| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6006191 | A. BUILDING: _____ B. WING _____ | C 08/15/2022 |

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| S 000 | Initial Comments<br><br>FRI of 6/15/2022/IL148878 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.120d)6<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>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:<br><br>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.<br><br>These Requirements were NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to provide adequate supervison for 3 of 3 residents (R1,R2,R6) reviwed for supervision. This failure resulted in R2 being physically aggressive with R1 and R2 physically attacking R6 which resulted in R6 being bit by R2 on the stomach and hand resulting in R6 bleeding and being sent out to the hospital due to human bite of right hand by R2. | S9999 | | |
| | Findings include:<br><br>(R1 and R2) Facility's (6/22/22) "FINAL Incident Investigation Report" regarding R1 and R2 documents in part: R1 diagnosis of Dementia and R2 Alzheimer ' s Disease, dementia with behavioral disturbances. On 6/15/2022 @ approximately 4 pm, resident alleges physical altercation with another resident. Administrator interviewed R1 who stated, "I was just sitting and talking with some of the other ladies when I heard R2 talking loudly, and I told him to stop. He started walking toward me and attempted to hit me. I blocked him and tried to hit him back." | | | |

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| S9999 | Continued From page 2<br>Administrator interviewed R2 and was unable to recall incident and what occurred leading up to the alleged abuse. Per C.N.A (V14) stated, "I was assisting residents by the nurse's station when I heard residents calling for help. I ran to the dining room and saw R1 sitting in a chair and R2 standing next to her trying to hit each other and swinging arms. I immediately separated the residents. Per C.N.A (V15), "I was around the corner assisting a resident in the hallway when I could hear noise coming from the dining room. I immediately went toward the dining room when I saw R1 and R2 trying to hit each other. I immediately separated each of them and had the nurse come and assess each of them." Per nurse on duty (V16), "I was called to the dining room from the C.N.A. Both residents had been separated. I completed a body assessment on both residents. Resident (R1) stated her arm were scratched along with her face was hit. Noted no markings on her arms and small swelling under her left eye. Resident (R2) body assessment noted 2 small scratches on his chest and small scratch noted on right ear. Basic first aid was applied. Residents were assisted to their rooms." (R1 no longer resides at the facility)<br><br>(R2 and R6) Facility's (8/13/22) "Preliminary 24-hour Abuse Investigation Report" regarding R2 and R6 documents in part:<br>(R2) Alzheimer's disease, Dementia with behavioral disturbances, HTN, Lack of Coordination, A/Ox1, BIMS=3. (R6) Dementia, chronic a-fib, hyperlipidemia A/Ox2, BIMS=8. On 8/13/2022 at approx 2 am, Administration was notified by staff of a physical altercation between 2 residents. Body assessment completed and pain assessment has been initiated. Small lacerations were noted on R6. | S9999 | | |

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| S9999 | Continued From page 3<br>On 8/13/22 at 9:00 am, V12 (HR Director) was observed sitting in the hallway, V12 said she is watching both the dining room and observing R2 because he is being sent out to hospital and needs to be monitored. V12 said, this is not R2's room (surveyor observed R2 in room next to dining room), he is just here for monitoring.<br><br>On 8/13/22 at 9:02 am, V13 (CNA) said there needs to always be a staff member watching the dining room when residents are there. V13 said, staff need to be in the dining room to monitor the residents and to supervise them. V13 said, the unit is Dementia and memory care and the residents need supervision.<br><br>On 8/13/22 at 9:06 am, V10 (RN) said there needs to be always a staff present over the residents in the dining room because this unit is memory care.<br><br>On 8/13/22 at 9:07 am, V11 (CNA) said, right now the dining room is being monitored by V12 (HR Director). V11 said, the staff take turns monitoring the dining room.<br><br>On 8/13/22 at 9:31 am, V14 (CNA) said, on 6/15/22 she was working the floor when the incident happened with R1 and R2. V14 said, when she was taking care of residents, someone called out for help. It was another resident. V14 said, she ran to dining room and saw R1 and R2 were fighting. V14 said, her and V15 (CNA) separated the residents. After they were both separated the residents (R1 and R2) and calmed them down, we called the nurse. R1 was angry with the situation. V14 further stated, the unit is memory care unit, and there should be a staff present all the time in the dining room if residents are there, however that time no staff were in the | S9999 | | |

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| S9999 | Continued From page 4<br>dining room,<br><br>On 8/13/22 at 9:44 am V15 (CNA) said, on 6/15/22 she was at the corner (not in the dining room), and heard someone yelling for help. V15 stated, R7 was yelling for help and she (V15) went to the dining room and saw R1 and R2 fighting. R2 was holding R1's hands and she separated the residents and called the nurse. R2 had a scratch on the ears and R1 had red hands from R2 holding her. V16 was the nurse. V15 said, no staff member was present during the altercation. V15 said, when she got to the dining room, there was no staff present and staff should be present to monitor residents. V15 further stated, someone needs to be there (referring to dining room) all the time to supervise the residents.<br><br>On 8/13/22 at 10:15 am V2 (DON) said, 4 south is a locked unit. V2 stated, it is a memory and psychiatric unit. V2 said, there should always be staff in the dining room to oversee the residents, to prevent falls, watch for change of conditions, aspiration, and behavior acts including fighting. V2 said, today V12 (HR Director) was watching R2 because he is being sent out to the hospital for psychiatric evaluation because he attacked R6. V2 said, R6 was sent out to the hospital for medical evaluation and is back now.<br><br>On 8/13/22 at 11:02 am, R6 was observed with V2 (DON). R6 had a dressing on the right thumb. R6 said, he was involved in a fight with another resident, but is unsure who that was. R6 said he was unsure if he was in pain because it is normal for him to forget. R6 said, he forgets and is unsure what happened. V2 said, R6 was hit in the stomach that is why he was sent out to the hospital. | S9999 | | |

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| S9999 | Continued From page 5<br><br>On 8/13/22 at 11:46 am, V1 (Administrator) said she is the abuse coordinator and she was called around 2 am by V18 (LPN). V18 said he called to report a physical altercation between 2 residents. V1 said, it was between R2 and R6. V1 said, R2 was being physically aggressive and R6 got a bite mark on his hand. It happened in R6's bed. V1 said, CNA were rounding on the unit, and heard commotion in R6's room. V1 said, she instructed V18 to separate the residents, make sure they are ok. 1 to 1 supervision was started with R2, and V18 alerted the police. V1 said, R6 was requesting to go to hospital because he wanted to have bite mark looked at on his hand. V1 said, she wanted to have R2 sent to hospital when they have a bed available to have a psychiatric evaluation completed. R2 was being 1 to 1 monitored until he was sent out to the hospital. Reportable was sent to the state. V1 said, regarding the incident in June he (R2) was sent out for psychiatric evaluation, it was determined he had UTI and this was associated to his confusion.<br><br>On 8/14/22 at 3:36 pm, V18 (LPN) said he was the nurse working for the night shift on 8/13/22. V18 said, he was doing round and CNA came to get him because R2 was attacking another resident. V18 said, it was after 1 am, when V18 got to R'6 room. V18 stated, he (V18) saw the resident (R6) in bed and R2 was next to the bed, bent over like 90 degrees and R2 had his face on R6's abdomen biting the resident. V18 said, he immediately got R2 off R6 and separated the residents. V18 said, there was blood on R2's face but it was from R6's right thumb because R6 was bleeding and R2 was not. V18 said, R6 had bite/teeth marks on his abdomen and was bleeding from right thumb due to R2 biting him. | S9999 | | |

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| S9999 | Continued From page 6<br><br>V18 said, he sent R6 out for medical evaluation because he was bit and wanted to make sure his abdomen was ok. V18 further stated, R2 was being monitored because he needed a psychiatric evaluation and a bed was not available yet. V18 also said, he called the police and made a police report and made doctor and family aware.<br><br>R6's (8/13/22) hospital discharge documents in part: diagnosis "Human bite of right hand".<br><br>R2's progress note (6/16/2022 at 3:51 pm) documents: This writer heard the CNA shouting on the dining room, writer run toward the dining room and saw residents was having fight with each other. This writer separated the residents right away and redirected to their room. NP was informed, Family was made aware, Admin, social service and, DON was notified about the situation with orders to strictly monitor both resident and keep their distance with each other.<br><br>R2's (6/25/21) care plan documents for "Interpersonal Behavior" : (focus) resident exhibits behavior symptoms including irritability, physical and verbal aggression towards others. his history includes physical behavior (hitting, pushing, punching) and verbal, cursing behavior. (6/15/22) R2 involved in an incident involving, however no updated interventions from 6/15/22 are noted on R2's care plan.<br><br>On 8/15/2022 at 12:21pm during exit conference, V1 stated, I (V1) was not aware interventions were not updated for R2 and I (V1) will let social services know.<br><br>Facility's (11/28/16) "Abuse Prevention and Reporting" policy documents in part: The resident has the right to be free from abuse, neglect, | S9999 | | |

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| S9999 | Continued From page 7<br>misappropriation of resident property, and exploitation. This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment.<br><br>Facility's " Facility Assessment Tool" documents in part: Part 2: Services and Care We Offer Based on our Residents' Needs:<br>Prevent abuse and neglect<br>Identify hazards and risks for residents<br><br>(B) | S9999 | | |