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| S 000 | Initial Comments<br><br>Complaint Investigation/Facility Reported Incident<br><br>2292547/IL145298<br>Incident of 03/09/22: IL145086 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>1 of 2<br><br>300.610 a)<br>300.690a)<br>300.690b)<br>300.690c)<br>300.1210 b)5)<br>300.1210 c)<br>300.1210d)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 300.690 Incidents and Accidents<br><br>a) The facility shall maintain a file of all | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.<br><br>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.<br><br>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.<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 | S9999 | | |

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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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

These requirements are not meet as evidenced by:

Based on interview and record review that facility failed to monitor and supervise a high fall risk resident and failed to implement appropriate interventions for one resident (R1) out of three residents reviewed for falls in a total sample of 10.
This failure resulted in R1 falling when ambulating unassisted and sustaining multiple

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| S9999 | Continued From page 3<br>brain bleeds requiring hospitalization. The facility also failed to report to IDPH a fall where a resident (R1) suffered a brain bleed for one out of three residents reviewed for incidents and accidents in a total sample of 10.<br><br>Findings Include:<br><br>R1 is a 65-year-old with the following diagnosis: cerebral infarction, chronic obstructive pulmonary disease, and schizoaffective disorder. R1 admitted to the facility on 01/26/06.<br><br>A Nursing note dated 3/10/22 documents R1 was observed lying on the left side next to the bathroom door following a loud noise. According to R2 (R1's roommate), R1 had just finished using the restroom and fell. R1 was placed on his back and a pressure dressing was applied to the bleeding site. A moderate amount of blood was noted to be coming from the head. There was an approximately 2-inch laceration to the left side of the face. 911 was called immediately. R1 remained verbally unresponsive for 5 minutes with labored breathing. R1 was noted with post ictal upper body movements.<br><br>A Nursing note dated 3/10/22 documents R1 was admitted to the hospital. The hospital called questioning R1's seizure activity. V6 clarified that the seizure activity happened after the fall.<br><br>The Fire Department Report dated 3/10/22 documents the injury for R1 occurred at 7:45 PM. The fire department was dispatched at 7:56 PM and arrived to R1 at 8:04 PM. The fire department was dispatched to the facility for a possible seizure. R1 was found lying on the floor with | S9999 | | |

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Kerlix wrapped around the head with a small amount of blood on the pillow that was beneath the head. Bleeding was controlled. R1 would look at you and talk; but when he would talk words were incomprehensible.

The Hospital Records dated 3/10/22 document R1 was found on the floor at the facility and may have had a seizure. R1 is alert and oriented times two at baseline, and normally gets around with a wheelchair but had gotten up out of bed to go to the bathroom and fell on the way back. The fall was unwitnessed and R1 has a laceration to the forehead. In the emergency room, R1 is alert and oriented times 1 to 2 and is arousable to voice. R1 has a 3 cm diameter abrasion with central maceration to the left frontal temporal region with a pressure dressing applied. There is bruising on the left frontotemporal region as well as the gluteal region. The CT of the head showed subarachnoid hemorrhages to the bilateral frontal and left temporal lobes and probable contusions. No fractures are noted. R1 was admitted to the neuro intensive care unit and was giving an anti-seizure medication. The admitting diagnosis was subarachnoid bleed and laceration of forehead.

R2 (R1's roommate) was the only person to witness the fall. On 04/02/22 at 3:33PM, R2 stated, "He (R1) always got up by himself. This time he fell in the doorway by the bathroom. It was around nighttime, but he got up by himself and fell. He wasn't supposed to walk alone but he always did. I know he had a wheelchair that he was supposed to use but he wasn't using it that night. He wasn't right towards the end. He couldn't do what he used to do. The staff got up and helped him right away. He wasn't laying there for a long period of time. It was maybe only a

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couple minutes. I don't really know anything other than that. No, he didn't look like he had a seizure before he fell. He just went down."

On 03/31/22 at 3:28PM, V6 (Nurse) stated, "I was at the nurse's station, and I heard a loud thump. Like a crack and we ran down there to see what happened. He was lying just outside the doorway of his bathroom. When I saw him, he was doing like a jerking tight motion, and he wasn't talking. After about a minute that went away and then it was a couple more minutes before he could start talking. He was only saying one or two words. Normally he talks fine in full sentences to you, so I knew that was wrong. He doesn't have a history of seizures, but he told me he had one before. I've never knew him to have a seizure here and he isn't on any medication for it. He normally uses a wheelchair to get around too. When I went into his room his wheelchair was at the foot of his bed. He was getting radiation treatments and chemo for cancer. He had recently become incontinent and wasn't doing well but the last three days he really came around. For this fall he basically just forgot to sit in the wheelchair and got up and went to the bathroom himself. The lighting was good, nothing was slippery, so he must've just lost his balance. There was a laceration to his forehead. I know the hospital called back to get some information and the nurse told me that they said that he had a subdural bleed. When he fell, I called 911 right away. I didn't wait. He wasn't on the ground more than 10 or 15 minutes before they got here. His bed was low, and his call light was in reach. That is all I can remember. He was too weak to get up from the chemo. He should've used a wheelchair. I don't remember him having any other falls before this. Not anything recent. We document our falls in a 24-hour sheet. After the fall we put in

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a new intervention. Normally restorative puts in an intervention. They investigate the fall and put in an intervention related to that. It should be done after every fall. It's also reported to the DON, the administrator and the doctor. I would say he had a change since having his chemo. He was just a lot weaker. He had become incontinent which it wasn't like him. Before that he would remind the nurse of his medications and what times he had to take them out. He also go down to the vending machine a lot for pop. Once he started getting chemo, he never did any of that because he couldn't. I don't remember of them putting in any other interventions when he first started getting chemo and weaker. Maybe he got some physical therapy, but I can't remember anything specific other than that."

The Fall Risk Review dated 1/13/22 documents R1 is at high risk for falls due to being chair bound and requiring assistance with elimination. R1 uses an assistive device. R1 has predisposing conditions/diseases (cerebral infarction) that make him at risk for falls.

The Fall Event dated 3/10/22 documents R1 was observed laying on the floor with a laceration to the left side of the face and a moderate amount of blood. R1 was verbally unresponsive with labored breathing. The level of consciousness is documented as responsive only to vigorous stimulation. The predisposing physiological factors are documented as: gait and balance, weakness/fainted, decreased safety awareness, decreased strength/endurance, and seizure activity. The predisposing situation factors are documented as: not using wheelchair.

R1 also had falls on the following dates: 1/13/22, 1/17/22, and 3/4/22. The following interviews are

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regarding these falls and policy and procedures the facility follows regarding falls.

On 03/31/22 at 2:37PM, V4 (CNA) stated, "The nurse will usually tell me who fell. I think we have a book at the nurse's station, but I don't know. I don't know how the agency staff find out about the High fall risks. I think they look at the book. I know they're supposed to put an intervention in after every fall so the falls stop."

On 03/31/22 at 2:42PM, V5 (Nurse) stated, "I think we just go off the fall risk assessment. I don't know who is a fall risk. You just kind of watch out for people that aren't walking right. We do the assessment after a fall but I'm not really sure who the Fall risk is here. I just started here a couple months ago. I don't see any book or list up here on who are high for us. I don't know who puts in the interventions." At this time, V5 was unable to provide a list or tell this surveyor who the high fall risks were on the 2nd floor.

On 03/31/22 at 3:31 PM, V1 (Former Administrator/Administrator) stated, "I was on vacation from March 10 through the 14th. They notified me that he did fall and there was a possible seizure. They said there was also a superficial laceration. I didn't report it because it was treated as a seizure. I don't know if we got any type of update on what his condition was at the hospital but it was treated more like a seizure than a fall so I didn't report it. I never heard about him having any bleeds. No, I never called the hospital to check on him. A fall is when a resident ends up on the floor on matter who they got there. Yes, this was a fall but it was also a seizure."

There was no documentation on any investigation

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| S9999 | Continued From page 8<br>regarding R1's fall on 03/10/22 and no documentation IDPH was notified of the fall with injury.<br><br>On 04/05/22 at 6:22PM, V10 (Agency Nurse) stated, "He got up to get to the bathroom and I guess he fell in there. I didn't see it, but the CNA came to get me to tell me. I went in there and he was laying down on the floor with his head kind of under the toilet. He couldn't tell me what happened, but I saw the floor was wet. I don't know if it was urine or if he was trying to wash his hands and slipped. He said he lay down because he got tired of sitting up. I assessed him and there wasn't any injuries. He denied hitting his head. He said he fell down on his butt and just laid back down to rest. He told me he tried to get up himself and I just told him that he couldn't do that. I told him he needed to call us for help before he did that again. I don't know what interventions he had in place. I don't know if he had a fall recently. I know he was using a wheelchair to get around, but I didn't see the wheelchair in the bathroom. Yes, he was a High fall risk. I don't really know why but he was unsteady. I don't know who puts in any interventions after a fall. I wouldn't know how to do that. No, I never saw a list of any High fall risks at the nurse's station. Usually, the nurse will tell you and report if someone is a High fall risk or you just kind of watch out. I reported the fall to everyone, but I never put in any interventions. I don't know how to do that. I'm guessing someone else did. I don't know who would." This was the fall on 03/04/22.<br><br>On 04/06/22 at 1:21PM, V3 (DON/Fall Coordinator) stated, "The fall coordinator goes and investigates the fall and puts an intervention | S9999 | | |

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in place. They try to see what causes the fall and put an intervention in place that relates to the fall. We then try to educate the resident and the family on the fall and what we're doing after to help prevent a fall from occurring again. We communicate the new interventions with the team, and we also care plan. We base the intervention and the care plan off of what kind of fall happened. This should be discussed the next day. The more serious things are put first but I wouldn't say any more than a day or two to have an intervention put in. There is no reason an intervention should not be put in in that timeframe. We do have a fall program here. We complete the fall risk assessments on admission, quarterly, after a fall, and any changes with the resident. I don't know how staff knows which residents are High fall risks. The fall coordinator we had just resigned so we are in the process of redoing the full program to better fit our facility needs."

On 04/06/22 at 1:37PM, V14 (Nurse) stated, "I don't remember the fall to be honest. I know lately he was very weak. I'm not sure why. He used to walk fine before his stroke. That was last year but then he was still able to get around in the wheelchair after the stroke. I don't know what his interventions were. I think those are on the care plan. I know restorative puts them in, but I don't know what happens after that. We know who is a High fall risk if you see someone walking around that's unsteady. We do fall risk assessments and those stay in the computer and that's how we know who is a High fall risk. I know we used to have a paper at the nurse's station with the names of the residents who are high fall risk so you could know but we haven't had that for about six months now. I don't know what happened to it. I also go around and check on the residents. If we

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| S9999 | Continued From page 10<br>hear something between round, we check on them to make sure nothing happened. I don't know how to find out what interventions to put in for people. If someone is up walking around that shouldn't be I just redirect them or guide them back to their room to sit down." This was regarding the fall on 01/17/22.<br><br>On 04/06/22 at 5:08PM, V15 (Director of Rehab) stated, "He was in therapy with us since January. We ended up having him evaluated after a fall and decided because of the decline he had he should receive therapy. We would work on educating him about the safety precautions and making sure he was using the assistive devices. He was always instructed to have supervision when he got up and most of his falls resulted because of that. He never called for assistance. He was also instructed to use the call lights and wait until someone came in for help. He was very impulsive and attempted to do stuff on his own. I would say he was oriented, but he was impulsive."<br><br>On 04/07/22 at 11:54AM, V16 (Medical Director) stated, "I only saw this resident once so I can't tell you much about him. I don't really know his history or what he was capable of. I don't know if he had a recent decline or not. If a resident does have a decline the facility needs to inform us. For falls they need to follow their protocol and put strategies in place for High fall risk patients. I don't know when they should put in these interventions all I can say is follow the protocol. I don't handle any interventions really unless they are from a medical standpoint. If any medications need to be changed around then I can do that, but the facility is responsible for putting in other interventions. Their main goal should be to be keeping people safe." | S9999 | | |

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A Nursing note dated 1/13/22 documents staff observed R1 lying on the left side of the face on the floor with both knees flexed in buttocks pointed upward. R1 reported attempting to reach for food and fell. No injuries were noted but the doctor ordered R1 to be sent to the hospital, but family declined. The physician also gave orders for therapy to evaluate and treat as R1 continues to decline. A Nursing note dated 1/17/22 documents R1 was noted on the floor on the left side lying position. R1 reported rolling out of bed after not realizing he was near the edge and fell. No injury was noted, and it was ordered to send R1 to the hospital for imaging but R1 refused. A Nursing note dated 3/4/22 documents R1 was found on the bathroom floor lying on the back with his head under the toilet. R1 reported falling but could not report how. The nurse noted the floor was wet at the time of the incident. R2 reported feeling dizzy. R1 initially fell and landed on the butt and reported laying back down afterwards. No injuries were noted. R1 was able to ambulate with assistance back to bed.

The Fall Event dated 1/13/22 documents R1 fell after reaching for food. R1 was found lying on the floor with both knees flexed and buttocks in the air. Predisposing physiological factors are documented to be: recent illness, gait and balance, incontinent, weakness/fainted, impulsive, and decreased safety awareness. The predisposing situation factors are documented as: admitted within the last 72 hours, wheelchair unlocked, and incident during unassisted self transfer. The Fall Event dated 1/17/22 documents R1 was noted on the floor beside the bed after rolling out of the bed. Predisposing physiological factors are documented as: recent illness, incontinent, and decreased strength/endurance.

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| S9999 | Continued From page 12<br><br>The Fall Event dated 3/4/22 documents R1 was found lying on the bathroom floor with his head under the toilet. Water was noted on the floor. R1 was unaware how the fall occurred but thinks he was dizzy. R1 reported initially falling and landing on his buttocks and got tired and laid backward. The predisposing physiological factors are documented as: decreased safety awareness. The predisposing situation factors are documented to be: incident during an assisted self transfer from bed.<br><br>The Care Plan dated 6/23/20 documents R1 is at risk for falls related to history of falls, weakness, cerebral infarction, and use of antipsychotic medications. There are no interventions documented after the fall on 1/13/22 and 1/17/22. The interventions that are documented include: educate R1 to use wheelchair instead of walking on wet slippery surfaces, ensure that R1 is wearing appropriate footwear when ambulating, keep needed items within reach, use side rails to enhance bed mobility, ask R1 during rounds if he needs to use the bathroom, and be sure R1 call light is within reach, and encourage R1 to use it for assistance as needed. R1 needs prompt response to a request for assistance. The Care Plan dated 03/2/22 documents R1 is at risk for falls related to (blank). There is nothing documented as to why R1 is at risk for falls. The interventions are documented as: be sure call it is within reach and encourage use for assistance, anticipate and meet individual needs of R1, and complete the fall risk review per the facility protocol.<br><br>The Physician Order Sheet dated 3/31/22 documents R1 was ordered a physical therapy evaluation and treatment due to gait and new therapy provider. The original physical therapy | S9999 | | |

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| S9999 | Continued From page 13<br>was from 1/13/2022. The Minimum Data Set (MDS) dated 01/19/22 Section G of the MDS Documents R1 needs a one-person physical limited assist for transfers, walking in the room, walking in corridors, locomotion on and off unit, and toilet use. It is documented when walking and moving in and off toilet R1 is not steady but is able to stabilize without staff assistance. It is documented that R1 uses a wheelchair as an assistive device. Section I of the MDS dated 2/1/22 documents R1 has not had any falls since readmission or reentry or the prior assessment. This documentation is incorrect because in progress notes it is documented that R1 had a fall on 1/13/22 and 1/17/22.<br><br>The Physical Therapy notes from 3/1/22 document R1 has been referred to skilled physical therapy to address remaining deficits to be able to return to previous level of function therapy is necessary to address impairments in muscle strength, balance, activity tolerance, cognitive and safety deficits. Without therapy, R1 is at risk for falls and functional decline. R1 has been in therapy since 1/14/22. R1's safety awareness is documented as minimally impaired. The cognition functional limitations are safety is limited by need for assistance in transfers, gait, and bed mobility. Current level of function for transfers is documented as R1 is able to safely complete a bed to wheelchair transfer with contact guard assist. R1 needs initiation of cues in verbal, tactile and visual instructions. R1 is able to ambulate 150 feet on level surfaces and requires a contact guard assist with a rolling wheelchair with initiation of cues and verbal, tactile and visual instructions for safety. The Occupational Therapy notes dated 3/1/22 documents R1 presented to occupational therapy following a decline in function and recent fall on | S9999 | | |

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| S9999 | Continued From page 14<br><br>1/13/22. R1 presents with deficits in balance, endurance, strength, and cognition. Recovery further complicated by occupational deprivation and current radiation treatment. Fall risk balance is documented as a high risk and fall recovery balance is documented as severely impaired. R1 is documented to have moderate cognitive abilities with frequent direction required in occasional situations. R1 requires cues and redirection for safety. The physical therapy discharge summary documents R1 had been improving in all areas but still required some assistance only to sustain safety in closer assist with functional gait.<br><br>The policy titled, "Fall Prevention Policy," with no date noted documents "Purpose: To ensure safety to all residents within their functional abilities, maximizing their independence and minimizing their risk for falls and associated injuries... 2. Residents at high risk will be monitored closely by staff for: gait, coordination and balance problems, lack of safety awareness and physical endurance."<br><br>(A)<br><br>2 of 2<br><br>300.610a)<br>300.1210b)<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 | S9999 | | |

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| S9999 | Continued From page 15<br>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.<br><br>These requirements are not met as evidenced by:<br><br>Based on interview and record review the facility failed follow their abuse policy and prevent resident to resident mental abuse that affected 2 of 4 residents (R7/R8) reviewed for mental abuse. This failure resulted in R7 showing copies of the nude photos and video of R8 to co-peers without R8's consent. R8 said that she feels terribly embarrassed, and it feels like her peers are holding something over her.<br><br>Findings Include:<br><br>R7 is a 56-year-old with the following diagnosis: | S9999 | | |

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| S9999 | Continued From page 16<br>bipolar disorder. R7 admitted to the facility on 11/19/20.<br><br>R7's Minimum Data Set (MDS) dated 2/13/22 documents the Brief Interview for Mental Status score as 15 (no cognitive impairment).<br><br>R8 is a 36-year-old with a following diagnosis: schizophrenia. R8 admitted to the facility on 7/24/21.<br><br>R8's MDS dated 1/9/22 documents the Brief Interview for Mental Status score as a 14 (no cognitive impairment).<br><br>A Social Service note dated 3/9/22 documents R7 was named in an incident for mentally abusing R8. This matter was reported to the administrator and the DON as well as the non-emergency police department. R7 was counseled to be of good behavior to peers and staff. R8 was counseled to remain calm, avoid confrontation, and be focused.<br><br>The Facility Incident Investigation Report dated 3/15/22 documents R8 allowed R7 to take a video on his phone when R8 was naked several months ago when they were in a romantic relationship. R8 alleged that R7 has shared the video with other residents without her consent and R7 is making negative comments. R8 reports they are no longer friends. R7 admitted to taking the video several months ago with the consent of R8, when they were in a relationship. R7 denied having the video any longer and reports deleting it. The cell phone was examined by the police department, and they were unable to find the video on the phone. Both residents have been receptive to 1:1 counseling and have agreed to avoid close contact. R8 was also counseled against allowing | S9999 | | |

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compromising videos or pictures to be taken of her. The police department did not take any action. Both residents reported feeling safe in the facility.

On 04/02/22 at 1:27PM, R7 stated, "R8 and I used to date. I did take a video of her that she knew about when we first started dating. We ended up breaking up and now we don't really talk or like each other. It was just over some boyfriend girlfriend stuff. I showed two other residents the video. R8 didn't know I was showing them. We were mad at each other, but I can't remember for what. I was just kind of talking to R8 crazy and then she told the staff members. I wasn't showing it to everybody, and I wasn't going to make a show out of it. I only showed it to 2 people."

On 04/02/22 at 2:55PM, R8 stated, "The first week I was here R7 took a video of me when I was naked. I had only a bra on. I don't remember what I was doing in the video. Last month, R7 started threatening to show people. He said he was upset with me, but I don't know why. I know R7 showed two residents. They told me not to have any contact with him, but he was telling me all this through text message. I was very manic when I first got here so I had no idea what I was doing. I was off my medication when I first got here so I would act in a way that I normally wouldn't. I feel terrible. I'm embarrassed to look at some of the staff members. I just feel like they think of me differently now when that person who was in those videos wasn't even me. It feels like he constantly has something over me. When I don't do something, he says, or I don't do something he likes then he's going to show the video to someone. I'm constantly having to worry about who's going to have to see the video."

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| S9999 | Continued From page 18<br><br>At this time R8 showed the surveyor text messages between R7 and R8. The conversation started with R7 threatening to show a video of R8 to unnamed residents. The text messages read the following: R7 wrote, "You might as well shoot to kill because I told everyone there was going to be a show Friday or Saturday with the video." R8 replied, " The video made me sick." R7 replied, "I'm going to show them you dancing and singing. I'm going to show them the one of you sticking things in your pu**y." R8 endorsed the police were called and a report was made. R8 denied any other issues with R7 at this point. R8 denies any other issues in the facility at this time.<br><br>On 04/05/22 at 11:36AM, V2 (Assistant Administrator) stated, "I know there was an issue with R7 allegedly showing video of R8 to other people. I didn't do that investigation so I can't say who is interviewed. No, I haven't looked at R8's phone and seen the text messages from R7."<br><br>On 04/05/22 at 2:14PM, V9 (Social Service Director) stated, " R7 had a video on his phone of R8. Some residents say they did see it and other residents said no they didn't see it. When I talk to R8 about it she told me that the video was taken and that R7 said he was going around showing people, so I told the administrator. We called the police and we had them search his phone, but we couldn't find the video. We asked him for the Sim card, but he said that phone was broken, and he didn't know where the Sim card was anymore. We told him that he can't be showing videos like that without people consenting. I counseled R8 to tell her to not make videos like that. R8 told me I made it when I just came here, and I wasn't myself. The only thing that she told me was that she didn't feel like herself when she first got here | S9999 | | |

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so that's why she made the video. One resident I know that saw it was R10. I went and talked to him, and he said he did see it. This would be considered mental abuse. R7 keeps using it in a threatening way."

On 04/05/22 at 2:40PM, R9 stated, "Yes, R7 showed me a video of R8. R8 was dancing and smoking something, I think. She didn't have any bottoms on. She only had a bra on top. I saw her butt and her vagina. I can't remember where we were but R7 just came up to me and said, 'hey you want to see this video?' I watched it but I didn't think he was going to show me that. He didn't tell me what he was showing me before. I went and I told R8 that R7 was showing people pictures of the video because I didn't want her to feel stupid. If someone showing videos of you like that you should know about it."

On 04/05/22 at 2:57PM, R10 stated, "R7 is a bully. He bothers a lot of women in here. One day R7 just approached me as a friend and said he had something to show me. I saw it was a video of R8 dancing around naked and doing some other stuff with her vagina. I was shocked. I told him I don't want to see anything like that. I also told him that it was really disrespectful of him to be showing that video even if they weren't together anymore. I stopped dealing with him after that. I don't want to associate with nobody like that."

On 04/07/22 at 11:54AM, V16 (Medical Director) stated, "I don't know if I'm involved with these residents; I'm not aware of the situation. I can't comment specifically on this. The facility needs to make sure that everyone is safe, and no one is causing harm to themselves or anyone else. The psychiatrist would better be able to take a look at

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| S9999 | Continued From page 20<br>their history to see what they should be doing to help that. They should be able to see if the resident is a good fit for the facility orif they need to go somewhere else. Everyone should feel safe in the facility."<br><br>R7's Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors dated 3/9/22 documents a total score of a four which indicates a substantial or significant problem with aggressive or harmful behavior. R7 has a history of destructive statements, behaviors, and threats.<br><br>The Care Plan dated 3/9/22 documents R8 demonstrates a pattern of situational and/or coping problems in areas such as psychosocial well-being, mood state and/or behavior symptoms related to alleged mistreatment. Symptoms are manifested by conflictual relationships with staff and peers.<br><br>R8's Screening Assessment for indicators of Aggressive and/or Harmful Behaviors dated 4/3/22 documents R8 is at a moderate risk for abuse due to a history of abuse, a psychiatric history and/or mental health diagnosis, diagnosis of depression or low self-esteem, in a presence of a dysfunctional behavior.<br><br>The Policy titled, "Abuse Prevention Program Facility Policy and Procedure," dated 1/4/18 documents, "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, I've got your services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residence, irrespective of any mental or | S9999 | | |

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| S9999 | Continued From page 21<br>physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enable through the use of technology. Willful, as using this definition of abuse, means of individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."<br><br>(B) | S9999 | | |