STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003826	A. BUILDING: _____ B. WING _____	C 08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWAY NEUROLOGICAL / REHAB CENTER	8540 SOUTH HARLEM BRIDGEVIEW, IL 60455

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S 000	Initial Comments Annual Certification Survey Complaint Investigations: 2296327/IL149997 2294737/IL148073	S 000		
S9999	Final Observations Statement of Licensure Violations: I of III 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to keep a resident free from abuse. This failure applied to one (R290) of one resident reviewed for abuse and resulted in R290 being transferred to local hospital and diagnosed with a broken nose as a result of physical abuse by another resident. B. Based on interview and record review, the facility failed to follow their smoking policy by not providing a safe smoking environment and failed to provide supervision to residents while smoking per their policy and residents' plans of care. This failure applied to two of two (R290 and R469) residents reviewed for accidents and supervision. These failures resulted in R290 being physically assaulted by R469, resulting in R290 getting a broken nose. C. Based on observation, interview, and record review, the facility failed to keep a resident free from physical abuse by a staff member. This failure applied to one (R310) of one resident reviewed for physical abuse as a result of R310 being hit in the eye by a staff member. Findings include: R290	S9999		

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S9999	Continued From page 2 R290 has resided at the facility since 2019, with medical diagnosis including, but not limited to other spondylosis lumbar region, schizoaffective disorder bipolar type, major depressive disorder, pain in another specified joint, etc. On 8/15/22 at 12:00 PM, R290 was observed in her room, alert and oriented and said that she still gets stomach pain, they give her a pain pill, but it does not work, she wants to go to the hospital to be evaluated but staff will not send her out, she saw the doctor sometimes ago and they did some tests but did not do any other thing. R290 added that she was attacked by another resident sometime last year while they were in the smoking patio for no reason, she sustained a broken nose and was sent to the hospital. R290 added that the resident who attacked her is no longer at the facility. Review of hospital record dated 5/28/2021 states that resident was found awake and alert, nurse stated that resident was involved in an altercation with another resident and patient was punched in the face, staff stated that the incident was not witnessed by any staff and the location is unknown. CT of facial bone done at the hospital on 5/28/2021 shows minimally displaced nasal septum fracture. Facility reportable identified the other resident as R469, who was admitted to the facility on 8/28/2020, past medical history including but not limited to schizoaffective disorder, hyperlipidemia, muscle wasting, etc. Resident was admitted from the hospital but was sent to the hospital from another facility for aggressive and violent behavior towards staff as documented in admission progress note. Facility assessment for aggressive behavior dated 9/20/2020, 1/8/2021,	S9999		

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S9999	Continued From page 3 4/8/2021 and 7/7/2021 all assessed resident as minimal risk for aggressive behavior. Review of progress notes for R469 on the contrary shows several documentations of agitation and aggressive behavior by R469 towards staff and other residents. Progress note dated 5/27/2021 states the following: Resident was involved in a physical altercation at 9:50pm with a peer on the patio. Residents were immediately escorted to units. Head to toe assessment was completed. Resident noted with swelling and discoloration to nose. No open areas. First aid was given. Ice pack was applied to area to reduce swelling. Pain was scaled at 8/10 prn pain med was given. Md made aware and ordered to send resident to the hospital for evaluation. Administrator, department heads and family made aware. Local police called awaiting on arrival. Vitals stable T97.4, b/p149/87, p84, r18,98%ra. Progress note dated 5/28/2021 reads: Received resident alert and verbally responsive. I/C D1/3. Swelling noted to bridge of nose. Ice pack applied to area. Denies pain currently. Due meds given. Appetite good for meals. No behavioral issues noted this shift. Resident is resting in bed. Staff will continue to monitor. Vitals stable T97.8, b/p135/82, p78, r18,98%ra. 8/16/2022 at 12:51PM, V1 (Administrator) said that he vaguely remembers R469 or his behaviors, resident is a smoker and the resident-to-resident altercation happened in the evening, he does not remember the specifics because it has been one year. V1 added that the incident was witnesses by staff and he does have statements.	S9999		

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S9999	Continued From page 4 On 8/16/22 at 12:51 PM, V33 (Social Worker) said that he recalls R469, he wanders and paces a lot and will start voicing out words, he recalls the resident-to-resident altercation. R469 already came to the patio agitated, asked for a cigarette but he did not have any to give him. V33 added that he did not witness the altercation, it was reported to him. On 8/18/2022 at 11:10 AM, V4 (Licensed Practical Nurse/LPN) said that she has worked at the facility for six years, she was the assigned nurse for R290 the day she was involved in a physical altercation with another resident. V4 said that she does not know the other resident but R290 was bleeding from her nose, she was sent to the hospital and came back to the facility. V4 said that R290 was hit on the nose by another resident, no one witnessed it, it happened during the night at their last smoking break. On 8/18/22 at 11:25 AM, V39 (Smoke Monitor) said that he does not recall R469 but knows R290, he cannot recall any altercation between R290 and another resident, did not witness any and no one reported any to him. A document presented by V3 (Director of Nurses/DON) titled abuse prevention program with a revision date of 3/1/2022 states in part that it is the policy of the facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. Under prevention, the same document states that as a part of social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse...or who have needs and behaviors that	S9999		

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S9999	Continued From page 5 might lead to conflict. Smoking care plan for R290 and R469 dated 1/19/2022 and 10/8/2021 both stated that staff will be observing and supervising residents' behavior, non- compliance will be documented in the medical record. Facility Smoking Policy (dated 11/10/2020) states in part: Purpose is to provide a healthy and safe smoke environment as possible for all residents...to include those who smoke and those who do not smoke. The document further states that all residents will be under supervision while smoking, resident must remain within eyesight of the smoking monitor. Smoking monitors will hold lighters for ignition of cigarettes. R310 R310 was admitted to the facility 4/6/22 with diagnoses that include Hemiplegia and Hemiparesis following Cerebral Infarction, Cognitive Communication Deficit, and Unspecified Convulsions. R310 has a BIMS (Brief Interview of Mental Status) of 10 (moderately impaired), is alert, oriented and appropriate during conversation and requires extensive one-person physical assistance with personal hygiene and toileting. On 8/16/2022 at 1:20 PM, R310 was observed alert and oriented dressed appropriately, sitting in wheelchair and not in any apparent distress. On 8/16/22 at 1:30PM R310 said, do you know the difference between an accident and on purpose? I was hit in my eye by a CNA(Certified Nurse Assistant). I don't know the exact date, but	S9999		

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S9999	Continued From page 6 it was a few weeks ago. She hit me in my eye and said I get on her damn nerves. My eye was a little red and swollen. It was my right eye. I have a glass eye in the left. I told the staff and my daughter, my daughter talked to them and then told me that I need to do what they say and not to argue with them. R310 indicated that the CNA was in the hallway and pointed them out. On 08/16/22 at 1:59 PM V9 (CNA) said, I don't usually work with R310 because I have a permanent set. One day, R310 got mad at me because we were trying to find the key to her personal refrigerator to warm her food and I went to tell her we were looking for it. She is impatient and when she gets frustrated, it frustrates the other staff. I never touched her. Later, the daughter asked me if I put my hands on her. The daughter told her that she can't curse people out. I'm pretty sure it was reported. The nurse was aware, and she told me to just stay away and stay clear. Nothing else happened after that. On 8/18/22 at 11:04 AM, V1 (Administrator) said, the only documentation of abuse would be in the reportable file sent to IDPH in the initial and final report. We do don't document allegations anywhere else. On 8/18/22 at 1:37 PM V1 (Administrator) said, we are still investigating the allegation presented by R310. The CNA stated to us that she spoke with the family about the allegation. No one from the Nursing department notified me or the administrative team of this allegation when it occurred. We are not yet able to determine the nurse that was working at the time this occurred. The staff is expected to report all allegations of abuse immediately to myself, the Assistant Administrator, or the Director of Nursing.	S9999		

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S9999	Continued From page 7 R310's Progress notes and Care plan reviewed. No evidence of allegation being reported was documented. No documentation or evidence was provided from the facility confirming that alleged abuse did not occur. Facility's Abuse Prevention Program (last revised 3/1/22) and includes: ABUSE AND CRIME REPORTING Policy This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals... All personnel must promptly report any incident or suspected incident of resident abuse, mistreatment, neglect, or exploitation including injuries of an unknown origin. (An injury should be classified as an "injury of unknown origin" when the source of the injury was not observed or known by any person, and the Initial Skin Tear/Bruise Investigation could not determine the cause of the injury... All personnel, residents, visitors, etc. are encouraged to report incidents of resident abuse, mistreatment or neglect or suspected abuse, mistreatment, or neglect, without fear of retaliation or retribution from the facility or its staff... For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain	S9999		

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S9999	Continued From page 8 or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm... 4. Physical Abuse: Hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment... 8. Neglect/Mistreatment means the failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident. Procedure Any alleged violations involving mistreatment, abuse, neglect, exploration, misappropriation of resident property, any injuries of an unknown origin, or reasonable suspicion of a crime against a resident MUST be reported to the Administrator or Director of Nursing. The Administrator is the Abuse Coordinator of the facility. Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse who will immediately report the allegation to the Administrator, regardless of the time lapse since the incident occurred. The charge nurse will immediately report the incident to the Administrator or to the DON during the Administrator's absence. Reporting procedures will be followed as outlined in the policy. The following information should be reported to	S9999		

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S9999	Continued From page 9 the Charge Nurse: 1. The name of the resident(s) involved. 2. The date and time that the incident occurred. 3. Where the incident took place. 4. The name(s) of all individuals suspected of committing the incident, if known. 5. The name(s) of any witnesses to the incident. 6. The type of abuse that was allegedly committed (i.e., verbal, physical, sexual, etc.)* or the reasonable suspicion of a crime against a resident. 7. Other information that may be requested by the Charge Nurse... After notification of alleged abuse, neglect or a suspected crime against a resident, the Administrator or DON in the Administrator's absence shall immediately commence an investigation of the incident reported. The findings of such investigation will be provided to the Administrator within five (5) working days of the occurrence of such incidents. The Administrator shall either rule-out or substantiate the allegation of abuse... Abuse allegations involving one resident upon another resident will be reported to IDPH... Upon receiving information concerning a report of abuse, the Administrator or Director of Nursing will request that a representative of the social services department monitor resident's feelings concerning the incident as well as the resident's reaction to his/her involvement in the investigation... NO VIOLATION Statement of Licensure Violations: II of III 300.610a)	S9999		

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S9999	Continued From page 10 300.620g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.620 Admission, Retention and Discharge Policies g) A facility shall not refuse to discharge or transfer a resident when requested to do so by the resident or, if the resident is incompetent, by the resident's guardian. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to keep a resident free from involuntary seclusion by not allowing a resident to discharge from the facility against medical advice immediately after the resident expressed the desire to discharge from the facility. This failure applied to one (R569) of one resident reviewed for discharge and resulted in R569 being kept in the facility against her will for two days and experiencing anxiety and psychosocial harm as a result of not being allowed to leave the facility. Findings include:	S9999		

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S9999	Continued From page 11 R569 was admitted to the facility on 8/8/22 with primary diagnosis of congestive heart failure and admitting diagnoses of lupus and anemia. Other diagnoses include essential hypertension, hypokalemia, and long term (current) use of anticoagulants. On 8/16/22 at 9:01 AM R569 was asked about her experience surrounding her admission and discharge to the facility and stated the following: I have my own apartment. I have CHF (congestive heart failure) and I don't have a vent (in my apartment) and only have fans. My neighbors smoke and everything comes in here. I was feeling sick and called 911, and the ambulance took me to (local hospital). Thinking that the hospital social worker would help me find a better place, I agreed to go to the facility. When I went into the room, I saw all these men running around, God knows what was going on. I asked what kind of place is this? I'm not mentally ill, why did they bring me here? I'm supposed to be at an independent living place. The hospital social worker told me that I am free to leave whenever I want. When I tried to leave, the security guard came and then called the med team and said they were going to give me a "shot." I told them they weren't going to give me anything and they better not touch me. They wouldn't let me leave so I called the police; they came, and the ambulance came. The police came and said I couldn't leave because the medical record said I was drunk and using drugs, I never used drugs in my life. The facility must have given them false information from my medical record, so they told me I couldn't go anywhere. After the police left, I went back into my room. They had such a nasty attitude and said no, I have to talk to the social worker tomorrow. My mind was in shock, I stayed up	S9999		

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S9999	Continued From page 12	S9999		

half the night and waited until the morning. I told the lady I was on my monthly and they still didn't give me anything to take a shower or nothing. Social work director or something like that came into my room in the morning and asked me why I was in this facility. I told him that I didn't know why I was here. He looked at the computer and said my record said I had meth and something in my system, I don't know what that is, I don't use drugs. They said I had alcohol in my system and slobbering at the mouth; I told him I never did any of those things. Then he looked and said that is not me, that's a man. I offered to show him my driver's license so he could see that it wasn't me. They treated me like a dog. They didn't feed me. I couldn't take a shower and I was on my cycle. The same way they are treating me, they are treating all of those people in there. The staff talk to people like they are dogs. I have no mental illness. I have lupus and heart problems. My niece had to sign me out of that place. It felt like a dream, or a movie, something that is not real. It's so sad. I cried and cried and cried. I have video and you can hear how they are talking to me, and you can hear me just crying.

R569 became very emotional and crying during interview; she stated that she always cries when she talks about this experience because she can't believe it actually happened.

Local Police Department - Event Report dated 8/8/22 20:26:40 documents the following information:
Nature: Assist Citizen
Caller: (Resident Name) R569
Notes: Caller is in (room#), would like to leave and is hysterical [8/8/22 20:28:10]
SAYS HER FRIEND IS ENRT TO GET HER, AND THEY ARE TELLING HER SHE CAN'T

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S9999	Continued From page 13 LEAVE [8/8/22 20:28:52] Subject is calm and was advised by staff that she cannot leave until she is evaluated by social worker tomorrow morning [8/8/22 20:46:30] Call Received: 8/8/22 20:26:40 Call Routed: 8/8/22 20:28:35 1st Dispatch: 8/8/22 20:31:20 1st En-Route: 8/8/22 20:31:20 1st Arrive: 8/8/22 20:41:36 On 8/18/22 at 4:39 PM, V19 (Social Service Coordinator) was asked about interaction with R569 since he had written a note in the medical record, documenting that resident had behaviors when redirected off the elevator. V19 stated that the resident was not on his caseload. V19 continued to explain that the resident was not allowed to leave as she requested because she needed to have someone sign her out and would not provide them with her address or the name of her landlord or phone number. It's part of the policy and procedure for residents to provide this information if they are leaving. She did not have a guardian or POA that I'm aware of. When asked why R569 had to provide the name and phone number of her landlord to discharge if she is her own decision maker. V19 said, we just want to make sure that residents have a safe discharge. We needed to make sure that someone is here to pick her up for her safety and her health. Surveyor asked V19 why a resident who is their own decision maker, has no guardian or POA, no diagnoses of mental illness or developmental disability, and no apparent skilled care needs was not allowed to leave AMA as requested? Further, why does someone need to sign this individual out? V19 stated that the situation was brought to the attention of his supervisor, V17 (Social Service Director).	S9999		

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S9999	Continued From page 14 On 8/18/22 at 4:51 PM, V17 (Social Service Director) was asked the same questions as were asked to V19. V17 said, R569 came in the day before and so I saw her the next day - we basically tried to see what she was here for and what we could do to help her. When I found out that she wanted to be discharged we called the doctor and informed him that she wanted to be discharged. I wanted to make sure that she had a safe ride and could make it to her destination. We tried to know where she was going to make sure that she had a legitimate ride for a safe discharge. From my understanding her ride didn't show up to pick her up. When her ride didn't show up, she needed a dial-a-ride to come and get her so the next day she left. There wasn't really a delay - her transportation didn't come to get her. Our number one concern was her safety. She was her own decision maker that I know of and did not have a POA. She just did not have transportation. When asked why transportation was a requirement for discharge? V17 stated that it was to ensure the resident's safety. On 8/18/22 at 5:07 PM V1 (Administrator) said, I spoke to the social services team on the 9th when they were trying to assist her, when they told me that a family member was going to pick her up. Social service wanted someone to be aware that she would be leaving. We gave her $5 and allowed her to go. She waited patiently for her family to come but they never arrived. There was conflicting information with the paperwork that we received from the hospital versus the packet that the patient arrived with, in social services trying to dissect that, they discovered the discrepancy. V1 was asked what the admissions process is in determining that a resident is appropriate for skilled nursing care and their facility. V1 responded that the resident was	S9999		

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S9999	Continued From page 15 appropriate because the PASRR showed that the resident was eligible for skilled care. When asked again what specific, skilled care needs the resident had, V1 stated that she had congestive heart failure. When asked if a diagnosis alone is sufficient to require skilled care, V1 referred to the clinical team that makes the determination if a resident is appropriate for medical care. V1 confirmed that R569 had no psychiatric diagnoses but was in the facility for medical care. V1 was asked what were the medical needs of the resident that caused her to be admitted and V1 did not answer the question and referred to V2 (Assistant Administrator), who is part of the clinical team that makes admission decisions. On 8/18/22 at 10:56 AM, R569 continued with interview and stated, that the facility wanted her to be signed out by someone when she told them she wanted to leave. I told them I have no family members in Chicago, and I have only been here for two years. If I had no one to sign me out, I would have had to stay there. They weren't going to let me leave without anyone. My niece in Louisiana had to email them back the form with a copy of her driver's license so that I could get signed out. Then (dial-a-ride) service came to pick me up. I had to pay (dial-a-ride) service $3.25 to come and pick me up (when I finally was allowed to leave). The first night a friend of mine paid someone she knows $40 to come and pick me up. My friend was there when the police came, and they told her too that I couldn't leave. The second night I called (dial-a-ride) service and the supervisor opened a case because it wasn't a 24-hour notice, and you are supposed to call 24 hours in advance, but when they came to pick me up, the facility still wouldn't let me leave with them. I have no care needs. I am fully independent and need no assistance with	S9999		

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anything. I have no problem taking my medication or accessing care or other needs. I have no pain management issues. I only have pain when my lupus flairs up and my skin gets irritated, but I just keep it clean and wash it. I just try to rest as much as I can. I never saw a doctor or nurse practitioner while I was in the facility. When they (facility staff) came toward me, I told them don't put your hands on me and they didn't touch me, but it felt like it came close. It's like a movie, I never seen such a thing in my life. I didn't even think anything like this ever existed. I told them they are holding me against my will, and they were just telling me that I wasn't going anywhere. I thought my life was gone. I'm in the medical field, I'm a lupus advocate and I know that they really give people "shots" to knock them out. They wouldn't take me to the hospital because they said, they will just bring me right back.

On 8/21/22 at 1:19 PM, surveyor received a return call from V44 (Hospital Social Worker). Surveyor asked V44 if she was familiar with (R569) and V44 recalled the resident well. When asked why R569 was admitted to a skilled nursing facility if her hospital discharge paperwork documents that resident was waiting for placement at an assisted living facility (ALF). V44 responded that the resident was ready to be discharged and it was taking long for any ALF facilities to get back to her and it was much faster to discharge the patient to a nursing home. She had gotten a response back from one other nursing home in the city. Also, they were waiting for the resident's toxicology screen to come back (which came back negative). When asked what care needs the resident had that needed to be provided by a nursing home, V44 responded that R569 did not have any care needs as she was

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S9999	Continued From page 17 "very independent." R569 seemed to just want to get out of the basement apartment that she was living in at the time. V44 also confirmed that R569 is her own decision maker and has no impairment in regard to making decisions on her own. On 8/18/22 at 3:46 PM V45 (Admissions Director) stated that she mostly works outside of the facility, meeting with residents and working on screening for admissions. When asked if she had met with R569 prior to admission, V45 stated that since COVID, she can't always go to the hospital to see the patient before admitted them. In that case, she will just go off the paperwork received from the hospital and will do an initial assessment and then forward it to the clinical team to decide about whether they can meet the residents care needs and if they are appropriate for the facility. V45 confirmed that she did not meet with R569 or provide her with any information about the type of facility this was. On 8/18/22 at 5:18 PM V2 (Assistant Administrator) was asked why R569 was admitted to the facility. V2 stated that the hospital paperwork said that she was admitted for smoke inhalation, she has diagnosis of congestive heart failure, and chest pain. The day that she came, she had a packet from the hospital. I think the hospital gave her the idea that she was going to an assisted living facility. The record says that she was cleared by cardiology for discharge and was awaiting placement at an assisted living facility. Asked how the determination is made to accept a resident. V2 said, we review the packet sent over from the hospital and if they have the PASRR. When asked what medical care needs or activities of daily living the resident needed assistance with, which required skilled nursing	S9999		

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S9999	Continued From page 18 care. V2 responded that (R569) had pain and did not provide any further details as to why the resident was admitted or what skilled care needs the resident had. Review of care plans and physician orders provided, do not include any orders for pain medication or any diagnoses related to any psychiatric disorders. Facility provided the following care plans (including but not limited to): -Discharge Potential / Discharge Planning Care Plan dated 8/8/22 includes: My discharge potential is: Fair My tentative plan is for me to move to: Not applicable Approaches/Interventions: As necessary, meet with me/my representative on a regular basis to help me with the mental preparation for discharge. Provide me with an opportunity to express my thoughts or feelings. Address my concerns prior to discharge. -R569 has a care plan for Specialized Psychiatric Programming dated 8/8/22 includes: I have a diagnosis and history of severe mental illness (SMI). The symptoms that I have are manifested by: Need for on-going psychoactive medication. Approaches/Interventions: Utilize assessment data (i.e., MDS, CAA's, Psychiatric Evaluation, Level of Functioning and Psychosocial History) to help determine my present needs, deficits, abilities and strengths. -Care plan for History of Suspected Abuse/Neglect/Trauma dated 8/8/22 and includes:	S9999		

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S9999	Continued From page 19 I have the following Strengths and Abilities: Able to make needs and wants known. Hospital records document an admit date of 7/22/22 and admitting diagnosis of Chest Pain, R/O ACS. - Assessment: Atypical chest pain, Lupus, Anemia, and Cardiology consult: 2D ECHO normal; non-coronary ischemia - Plan: Cleared by cardiology for discharge, Anemia workup as outpatient - Social worker paid a visit and will be reverting to the patient regarding an assisted living facility. Awaiting placement in an assisted living facility. - UDS (urine drug screen): Negative 8/5/22 - Discussed with ER MD - Apparently patient is waiting for placement History of present illness: 49yo F with PMH SLE and CHF presented to the ED with non-radiating left chest pain that woke her up from sleep this morning after smelling smoke coming from the units above her basement. She also reports having some palpitations and mild dyspnea earlier, but they are now subsided. No fever, chills, cough/URI symptoms, N/V, leg swelling/pain, back pain, or other acute physical complaints. No recent travel or sick contact. Denies tobacco or illicit drug use. Pt denies any chest pain now. Review of New Admission packet for R569 includes (but not limited to) the following information: Approved by V2 (Assistant Administrator). Admission packet also includes copy of PASRR Screen Outcome which documents PASRR Level I Determination: No Level II Required - No SMI/ID/RC ...Your Level I screen does not show that you have a serious mental illness or an intellectual/developmental disability (IDD). You	S9999		

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S9999	Continued From page 20 do not need more screenings unless you have or may have a serious mental illness or an IDD and experience a significant change in treatments needs. Please note admission to a nursing facility is a choice made by you or the legal entities that have the authority to make decisions for you. This nursing facility screening notice does not require you to admit to a nursing facility. Typical Living Situation: Home alone Mental Health Diagnoses: No mental health diagnosis is known or suspected Substance Related Diagnoses - Does the individual have a substance related disorder (abuse or dependency)? Yes, Opioids, When was the last known use - Less than 7 days Is the request for nursing facility in any way associated with or resulting from the substance related disorder? No Dementia/Neurocognitive Disorders - Does the individual have a diagnosis of dementia/neurocognitive disorder? No Behaviors & Symptoms - Interpersonal Behaviors There are no known mental health behaviors which affect interpersonal interactions There are no known mental health symptoms affecting the individual's ability to think through or complete tasks which she/he should be physically capable of completing. There are no known recent or current mental health symptoms Behavioral Health Services - Has the individual received any of the following mental health services now or in the past? NO Behavioral Health Impact - Has there been legal intervention due to mental health symptoms/behaviors? NO Has the individual had to move to another setting because of mental health symptoms? NO Has the individual even been homeless? NO Are there other examples where the individual's	S9999		

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life has been seriously affected because of mental health symptoms? NO
Does the individual have a diagnosis of an intellectual disability? NO
Is the individual suspected to have an intellectual disability that has not been diagnosed? NO
Recommended Services - No recommendations at this time
Recommended Supports - No recommendations at this time

On 8/18/22 at 12:44 PM V3 (Director of Nursing) was asked about the procedure for residents wanting to discharge AMA (against medical advice). V3 stated that if they are their own responsible party, they call the physician and get orders. As long as the resident is stable, we provide education and have them sign AMA paperwork.

On 8/19/22 at 2:39 PM, V43 (Medical Director) was asked if he was made aware that R569 requested to be discharged against medical advice. V43 confirmed that he was made aware. V43 said, I advise them that you have to consider the resident's mental condition but there is consideration for the patient's medical and psychiatric condition; but we investigate every allegation of abuse. Whenever the allegations come thru, they take it extremely serious no matter what time of day; they call me at my cell phone at any time of day. A lot of the patients' say that they are being abused so that they get attention. There is no shot except for COVID testing and shot for vaccination; that's not a threat. This is a free country and people can leave; there is free will. The resident could not be held at the hospital any longer, so we found the fastest way to get her out of there. We asked

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S9999	Continued From page 22 her to bring a family member to sign her out for her safety. I told them to give her a day or two, sometimes the resident's say they want to leave but need time to adjust. Review of AMA (Against Medical Advice) Form - Release of Responsibility for Discharge (completed for R569) Dated 8/10/22, Time: 1pm Form is signed by R569 and witnessed by V17 (Social Services Director) Form reads: Authorization must be signed by the resident, or by the nearest relative when the resident is physically or mentally incompetent. Facility AMA - Against Medical Advice Policy (undated) reads: It is the policy of the facility to administer care and treatment to the residents according to physician orders and care plans based on assessments and observations of the nursing home staff and other appropriate providers. If the resident decided to leave the facility for whatever reason while at a time in the course of their stay where their physician and other disciplines in the facility feel that it is not recommend as being in the best interest or welfare of the resident, this is considered leaving "AMA" or Against Medical Advice. Should this desire on the part of the resident be expressed, the following should happen: Procedure: 1) As soon as the resident expresses a desire to leave "AMA," appropriate leadership staff to include the Administrator/DON/SSD and the physician or Nurse Practitioner as available should meet with the resident in an effort to discover the reason why the resident is wanting to leave.	S9999		

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S9999	Continued From page 23 Note: Examples of reasons residents might choose to leave AMA include, but are not limited to ...b) they change their mind about being a "nursing home resident ..." 2) When possible to discern the reason they desire to leave, the appropriate facility staff will help them formulate a plan that can address and lessen or even possibly solve their issue of concern. 3) If they are adamant on leaving, be sure that the risks of their leaving against medical advice are clearly explained to include possible negative outcomes when the services, care, treatments and whatever they will not be receiving if they leave - are no longer available to them. This must be clearly documented. 4) If they are not their own representative, their representative should be involved in a care plan meeting prior to the resident leaving ... 5) The resident has the right to leave the facility. The facility will ensure that leaving is an informed decision as much as possible. The facility will be respectful of the resident's decisions. 6) All discharge paperwork will be completed to include the discharge summary information. The related doctor's orders will be followed. This will include assisting in making any follow up appointments arranging for any ordered Home Health and disposition of meds/prescriptions per policy ... Note: Detailed timely and accurate documentation must be done on any resident who chooses to leave AMA. The AMA form must be completed and copies of all documents given to the resident must be kept on file at the facility. "B" Statement of Licensure Violations: III of III 300.1210b)	S9999		

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S9999	Continued From page 24 300.1210d)1)3) 300.1810c)3) 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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. Section 300.1810 Resident Record Requirements c) Record entries shall meet the following requirements: 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including,	S9999		

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S9999	Continued From page 25 but not limited to, radiologic or laboratory reports and other similar reports. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to plan and implement an effective plan to monitor a resident with known behaviors of refusing and not taking medication. The facility also failed to have thorough documentation, including the resident's medication administration record of resident refusals to take a significant medication. These failures resulted R122 requiring five hospitalizations within a six-week period for subtherapeutic levels of Depakote (anticonvulsant and mood stabilizer) in one (R122) of one resident reviewed for nursing care. B. Based on interview and record review, the facility failed to ensure that a resident was receiving a significant medication at therapeutic levels to prevent hospitalization. This failure applied to one (R122) of one resident reviewed for repeated hospitalizations and resulted in (R122) having subtherapeutic levels of Depakote (anticonvulsant and mood stabilizer) which required five hospitalizations within a six-week period for seizures/pseudo seizures and subtherapeutic medication levels. Findings include: R122 was admitted to the facility on 6/7/22 with admitting diagnoses that include: epilepsy, heart failure, schizophrenia, schizoaffective disorder, bipolar disorder, anxiety, major depressive disorder, and violent behavior. R122 was transferred to the hospital multiple times during stay at the facility.	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 26 Review of medical records and resident census records document that billing was stopped, (related to hospital transfers) on the following dates: 6/28 - 6/30/22 7/12 - 7/15/22 7/24 - 7/28/22 8/3 - 8/5/22 Hospital transfer on 8/7/22 with no documented return date. MAR (Medication Administration Record) for June 2022 includes order for Depakote Delayed Release 250 mg - Give 1 tablet by mouth two times a day for Mood swings - Start date 6/8/22, D/C date 6/30/22 - All doses documented as received in the MAR, No documentation of missed doses / refusals during this time frame. Review of medical records for R122 include the following: Hospital record for admission on 6/28/22 documents: (History of Present Illness) ...(R122) presents from (nursing home facility) neuro for seizure activity...History of multiple hospital admissions for seizure activity where valproic acid level was subtherapeutic and therefore given loading dose and being discharged. Recent admission on June 23 at (local medical center)... (Assessment and Plan) Seizure activity, Pseudo activity vs Breakthrough seizure, -Multiple hospitalization with above complaint - Subtherapeutic Depakote level - Loaded in ED, given Keppra as well - Neuro consult...Level of care: Based on the patient's presentation on admission, I expect the patient to require at least 2 midnights of medically necessary Hospital services.	S9999		

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	IL6003826	A. BUILDING: _____ B. WING _____	C 08/19/2022

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S9999	Continued From page 27 MAR (Medication Administration Record) for July 2022 includes order for Depakote Delayed Release 250 mg - Give 1 tablet by mouth two times a day related to Epilepsy, unspecified not intractable without status epilepticus - Start date 7/1/22, D/C date 7/13/22 - All doses documented as received in the MAR, No documentation of missed doses / refusals during this time frame. Hospital admission 7/12/22 documents: (History of Present Illness)...sent to ER from (nursing home) neuro for seizure activity. Patient was admitted with the same problem on 6/28/22. Patient is a poor historian and does not remember what happened to her today. Per ER records, she was observed to have tonic-clonic activity at the nursing home. She also hit her head on the ground. Her Depakote dose was also decreased recently. During her last hospital admission, her recurrent episodes of seizure like activity was suspected to be secondary to pseudo seizures...Serum valproic acid level is low at 14...She has a witnessed seizure-like activity at the ER when her eyes flickering and bilateral upper extremities twitching. She was given a dose of Ativan and Keppra 1000mg. She was also given valproate 1760 mg. Neurology consult obtained. Lab Result for Valproic Acid (Collection Time: 7/12/22 12:09PM) value is 14 (L) Ref Range 50 - 125 mcg/mL. MAR (Medication Administration Record) for July 2022 includes order for Depakote Delayed Release 500 mg - Give 2 tablets by mouth every 12 hours related to Epilepsy, unspecified not intractable without status epilepticus - Start date 7/15/22, D/C date 7/25/22 - All doses documented as received in the MAR, No	S9999		

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S9999	Continued From page 28 documentation of missed doses / refusals during this time frame. Hospital admission of 7/24/2022 documents ...Recently admitted with similar issues and patient was sent back on Depakote ER 2000mg twice a day and Keppra 1000mg twice a day. Lab Result for Valproic Acid (Collection Time: 7/24/22 2:56PM) value is 30 (L), Ref Range 50 - 125 mcg/mL. Discharged on 7/28/22 with discharge medications including: Depakote 500MG delayed release EC tablet, Take two tablets by mouth every 12 hours. Depakote Delayed Release 500 mg - Give 2 tablets by mouth every 12 hours related to Epilepsy, unspecified not intractable without status epilepticus Total Dose 1000 mg q 12 hours - Start date 7/28/22, D/C date 8/5/22 - One missed dose documented as "refusal" on 8/2/22 at 2100, No other documentation of missed doses / refusals during this time frame. Hospital records for stay of 8/3 - 8/5/22 documents: (History of Present Illness) Per EMS patient was noted to have seizure-like activity that was characterized by head being fixed in 1 direction with gaze deviation, and mild head shaking...Patient having seizure-like activity in ED consisting of eyelid fluttering, RUE arm twitching, jaw tremor. Administered IV Ativan 2mg. VSS. STAT labs drawn. Noted to have some improvement in symptoms and tracking with her eyes...Of note, patient hospitalized from 07/24 - 07/28 recently. Presented with seizures at that time. Depakote level was subtherapeutic. (Assessment and Plan) Unclear if seizure or pseudo seizure on presentation. Patient was	S9999		

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S9999	Continued From page 29 noted to be tracking with eyes while having seizure-like activity. VPA (valproic acid) level therapeutic 66. On 8/19/22 at 12:24 PM V46 (Medical Doctor) was asked about orders prescribed for his patient (R122) and stated, they have called me so many times about her. She has many psych issues. If it's a medical issue, you fix the issue but when it's a psych issue, it's a revolving door. She was having pseudo seizures - if someone wants to go to the hospital, all you have to do is lie on the floor and shake. The biggest issue with her was that she didn't want to be here. (Re: Depakote) It's a very hard medication to get right. If you miss a dose or check levels at the wrong time it may not reflect. It's a dual medication, given for psych and seizures. When it's given for psych reasons, I let the psychiatrist adjust the Depakote, if medical, I manage it. If the psych issue is controlled, then the levels are okay. On 8/19/22 at 2:39 PM V43 (Medical Director) was asked about R122 and confirmed that he was familiar with the resident. V43 was asked about repeated subtherapeutic levels of Depakote. V43 said, the order is one thing but if the nurses say they give it is another. The nurses try to give her the medication many times and she refuses and/or spits it out. If she had been taking the medication (Depakote) she would be free of seizures; this would keep her seizure free. You know that with this high dose, if she was taking it, it would show in the levels and not be low. Generally, with Depakote, labs are done monthly or every two months. If they are low, we do them more often. We do them as the patient allows. If they are refusing, we send them to the hospital to get the adequate level. If there are mistakes with nursing and medications, I will give in-service for	S9999		

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S9999	Continued From page 30 these mistakes. We try to get the staff to administer medications correctly and the director of nursing and pharmacy do random inspections to check for compliance. On 8/19/22 at 10:47 AM V3 (Director of Nursing) was asked where the resident is currently since there are no notes in the record: "I had someone follow up with local hospital and we were informed that (R122) had been placed to a different home. Hospital failed to disclose further information to us as regards to her whereabouts." Review of medical record does not show that effective interventions were in place to address the resident having frequent hospitalizations and subtherapeutic levels of a significant medication. NO VIOLATION	S9999		