to distal vaginal opening. Findings Include: Facility reported incident dated 6/15/22 reads in part: R11 alleged inappropriate contact by R21. Conclusion: R11 stated that R11 went into R21's room to watch television and did not anticipate having sexual intercourse with R21. R11 stated that R11 and R21 began kissing and that they had intercourse in R21's bed. R11 stated she did not want to have intercourse with R21. R11 informed staff the next morning that R11 did not want to have intercourse with R21. R11 was sent out for medical evaluation and returned the same day with no new orders.	S9999		

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S9999	Continued From page 4 R21 was interviewed and denies having sexual intercourse with R11. The facility is unable to substantiate the allegation made by R11. R11's Progress note dated 6/15/2022 at 9:00AM, reads in part: resident reported this AM to staff alleged abuse received from peer. Per resident "I was in peers' room last night and was touched inappropriately". Hospital records reviewed and read in part: stated complaint: possible sexual assault. 6/15/22 at 12:12PM body assessment reads in part: abrasions to anus, redness to vaginal area, sexual assault 6/14/22, type of assault-anal penetration, last voluntary intercourse/sexual activity: last year, contraceptive used by penetration: no, skin inspection: abrasion, genital inspection: abrasion. 6/15/22 at 1:39PM reads in part: upon examination redness noted to vaginal area, small tears noted to rectal area in internal and external area, small blood noted on swab when anus was swabbed. 6/15/22 Emergency Room: pelvic exam shows dark redness to impending bruising to distal vaginal opening, also has multiple external rectal tears without bleeding. Police report dated 6/15/22 at 12:05PM, reads in part: Criminal Sexual Assault Investigation. V59 (Nurse) related that R11 claimed R11 was raped by R21. R11 related that R11 had messaged R21 and asked R21 if R21 wanted R11 to go to his room. Once inside R21's room, the two sat on the bed and R21 allegedly began kissing R11 on the mouth. R21 then removed R11's shorts and underwear and vaginally penetrated R11 with R21's penis. R11 did not say to stop or put up any resistance. R21 then began to anally penetrate	S9999		

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S9999	Continued From page 5	S9999		

R11 causing R11 pain where R11 then stated for R21 to stop. R11 stated R11 did not tell R21 to stop or prior to R21 penetrating R11 sexually. R11 stated R11 was once raped when R11 was younger so R11 just froze and did not say anything because R11 did not want R21 to hurt R11 physically. R21 stated that R11 agreed to go to R21's room to watch TV and further stated that R21 and R11 only watched television and that they did not have sex. R21 also stated that they did not kiss or did anything sexually.

Sexual assault kit picked up by the local police and turned into the lab. Results are still pending. Results not yet available at this time.

On 9/7/22 at 12:00PM, V59 (nurse) stated that V59 remembers the time when R11 reported the incident that happened on 6/14/22. V59 cannot remember the complete details but remembers that R11 reported to her that R11 was raped by R21.

On 8/26/22 at 1:30PM, V1 (Administrator) stated that R11 reported to the nurse that R11 was raped and stated it was a black man, and then mentioned the name of R21. Before the police came and before sending R11 out to the hospital, R11 was able to give more details about watching television and kissing with R21. Further investigation R11 reported that she went to R21's room, watched television, but it was not R11's intention to have sex with R21.

R11 and R21 are both not available for interview. Both residents have been discharged.

Facility reported incident dated 7/14/22 reads in part: R22 was physical towards co-peer R33. Conclusion: Per staff, they witnessed R22

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S9999	Continued From page 6 wandering the dining room during mealtime as staff was trying to redirect R22 to his table, R22 was swinging his hands and accidentally bumped into R33. R22 is care planned for aggressive behavior with initial date of 1/6/21 and revision date of 7/8/22). The resident has a history of aggression (physical and verbal), inappropriate, and attention-seeking. R22's history includes conflicts/altercations with others, threatening behavior and verbal/physical aggression. R22's care plan interventions: Place resident on 72 hours well-being checks in order to monitor any mood and behavior changes and document accordingly (1/6/21). Remove resident from triggering environment. Motivate resident to exercise safety (initiated 11/27/21, revision on 8/31/22). Staff will monitor for aggressive behavior and redirect as necessary initiated 1/6/21. On 8/26/22 at 9:45AM, V20 (Assistant Administrator) stated that V20 investigated the incident. V20 stated that V20 asked the nurse assigned on the floor what happened. The nurse reported to V20 that R22 was walking around the unit pacing and accidentally bumped into R33. R22 was walking with his hands flaring and hit R33. The nurse immediately attended to the situation. The nurse separated residents immediately. The nurse completed an assessment on R33, no injury or pain noted. R22 was placed on one-to-one monitoring immediately. The incident was reported to Cicero police. The incident was a physical altercation, and it was part of the seven types of abuse, and it is the resident rights to be free from abuse. We did our diligence in our part to report and investigate the incident.	S9999		

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S9999	Continued From page 7 R22 has the behavior of flaring his hands. R33 was in a wheelchair, in the hallway when R22 passed by and accidentally hit R33. R22 has history of accidentally hitting other residents. V20 stated I cannot recall how many but more than one incident. During this incident, other staff were providing care with other residents and did not witness the resident-to-resident physical altercation. Only the nurse observed this incident. Prior to this incident, R22 was placed on one-to-one monitoring multiple times because of R22's aggressive behavior. When V20 was questioned about the location of the conflicts (reported to the state agency (SA)) V20 stated the incident happened in the hallway. V20 then stated "I apologize, if the final report says dining room, then that was where the incident happened. We have lots of incidents and I probably confused it with another incident". On 8/26/22, V23 (Dementia Care Coordinator) stated "I was in the facility the day of the incident. I believe it was the nurse that informed me that R33 reported to the nurse that R22 hit him. R33 is able to report if someone hit him. I believe R22 has a history of hitting other residents. I know we do close monitoring for R22 because of R22's aggressive behavior. This incident happened it the hallway, around the corner from R33's room. If someone hit R33, I know R33 is able to report it to staff. This is the first time I heard R33 report that a resident hit him. R33 did not have any other physical abuse allegation except for this incident. R33 was not hurt, no injuries and no reported pain. We are closely monitoring R22. V23 stated R22 has the tendency to swing R22's arms and hit others unintentional and unprovoked.	S9999		

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S9999	Continued From page 8 On 8/30/22 at 12:20PM, R33 stated that 3 months ago someone hit him on the back of the head. Per R33, he was watching television in the dining room. R33 noticed R22 walking in the dining room, then R22 got close to R33, and before the staff can get to R22, R22 already hit R33. R22 was just walking everywhere, and no one was watching R22 at the time. R33 stated that R33 was not expecting that R22 would hit R33. R33 stated R22 hit me in the head and my ear was warm for a while and painful at the time of the he hit me, but the pain went away. Since the incident R33 have not been close to R22. On 8/26/22 at 2:15PM, V50 (LPN) stated "I was doing rounds in the morning and R33 met me in front of R33's room and reported to me while pointing at R22 who at the time was coming out of the washroom. R33 stated "R22 hit me in the head" and I asked R22 what happened, R22 just muffled and walked away. I assessed R33, no pain and no injury. I monitored R33 then reported the incident to the administrator immediately. R22 wanders on the unit majority of the time, but I have not seen R22's hand swinging when walking. I am not aware of any history of R22 hitting another resident prior to this incident R33 is alert and oriented and able to report if something happens to R33. It was shift change at the time the incident happened, and I am pretty sure the other staff were doing patient care, there are no witnesses". Abuse Prevention Program with a revised date of 3/1/21, reads in part: 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. The following procedures shall be implemented when an employee or agent	S9999		

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S9999	Continued From page 9 becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party. R4 has the diagnoses of schizophrenia and altered mental status. R4's Brief Interview for Mental Status dated 8/15/22 documents a score of zero which indicates severe impairment. R4's care plan initiated and revised on 2/21/22 documents: Comprehensive assessment reveals past trauma and or other factors that may increase R4's susceptibility to abuse/neglect. R4 presents with an alteration in ability to communicate related to mental illness as evidenced by being selective with when and who she will communicate with. On 8/24/22 at 3:40PM, R4 was unable to report any physical abuse occurred. On 8/24/22 at 3:41PM, R26 (R4's roommate) who was assessed to be alert and oriented to person place and time, stated R27 entered our room, standing at R4's bedside. R4 asked R27 to get out. R27 hit R4 in the face and head multiple times. R4 tried to fight back. R27 stopped hitting R4 on her own and left our room. I informed staff. On 8/24/22 at 3:21PM, V17 psychiatric rehabilitation service director (PRSD) stated, R27 was impulsive and difficult to deescalate. Both R4 and R27 have cognitive delays and were unable to report what happen. R27 has a history of being impulsive and physically/verbally aggressive. R27 became physically aggressive without any warning towards R4. On 8/24/22 at 3:30PM, V20 (assistant administrator) stated, R27 was standing at R4's bedside. R4 was trying to redirect R27. R27	S9999		

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S9999	Continued From page 10 made physical contact with R4. Nursing Note dated 7/29/22 documents: Resident (R4) received physical contact from her co-peer (R27) inside her room as per witness by roommate (R26). Observed resident (R4) had a small superficial scratch on her face. Incident report dated 7/29/22 documents: R4 received physical contact from co-peer (R27). R27 was physically aggressive towards peer (R4). Witness R26. Abuse Prevention Program revised 3/1/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect and exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. #4 Physical Abuse: Hitting, slapping, punching and kicking. R36 has the diagnosis of schizoaffective disorder and cognitive communication deficit. R36's brief interview for mental status dated 8/29/22 documents a score of fifteen which indicates cognitively intact. On 8/24/22 at 3:32PM, V17 (PRSD) stated, R27 is impulsive, physically and verbally aggressive. On 9/7/22 at 2:36PM, R36 was unable to articulate what happened related to the altercation with R27. On 9/7/22 at 3:16PM, V61 psychiatric rehabilitation services coordinator (PRSC) stated, I did a wellbeing check on R36. I asked R36 if she was ok, related to an alleged physical altercation with a co-peer (R27). On 9/7/22 at 3:32PM, V21 (nurse) stated, R27	S9999		

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S9999	Continued From page 11	S9999		

was supposed to have hit R36. R27 has mental illness, unpredictable thoughts and actions. Sometimes things happen with the residents that is out of our/staff control. The incident with R27 and R36 that was unpredictable. I was called by staff (unable to recall who) to assess the situation. V21 stated use my charting as my factual statement. I assessed both R36 and R27 after an alleged physical altercation for alterations in skin. Incident report dated 7/21/22 documents: R36 allegedly received physical contact from peer (R27). No witnesses. Nursing note dated 7/21/22 documents: R36 observed within bedroom allegedly received physical contact from R27. Reportable dated 7/25/22 documents: R27 had physical contact towards her co-peer (R36).

On 8/26/22 at 11:56AM, R23 who was assessed to be alert to person, place and time stated, I was hit by a staff member who was tall, ball head and black. I was sleeping and he (unknown staff) hit me. He monitored the hallway.

On 8/30/22 at 3:14PM, V20 (assistant administrator) stated, R23 is alert and orient to person, place and time. R23 reported to V53 (nurse) that someone came into his room and hit him in the eye. R23 was unable to report who hit him and did not give a description. R23 has never accused anyone of hitting him prior to this incident. R23 has never hit himself.

On 9/1/22 at 9:45AM, V53 (nurse) stated, I saw R23 come out his room with a black eye. R23's injury was consistent with being hit. R23 did not have any other injuries

Nursing note dated 7/24/2022 documents: Resident (R23) was noted with swelling and discoloration to left side of his face. Resident

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S9999	Continued From page 12 (R23) was unable to recall events that led to the swelling. R28 has diagnoses of dementia and disorganized schizophrenia. R28's brief interview for mental status dated 7/8/22 documents cognitive skill for decision making is severely impaired. Care plan initiated 11/04/20 and 8/11/21 documents: R28 has a history of being a target of aggression from peers. Redirect when roaming into others rooms to decrease and avoid any problematic situations. R28 has wandering behaviors, R28 wanders in the hallway, dining room and other peer's room. Social service note dated 8/17/22 document: Without provocation, R16 made physical contact with another peer (R28). R28 was seen due to being a target of physical aggression. Another peer (R16) made physical contact with resident (R28). Incident report dated 8/17/22 documents: another peer (R16) made physical contact with resident (R28). No witnesses. Reportable dated 8/21/22 documents: R16 was physically aggressive toward his co-peer (R28) when R28 was found wondering into R16's room taking some of R16 personal belongings. R28 was noted to have an injury to the left side of his face. (B) Statement of Licensure Violation 2 of 2: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)3) Section 300.610 Resident Care Policies	S9999		

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

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S9999	Continued From page 13 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 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	S9999		

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S9999	Continued From page 14 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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	S9999		

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S9999	Continued From page 15 and goals to be accomplished, physician's orders, and personal care and nursing needs. 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. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to develop a plan to monitor and supervise a resident with a history of suicidal ideations and self-injurious behaviors. The facility also failed to have a plan to monitor and supervise residents with physical aggression. These failures affected 4 of (R22, R23, R27, R28) 4 residents reviewed for supervision. This failure resulted in R23 being found in the dining room attempting to hang himself from a pipe with a belt around his neck. R23 was taken down and sent to the local hospital for a psychiatric evaluation. Findings Include: R23 was admitted with schizoaffective disorder. R23's brief interview for mental status (BIMS) dated 7/21/22 documents a score of 9 which indicates moderately impaired and disorganized thinking. The facility placement assessment summary dated 4/14/21 documents: R23 is a high level for self-injurious behavior both recent and remote. R23 has a history of wanting to hurt himself. Screening assessment for evaluation self-harm/suicide risk and indicators of aggressive and/or harmful behavior dated 7/21/22	S9999		

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S9999	Continued From page 16 documents: R23 was a moderate risk. On 8/30/22 at 4:36PM, V35 (nurse) stated, I heard R29 screaming at 6:30AM. I ran to the dining room. R23 was hanging from a pipe with a belt tightly around his neck and the other end around the pipe. The belt gave away from the pipe causing R23 to fall to the ground. R23 was unresponsive. At the time of the incident the dining room was not being monitored by staff. On 8/31/22 at 10:52AM, V17 psychiatric rehabilitation service director (PRSD) stated, the facility placement assessment summary is used to determine psychosocial needs. R23's high level for self-injurious behavior both recent and remote and a history of wanting to hurt himself should have been a red flag. I would have processed R23 to determine if his self- injurious behavior was active or passive. Moderate risk on the screening assessments dated 7/21/22 would indicate R23 needed close observation which entails a staff member within R23's area to visually watch/monitor R23. There aren't any nursing notes that document R23 was being monitored closely. R23 was at risk for self-harm due to a history of self-destructive behavior including suicidal thought and suicidal actions, severe mental illness and recent aggressive/agitated behaviors. V17 stated residents should not be in the dining room without supervision. On 9/1/22 at 9:58AM, R29 stated, I saw R23 hanging from the pipe with a belt around his neck. R23 fell to the floor. I called the staff to hurry to come into the dining room. We did not have a monitor in the dining room. On 9/1/22 at 10:02AM, R31 and R32 where	S9999		

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S9999	Continued From page 17 observed in the dining room, sitting without staff supervision. Nursing note dated 7/31/22 documents: 6:40AM resident alerted this nurse to come in the dining room. Upon entering resident was noted with his belt wrapped around his neck on one end and the other around a pipe in the ceiling. R23 fell to the floor. Standard supervision and monitoring dated 2/2/22 documents: This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial 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 R27 has the diagnosis of violent behavior. Care plan initiated on 7/21/22 documents: R27 displayed conflictual, difficult behavior with other persons related to severe mental illness (schizophrenia and delusion disorder) and psychosis (audio, visual hallucination and disorganized delusion thoughts). Behavior: symptoms are manifested by impulsivity and unprovoked expressions of anger towards staff and peers. R27 demonstrates behavioral distress related to being challenged by mental illness. Problems: are manifested by verbal and physical abusive behaviors when agitated, alleged behavior towards peers. On 8/31/22 at 10:55AM, V17 (PRSD) stated, R27 has poor boundaries, difficulty redirecting, and refusal to process with staff. R27 is impulsive and actions where all of sudden.	S9999		

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S9999	Continued From page 18 On 9/7/22 at 3:32PM, V21 (nurse) stated, R27 has a mental illness, unpredictable thoughts and actions and sometimes things happen with the residents that are out of our/staff control. The incident with R27 and R36 was unpredictable. I was called by staff (unable to recall which staff) to assess the situation. Incident report dated 7/21/22 documents: R36 allegedly received physical contact from peer (R27). No witnesses. Final Reportable dated 7/25/22 documents: R27 had physical contact towards her co-peer (R36). On 8/24/22 at 3:41PM, R26 (R4's roommate) who was assessed to be alert and oriented to person place and time, stated R27 entered our room, standing at R4's bedside. R4 asked R27 to get out. R27 hit R4 in the face and head multiple times. R4 tried to fight back. R27 stopped hitting R4 on her own and left our room. On 8/24/22 at 3:21PM, V17 psychiatric rehabilitation director (PRSD) stated, R27 was impulsive and difficult to deescalate. R27 has a history of being impulsive and physically/verbally aggressive. R27 became physically aggressive without any warning towards R4. On 8/24/22 at 3:30PM, V20 (assistant administrator) stated, R27 was standing at R4's bedside. R4 was trying to redirect R27. R27 made physical contact with R4. Incident report dated 7/29/22 documents: R4 received physical contact from co-peer (R27). R27 was physically aggressive towards peer (R4). Witness R26. Standard supervision and monitoring dated 2/2/22 documents: This guideline emphasizes a proactive intervention promoting enhanced	S9999		

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S9999	Continued From page 19	S9999		

physical and psychosocial 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.

R28 has diagnoses of dementia and disorganized schizophrenia. R28's brief interview for mental status dated 7/8/22 documents cognitive skill for decision making is severely impaired. Care plan initiated 11/04/20 and 8/11/21 documents: R28 has a history of being a target of aggression from peers. Redirect when roaming into peers' rooms to decrease and avoid any problematic situations. R28 has wandering behaviors in the hallway, dining room and other peer's room.

On 8/30/22 at 3:56PM, V57 (cna) stated, R28 wanders and requires constant supervision. I have to sit outside R28's room in this chair to prevent R28 from wandering into other resident's room.

On 9/1/22 at 9:09AM, R28 was observed coming out of co-peer R9's room. R9 who was assessed to be alert and orient to person, place and time stated, R28 just came in my room and sat on that bed. I did not ask R28 to come into my room nor did I want R28 in my room. Social service note dated 8/17/22 documents: R28 was seen due to being a target of physical aggression of peer R16. (R16) made physical contact with resident (R28) without provocation. Incident report dated 8/17/22 documents: another peer (R16) made physical contact with resident (R28). No witnesses. Reportable dated 8/21/22 documents: R16 was physically aggressive toward co-peer (R28) when R28 was found wondering into R16's room taking some of R16's personal belongings. R28 was

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S9999	Continued From page 20 noted with injury to the left side of his face. Facility reported incident dated 7/14/22 reads in part: R22 was physical towards co-peer R33. Conclusion: Per staff, they witnessed R22 wandering the dining room during mealtime and as staff was trying to redirect R22 to his table, R22 was swinging his hands and accidentally bumped into R33. R22 has diagnoses not limited to schizoaffective disorder bipolar type and dementia without behavioral disturbances. R22's Care Plan review date 1/6/21 with revision date of 7/8/22, reads in part: Socially inappropriate behavior. Resident has presented with inappropriate personal boundaries manifested by inappropriately touching peers and staff, screaming and yelling in the hallway. Interventions: Staff will continue to re-direct and offer assistance when resident is on the floor (date initiated 4/5/2021). Staff will provide redirection and place resident on close monitoring when suspected or any reports of inappropriate behavior (Revised 1/6//21). Staff will provide redirection when observed entering others room or personal area (Revision on 1/6/21). R22 is care planned for aggressive behavior with initial date of 1/6/21 and revision date on 7/8/22). The resident has a history of aggression (physical and verbal), inappropriate, and attention-seeking. R22's history includes conflicts/altercations with others, threatening behavior, verbal /physical aggression. Interventions: Place resident on 72-hour well-being checks in order to monitor any mood and behavior changes and document accordingly (1/6/21). Remove resident from triggering environment. Motivate resident to	S9999		

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S9999	Continued From page 21	S9999		

exercise safety (initiated 11/27/21, revision on 8/31/22). Staff will monitor for aggressive behavior and redirect as necessary. Abuse and Neglect indicates: Resident is noted to have been the target of aggression from peers and to display inappropriate behaviors and aggression such as throwing things while in on the unit. These behaviors are unprovoked and unpredictable (initial date of 1/6/21 and revision on 5/12/22).Interventions: Staff will remain available for any behavioral changes (initiated 8/20/22 and revision 8/31/22). Place on 72-hour wellbeing checks when the target of aggression to further monitor any changes (imitated 11/11/21 and revision on12/5/21). Remove resident from triggering environment. Motivate resident to exercise safety. Place on 1:1 supervision (date initiated 8/20/22 and revision on 8/31/22) Staff will immediately intervene if observing resident and see signs of abuse/neglect (initiated 1/11/21 and revision on 11/22/21).

On 8/26/22 at 9:45AM, V20 (Assistant Administrator) stated that V20 investigated the incident. V20 stated that V20 asked the nurse assigned on the floor what happened. The nurse reported to V20 that R22 was walking around the unit pacing and accidentally bumped into R33. R22 was walking with his hands flaring and hit R33. The nurse immediately attended to the situation. The nurse separated the residents immediately. The nurse completed an assessment on R33, no injury or pain noted. R22 was placed on one-to-one monitoring immediately. The incident was reported to Cicero police. V20 stated the incident was physical altercation, and it was part of the 7 types of abuse, and it is the residents right to be free from abuse. V20 stated we did our diligence on our part to report and investigate the incident. R22 is

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S9999	Continued From page 22 noted to have the behavior of flaring his hands. V20 stated R33 was in a wheelchair in the hallway and R22 passed by and accidentally hit R33. R22 has history of accidentally hitting other residents, I cannot recall how many but more than one incident. During this incident, other staff were providing care to other residents and did not witness the resident-to-resident physical altercation. Only the nurse observed this incident. Prior to this incident, R22 was placed on one-to-one monitoring multiple times because of R22's aggressive behavior. When V20 was questioned about the location conflicts (reported to the state agency (SA)) and interview. V20 stated that incident happened in the hallway, V20 stated "I apologize, if the final report says dining room, then that was where the incident happened. We have lots of incidents and I probably confused it with another incident". On 8/26/22, V23 (Dementia Care Coordinator) stated "I was in the facility the day of the incident. I believe it was the nurse that informed me that R33 reported to the nurse that R22 hit him. R33 is able to report if someone hit him. I believe R22 has a history of hitting other residents. I know we do close monitoring for R22 because of R22's aggressive behavior. The incident happened it the hallway, around the corner from R33's room. If someone hit R33, I know R33 is able to report it to staff. This is the first time I heard R33 report that a resident hit him. R33 did not have any other physical abuse allegation except for this incident. R33 was not hurt, no injuries and no reported pain. We are closely monitoring R22 and redirecting R22. Sometimes R22 has the tendency to swing R22's arms and hit others unintentional and unprovoked.	S9999		

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S9999	Continued From page 23 On 8/30/22 at 12:20PM, R33 stated that 3 months ago someone hit him on the back of the head. Per R33, he was watching television in the dining room, near the television. R33 noticed R22 walking in the dining room, then R22 got close to R33, and before the staff could get to R22, R22 had already hit me (R33). R22 was just walking everywhere, and no one was watching R22 at the time. R33 stated that R33 was not expecting that R22 would hit R33. R22 hit me in the head and my ear was warm for a while and painful at the time of the incident but the pain went away. Since the incident R33 has not been close to R22. On 9/7/22 at 12:45PM, V2 (Director of Nursing) stated "I was not part of the investigation. An abuse allegation usually goes to the administrator. R22 is a wanderer. If R22 is having behaviors such as not redirectable or altercation with someone either verbal of physical, or if R22 becomes aggressive with staff we will do a one-to-one supervision. We will keep R22 on one-to-one monitoring for as long as R22 presents aggressive behaviors". On 8/26/22 at 2:15PM, V50 (LPN) stated "I was doing rounds in the morning and R33 met me in front of R33's room and reported to me while pointing at R22 who at the time was coming out of the washroom. R33 stated "R22 hit me in the head" and I asked R22 what happened, R22 just muffled and walked away. I assessed R33, no pain and no injury were noted. I assessed R33 and then reported it to the administrator immediately. I observe R22 wandering on the unit majority of the time but have not seen R22's hand swinging when walking. I am not aware of any history of R22 hitting another resident prior to this incident R33 is alert and oriented and able to report if something happens to R33. It was shift	S9999		

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S9999	Continued From page 24 change at the time the incident happened, and I am pretty sure the other staff were doing patient care, there are no witnesses". On 9/2/22 at 11:00AM, R22 was observed to be ambulating the hallway. R22 was observed walking from the dining room area to the end of the hallway where R22's room is located. R22 stayed in the hallway, paused for a short period of time and went back into the dining room. There was no staff member redirecting the resident or monitoring R22 at that time. Other residents are observed in the hallway and dining room area. One staff member observed in the nurse's station, sitting in front of a computer. On 9/6/22 at 1:00PM, R22 was observed again walking from the dining room to the end of the hallway. R22 observed would pausing for a short time then started walking back to the dining room. Other residents observed walking the hallway also. There are no staff to visually monitor the resident at the end of the hallway, close to R22's room. (A)	S9999		