STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006134	A. BUILDING: _____ B. WING _____	C 08/05/2022

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UPTOWN CARE AND REHABILITATION	4920 NORTH KENMORE CHICAGO, IL 60640

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S 000	Initial Comments Facility Reported Incident of 6/30/22/IL148812	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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. 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. 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. Section 300.3240 Abuse and Neglect e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the	S9999		

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S9999	Continued From page 2 perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements were not met as evidenced by: Based on observations, interviews and record reviews the facility failed to keep 2 residents (R1 and R8) free from abuse for 2 out of 5 residents reviewed for abuse. This failure has caused R1 to become afraid and not feel safe in the facility; and caused R1 hip pain and R8 pain in contracted leg during incontinence care. The facility also failed to ensure 3 residents (R2, R5, R11) were free from verbal abuse from each other. Findings include: R1's face sheet documents: R1 admitted on 02/21/22, medical diagnosis: pain in right hip, difficulty in walking, abnormal posture, unsteadiness on feet, type II diabetes, anemia, sarcoidosis of lung, major depressive disorder, and essential hypertension. Reviewed R1's comprehensive care plan dated 03/07/22-R1 has the potential for pain related to restless leg syndrome, right hip pain, interventions are to anticipate R1s needs for pain relief and respond immediately to any complaint of pain, monitor and document each pain episode, monitor, record, and report to nurse any signs or symptoms or verbal complaint of pain. R1 has bowel incontinence; provide peri care after each incontinent episode. R1 is resistive to care dated 07/05/22, intervention; to allow R1 to make	S9999		

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decisions about treatment regime. MDS [Minimum Data Set] dated 05/27/22 section C [Brief Interview Mental Status] score 14 indicates cognitive intact, section G read: R1 need extensive assistance with bed mobility, transfers, dressing, toilet use, and person hygiene. R1's medical record did not indicate that R1 was assessed for being at risk for abuse. R1's care plan did not indicate an at risk for abuse or the care plans was not updated after the allegations of abuse dated 06/30/22. Initial/Final State report that was sent to IDPH documents in part dated 06/30/22, nurse on duty [NOD] gave R1 ibuprofen for pain. Last psychological assessment was dated 06/24/22.

On 08/04/22 at 12:06 PM, R1 stated, "In the middle of the night V10 [Certified Nurse Assistant-CNA] came into my room and said, 'pants off, pants off'. I told V10 that I did not want to take my pants off because I was cold. V10 said but they are coming off. V10 stood at the end of my bed and proceeded to take my covers off and then she grabbed my pants by the ankles and start yanking my pants, pulling me around and pulled my pants completely off of my body. I told her stop, no, I was dry, but she kept going causing me pain in my hip. I cannot move my right leg because I had hip surgery in the past. I told her to stop, and it was hurting me, but V10 kept going. Once V10 pulled my pants off she rolled me roughly on my side and snatched my under-brief off. I kept yelling stop, and V10 was really angry with me and said, 'I'll rub this diaper in your face'. I told her [V10]; I will rub it back in your face. I then told her to get the f**k out of my room, and I was going to report her, she said, 'So, I don't care'. V10 left out of my room, and I was left naked and cold, I was able to pull my sheet over me. In the morning I told the

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administrator [V1] everything that happened, and he [V1] told me that everything would be taken care of. I also told the administrator I do not ever want her to take care of me again and he told me that V10 will not take care of me again. Last night V10 came back into my room grabbed my covers off, push me onto my side and snatched off my diaper again and said I'm back and I'm going to change you again. V10 pulled off my diaper so hard and flipped me over to my side, my hip started hurting. I was soiled with urine and poop, but I rather stayed soiled until the morning, because V10 is always rough".

R1 stated, "I did not report this to the administrator [V1] this morning. The last time I reported V10, V1 did not do anything about it. V1 told me that V10 would not come back into my room to clean me up anymore, but she did anyway and hurt my hip again. I am scared, and afraid that V10 will come back into my room and hurt me again. V10 has always been rough while providing care, but the last two times I felt V10 purposefully tried to hurt me. There have been other times, after the incident on 06/30/22, when V10 came into my room at night to change me. I would tell her no, and that I was dry, then she [V10] would leave out my room. However, I was wet with urine and feces, but I was afraid to allow her to change me. I was upset, because V1 told me V10 would not provide care for me anymore. In the mornings after V10 worked my boyfriend R10, he lives on here also, would come and clean me up. We care for each other and help one another all the time. I do not mind that R10 clean me up and changes my under brief, because R10 is gentle."

Surveyor observed R1 crying, throughout the interview.

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R1's progress note affirms emotions distress dated 8/4/2022 06:04, Nurses Note V17 [Registered Nurse] - CNA [V10] reported resident [R1] is refusing to be changed and that she has told the administrator that she doesn't want to be changed by the CNA. Writer followed up with resident. Resident verbalized she is refusing change because her boyfriend changes her every morning.

Nursing staff assignment sheets, on the following dates V10 was assigned to R1 and R8's room since the 06/30/22 allegation of abuse: 07/06/22, 07/18/22, 07/20/22, 07/27/22, and 08/03/22.

On 08/04/22 at 12:18 PM, R8 stated, "I remember the night [06/30/22] when V10 came into our room. I heard what she [V10] said to R1. V10 said she would take that under brief and rub it in R1's face. V10 was mad at R1 because she [R1] kept yelling stop, don't change me, then I heard V10 tell R1 that she [V10] would put the soiled under brief in R1's face, then R1 called V10 a b***h. V10 was also rough with me the same night, while changing my under brief. V10 was already mad at R1 and took it out on me as well. I told V10 that she [V10] was not going to treat me [R8] like R1, and to stop being rough. However, V10 continued to be rough and caused my contracted leg to hurt. V10 came in our room last night, [08/03/22] and changed R1 and R1 kept saying no, not the change her [R1], but V10 changed her [R1] anyway. Then V10 changed me last night, but she was not rough with me last night."

On 08/04/22 at 12:25 PM, R9 stated, "I was R1's roommate on 06/30/22, I remember the night that V10 came into our room and there was a big

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argument. V10 came in our room trying to clean up R1, but R1 kept telling V10 to stop and that she [V10] was hurting her [R1]. All of a sudden, I heard V10 tell R1 that she was going to put the soiled under-brief in her face. R1 told V10 to get out of the room. I could not see what was happening, because I had my curtains pulled closed. V10 have never hurt me, because I can clean my own self up, I do not need any assistance. I have no concerns regarding abuse."

On 08/04/22 at 12:50 PM, R10 stated, "This morning I did not have to change R1, she was clean and dry. R1 told me that V10 changed her last night, even though she [R1] said no. V10 made her hip hurt again last night. Sometimes I help and change my girlfriend's [R1] under brief, put her sweatpants and shoes on. A few times in the morning, R1 had poop on her because V10 worked the night shift and R1 refuses for V10 to clean her up. R1 told me that V10 throws her around like a rag doll. The CNA's need to be gentle because R1 had surgery on her hip. I don't mind changing R1, she's, my girlfriend. I don't suppose to change R1 technically, it is their job to do it, not my job. If something happens to her [R1] while I'm changing her, it would be liability for the facility. R1 only complains about V10, the other CNAs are okay with R1. I have not been abused in this facility; I have no concerns for me regarding abuse."

On 08/04/22 at 1:00 PM, R12 stated, "I was sleep and did not hear anything. I have no issues with V10 because she does not provide care for me. I am able to care for myself; I have no concerns regarding abuse."

On 08/04/22 at 1:10 PM, V1 [Administrator] stated, "I completed the abuse allegation

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regarding R1 and V10 [Certified Nurse Assistant] on 06/30/22. R1 alleged V10 came into her room and wanted to remove her [R1] pants and to check to see if R1 was wet. R1 told V10 that she was clean and dry, and wanted to keep her pants on. V10 proceeded to remove R1's pants, R1 told V10 to stop touching her, and called V10 a f***ing b***h. V10 proceeded to changed R1's soiled under brief. R1 said during incontinent care, her hip started to hurt. V10 told me the only reason she asked R1, if she wanted to see the under brief was because R1 said she was dry, and V10 wanted to show R1 she was not dry. The outcome was that V10 did not inflict willfully injury upon R1. R1 has a history of a hip replacement. While doing peri care could be painful. The allegation was not substantiated. State report dated 06/30/22 on the initial report under the "Action Taken" read in part: [This writer asked if the resident [R1] would like to go to the hospital, resident [R1] refused and said she is feeling fine but does not want the employee [V10] to assist her again]. I agreed with R1, that V10 should not provide care for her again."

On 08/04/22 at 1:52 PM, surveyor notified V1, today at 12:06 PM, R1 was crying and reported last night [08/03/22] V10 came into her room and said that she [V10] was there to change he r[R1]. R1 told V10 no, that she was dry, but V10 proceeded to changed R1 roughly and caused R1 hip to hurt. R1 said she did not report the incident to V1 today, because the last time she [R1] reported V10, nothing happened. Also, a few times, V10 has been her CNA [Certified Nurse Assistant] since 06/30/22, but V10 will come in the room and ask [R1] if she was wet. R1 said she would lie and tell V10 that she was dry, because R1 was afraid. R1 said there were times that she [R1] laid in bowel movement until her

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S9999	Continued From page 8 [R1] boyfriend came in the morning to clean her up and change her [R1] under-brief. R1 explained while crying that she is afraid, scared and do not feel safe, because she [R1] is not protected from V10. Also, R1's roommate, R8 reported, V10 has been rough with her [R8] a few times in the past, causing pain to her contracted leg, and V10 always have a terrible attitude while providing care. R8 said on 06/30/22, V10 was mad at R1 because R1 kept yelling "stop, don't change me", then heard V10 tell R1 that she [V10] would put the soiled under brief in R1's face; then R1 called V10 a b***h. R8 said, V10 was rough her [R8] the same night [06/30/22] while changing her [R8] under brief, and that V10 caused her [R8] contracted leg to hurt. R8 said last night [08/03/22], V10 came into their room [R1, R8] and changed R1 even though R1 kept saying "no, don't change me." Then V10 changed R8's under brief, but she was not rough with R8 last night. On 08/04/22 at 2:00 PM V1 stated, "I was not aware that V10 was still providing care for R1. I will send in an initial reportable to IDPH and start an investigation into the new abuse allegation regarding R1 and R8 today. R1's boyfriend is R10 and resides here in the facility. I was not aware that R10 was cleaning up R1 and changing her [R1] under brief. It is not appropriate for a resident to provide incontinence care to another resident, it could potentially cause a dignity issue, the resident could fall off the bed and get injured, infection control, or the resident providing care could possibly get injured. It is the facility's nursing staff responsibility to provide incontinence care to residents. During the first allegation on 06/30/22, I told V3 [Human Resource/Nurse Scheduler] to move V10 to another unit, but I did not explain to V10 that she was not allowed to provide care for R1 anymore, I guess it fell	S9999		

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through the cracks. If a resident refuse care, but care was forced, it can potentially cause mental or physical abuse. New hires received abuse training in orientation, prior to working with the residents. Current employees receive abuse training annually and whenever there is an abuse allegation."

V1 presented a noted on 08/04/22 documents: This writer [V1] spoke with V10 CNA [Certified Nurse Assistant] via telephone on 6322 about recent complaints about the way she provides care. A couple of residents stated she is too rough and needs to be gentle during peri care. Also, if resident have trouble understanding to please bring another staff member to clarify in the event the resident does not understand.

On 08/04/22 at 2:15 PM, V9 [Social Service Director] stated, "V1 investigated the allegation of abuse dated 06/30/22, involving R1 and V10. V1 explained to me that during incontinence care V10 allegedly was rough with R1 causing pain to her hip. After the abuse allegation, I offered R1 in-house counseling from the facility therapist once a week. R1 told me that she[R1] was okay and refused psych services. Typically, psych services, counseling or therapy is documented in the resident's medical chart, under progress notes. R1 refused psych services, that's why no documentation was placed in R1's progress notes from 06/29/22 to 08/04/22. I should have documented her [R1] refusal of psych service in the progress notes. I spoke briefly with R1 today regarding last night 08/04/22 allegation. R1 reported, V10 came into her room and said she [V10] was there to change her [R1] under brief. R1 said she refused, and told V10 no, and that she was clean and dry. V10 proceeded to change R1 anyways despite her [R1] refusal; V10 was

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rough and caused her hip to hurt again. The residents have rights, any resident have a right to refuse care. If resident rights are violated, it can cause mental abuse. R8 has never reported to me any concerns regarding V10."

On 08/04/22 at 2:30 PM, V7 [Licensed Practical Nurse], stated "I work 12-hour shift from 7AM-7PM, for the last two years. The last time I received abuse training was a couple of weeks ago. Some types of abuse are physical verbal mental and financial. If I witness abuse, I will report it immediately to our administrator. I worked on 06/30/22 from 7AM to 7PM, during my interactions with R1, she never told me anything regarding an incident between her[R1] and V10. R1's behavior to the best of my memory was the same, nothing stood out, being abnormal. This morning R1 did not report any incident that occurred last night [08/03/22], because if she did, I would have reported the incident to the administrator. R8 has never reported any concerns regarding V10."

On 08/04/22 at 2:35 PM, V6 [Licensed Practical Nurse] stated, "I worked here in this facility for 20 years. The last time I received abuse training was a couple of weeks ago. Some types of abuse are mental, financial, verbal and sexual. If I was told by a resident that they were abused I would notify the abuse coordinator immediately."

On 08/04/22 at 2:45 PM V8 [Certified Nurse Assistance] said, "I usually receive abuse training every year, but we also get abuse training throughout the year it just depends on if there is a problem in the building. The last time I received abuse training was two to three weeks ago and some types of abuse are sexual physical verbal and seclusion."

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S9999	Continued From page 11 On 08/04/22 at 3:00 PM, V13 [Certified Nurse Assistant] stated, "I have received abuse training last week. Some types of abuse are financial so verbal and physical. If I was to witness abuse, I will make sure first the resident is okay and then I will report it immediately to the administrator." On 08/04/22 at 3:05 PM, V14 [Certified Nurse Assistant] stated, "I receive abuse training every year and why never an allegation arises. The last time I had abused training was about two weeks ago and some types of abuse are financial, mental, verbal and physical. If I'm told by a resident that someone abused them, I would immediately contact the administrator." On 08/04/22 at 3:34 PM, V10 [Certified Nurse Assistant] stated, "On 06/29/22 around 12:30 AM, I was making rounds on my assignment. R1 told me that she was not wet. I asked her if I could check her to be sure that she was dry and R1 agreed. I explained to her that she should not sleep in her pants and that I was going to help her take the pants off so she could sleep comfortably. R1 told me, that she did not want me to take off her pants. However, I could smell she had a bowel movement, so I rolled her to the side and underneath her pants were soaked with urine and bowel movement. I removed her pants and then I removed the soiled under brief and held up the soaked under brief. I said to R1, look this under brief it is soaked with urine and bowel movement. The only reason that I showed her the under brief was because when I came into the room, she said that she was dry and clean. Later, I was suspended for an investigation regarding abuse. I was suspended from work for one day and then I came back to work. Upon me returning back to work, nobody told me not to work with R1. I will	S9999		

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S9999	Continued From page 12 come into work and follow the schedule and take care of the residents on my assignment. Sometimes I would have R1 on my assignment to take care of, I would go in her room and ask R1 was she clean or need to be changed. R1 will tell me that she was clean and dry every time, then I would leave out of R1's room. Last night on 08/03/22 night shift, R1 was on my assignment. I made rounds and asked R1 if I could check to see if she was wet. R1 told me no, and that she [R1] will wait until the morning for her[R1] boyfriend to clean her [R1] and change the under brief. I reported the refusal to V17 [Registered Nurse]. I have taken care of R8, and she has never expressed any concerns to me, about the care I provided to her[R8]. R8 and I have never had any disagreements, and R8 has never refused for me to take care of her[R8]. I received abuse training a few weeks ago. Some types of abuse are physical, verbal, financial, involuntary seclusion, and mental. If witness abuse, I would report it the administrator immediately." On 08/04/22 at 4:35 PM, V2 [Director of Nursing] stated, "The incident on 06/30/22 regarding V10 and R1, there was an allegation of abuse during incontinence care. V10 went into R1's room to provided incontinence care, but R1 did not want to be changed. V10 proceeded and pull down R1's pants and caused R1's hip to hurt. Also, while changing R1's under brief, R1 said V10 threaten to put the soiled under brief in her[R1] face. R1 mentioned that she no longer wanted V10 to provide her [R1] care. I agreed with R1, and I told V10 not to provide care to R1 anymore. I cannot confirm if V10 was told not to work with R1. I told V10 that there would be some changes with her assignment'. V3 [Human Resource/Nurse Scheduler] was	S9999		

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S9999	Continued From page 13 asked to change V3's assignment. V3 stated, "I should have been more concrete with V10 and actually told her do not work with R1 again. I was recently made aware that R1 alleged today that V10 came into her room last night [08/03/22] and provided incontinence care, while R1 was refusing care. Also, R8 had some concerns with V10 as well. I was not made aware that R10 was providing incontinence care and changing R1's under brief. If a resident is providing ADL care for another resident, it can potentially cause a fall, injury, and issues with infection control. R8 has never reported an allegation of abuse to me regarding V10. The facility's ADL policy is that nursing staff make rounds at least every 2 hours. Upon making rounds, if a resident refuses care, the staff member, need to stop and report the refusal to the nurse. The nurse should speak with the resident to find out the reason for the refusal and document the encounter". On 08/05/22 at 9:14 AM, V3 [Human Resource/ Nurse Scheduler] stated, "V1(Administrator) notified me of the allegation between R1 and V10 that occurred on 06/30/22. V1 investigated the allegation, and V10 was suspended and brought back to work. V1 did not substantiate the allegations. I cannot confirm or deny V1 told me, not to assign V10 to R1's room, I cannot recall." On 08/05/22 at 12:35 PM V17 [Registered Nurse] stated, "On 08/03/22 night shift, V10 told me, R1 refused incontinence care. R1 said, she did not want to be changed by V10, and that she has told the administrator [V1]. R1 reported to me that her boyfriend [R10] changes her every morning. R1 did not report any conflict between her [R1] and V10. I did not offer R1 another CNA, or nurse to provide incontinence care, because R1 was adamant R10 would clean her up in the morning.	S9999		

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S9999	Continued From page 14 I did not report the refusal to V2 [Director of Nursing]. The last time I received abuse training was a couple of weeks ago. R8 has never reported any allegation of abuse to me regarding V10. Some types of abuse are, verbal, physical, theft, sexual, and mental. Abuse is reported to the administrator immediately." Policy: Documents in part Abuse, Neglect and Misappropriation dated 05/2021 -Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but it's not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residence must not be subject to abuse by anyone, including but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the residents, family members, legal guardians comma friends or other individuals. -mental abuse includes but it's not limited to humiliation, harassment, threats of punishment or deprivation. -neglect means failure of the facility, its employees, or other service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or, emotional distress. Resident Rights for People in Long Term Care Facilities -You must not be abused by anyone physically, verbally, mentally, financially, or sexually. -Your facility must make reasonable arrangements to meet your needs and choices.	S9999		

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S9999	Continued From page 15 ADL Policy and Procedure (undated) -Dependence on others for ADL care assistance can lead to feelings of helplessness, isolation, diminished self-worth, and loss of control over one's destiny. \\\\\\\\\\ On 08/04/2022 at 11:32am, V2 (Director of Nursing-DON), said "I was passing medications and I heard screaming between V4 (R5's family member) and R11." V2 said V4 and R11 were "bickering and screaming at each other in the hallway." V2 said V2 did not hear what V4 and R11 were saying to each other but V2 heard them screaming at each other. V2 said R11 was going into R5's room to visit R2, (who is R11's mother). V2 said R2 and R5 were roommates. V2 said V5 (Certified Nursing Assistant-CNA) was near where the screaming was coming from. V2 separated R11 and V4. V2 told V4 that V4 should not be yelling and shouting while in the facility. V2 told R11 to go to R11's room. V2 told R11 to come back latter to visit R2 (R11's mother) when R5's family leaves. V2 then called V9 (Social Services Director), who was not in the facility and told V9 about the incident. V2 said since V2 notified V1 (administrator), V2 did not document the incident in R2, R5, and R11's charts. V2 said V2 should have documented the incident in R5, R2 and R11's charts. On 08/04/2022 at 3:06 pm, V2 (Director of Nursing-DON), V2 said that R2 was also involved because R2 was defending R2's son (R11). V2 did not separate R5 and R2, and R5 and R2 remained in the same room for a couple of days. V2 said V2 should have separated R5 and R2 right away after the altercation, to keep the residents safe. V2 said "yes, abuse verbal altercation is a form of abuse and if residents	S9999		

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S9999	Continued From page 16	S9999		

have a verbal alteration, the residents should be separated".

On 08/04/2022 at 11:18am, V4 (R5's family member) said V4 was at the elevator with R5 when R11 came towards V4 and R5. R11 started cursing at V4 and R5. V4 said, "R11 was trying to start something, so V4 told R11 to leave R5 alone. V4 said R5 was mad at R11 for going into R5's room to visit R2 (R11's mother) who shared a room with R5. V4 said that while visiting R5, R5's roommate, R2 "said something smart and called V4 "this bitch." V4 said "staff saw it."

On 08/04/2022 at 12:40pm, R11 was observed in the dining room. R11 said R11 had just finished lunch. R11 was on R11's power wheelchair. R11 was alert and oriented to person, place, and time. R11 said on the day of the incident (6/25/2022), R5 brought R5's kids to "beat me up because I was visiting my mom (R2) in R5's room". R11 said R11 was scared at that time because R5's kids were calling R11 names. R11, V2 and V5 were nearby and heard the altercation. R11 said R11 notified V1 about the incident the following morning.

On 08/04/2022 at 12:48pm, R5 was observed in R5's room eating lunch. R5's roommate was also in the room eating lunch. R5 had a guest in the room. R5 said R5 "will defend myself if anyone messes with me." R5 said R5's twin daughters will defend R5 if anyone "messes with me." When asked about the incident with R2's son, R5 said, "Nobody messes with me. My kids protect me." R5 did not say how R4's kids protect R5.

On 08/04/2022 at 1:45pm, V1(Administrator) said that R5 had an issue with R11 coming to R5 and R2's room to visit R2, who is R11's mother. V1

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S9999	Continued From page 17 said "Some words were exchanged between R2, R5 and R11 because R2 and R5 were displeased with each other." V1 said shouting and cursing for R2 and R5 is a "cultural thing." When asked what V1 meant by "a cultural thing", V1 did not elaborate. V1 said residents name calling and cursing at each other is a type of abuse and the residents should have been separated immediately, since they were "displeased with being roommates." On 8/4/22 at 2:10pm, V9 (Social Services Director) said V9 was at home on a Saturday (6/25/2022), about 5pm, V9 said V9 received a call from V2. V9 said V2 told V9 that R11 was extremely upset on the unit, and V2 needed a social worker. V9 said V9 asked V2 to put R11 on the phone. V9 said V2 said V2 was busy at this time passing medications and would call V9 latter, but V2 never called V9 back. V9 said V9 did not go back to the facility until Tuesday, the following week. V9 said when V9 got back to the facility on Tuesday, V1 told V9 details of the incident. V9 interviewed R5 about the incident and R5 said, if someone attacks R5, then R5 will "feed for R5." V9 said R5 was moved to another floor 3 days after the incident. V9 said verbal altercation is a form of abuse, and R5 and R2 should have been separated from being roommates immediately, and not waited for more than three days. On 8/4/22 at 3:48pm, V5 (Certified Nurse Assistant-CNA) said that on 6/25/2022 at about 5pm, V5 heard V4 (R5's family member) say V4 did not want anyone in the room of R5 when V4 and other R5's family members were visiting R5. V5 said V4 was very loud when V4 said "I don't want anyone else in R5's room when I (V4), is	S9999		

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S9999	Continued From page 18 visiting R5". Facility policy titled Abuse, Neglect & Misappropriation, dated 5/2019 document; " "Verbal abuse" means the use of oral, written, gestured language that willfully includes disparaging and derogatory terms. Facility reported incident investigation, titled State report, dated 6/25/2022, note: " Action: R5 was sent out to the hospital (unrelated to this incident) and upon return, the facility will find a different room for R5 and will be separated from R2. Facility reported incident investigation final, titled State report, dated 6/25/2022, documents; Both R2 and R5 used inappropriate language with one another to express dissatisfaction with one another. It seemed R2 and R5 did not want to be roommates. Being that these residents can use this language out of their nature when they are not thrilled with something, the inappropriate language was used to express their displeasure. Facility census documents; R5's room change after incident was on 6/28/2022. R5, R2 and R11 medical records- No documentation of incident of 6/25/2022 in progress notes. R5's care plan dated 7/5/2022 documents; R5 is verbally aggressive (Uses Profanity, yelling, insulting, threatening) r/t (related to) ineffective coping skills, Mental/emotional illness, poor impulse control, anger issues. Interventions include; Analyze, of key times,	S9999		

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S9999	Continued From page 19 places, circumstances, triggers, and what de-escalates behavior and document When the R5 becomes agitated, intervene before agitation escalates, away from source of distress. R5's triggers for verbal aggression are (when another res'd (resident) speaks disdainfully about R5. Facility check in log for 6/25/2022 document that V5 (R5's family member) was at the facility on 6/25/2022 Nurses' progress note dated 6/27/ documents R5 was sent to the hospital for unrelated issues on 6/27/2022 Psychosocial Note dated 6/28/2022 R5 was transferred to another unit on 6/28/2022 R11's care plan document; Assessment reveals factors that may increase R11's susceptibility to abuse/neglect Interventions: Assure that R11 is in a safe and secure environment. R2's care plan documents; R2 is verbally aggressive (insulting, making rude remarks, yelling, accusing/blaming, using profanity r/t (related to) ineffective coping skills, mental illness. Interventions-analyze of key times, places, circumstances, triggers and what to de-escalate behavior and document. (A)	S9999		