Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015333	A. BUILDING: ______ B. WING ______	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments 22910294/IL154750	S 000		
S9999	Final Observations Statement of Licensure Violations: One of five findings: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6) 300.1220b)3) 300.3210t) 300.3240a) 300.3240d) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 300.1210 Section General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the	S9999		

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resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

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d) 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 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)

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These regulations were not met as evidence by:

Based on observation, interviews and record reviews, the facility failed to follow their abuse policy and procedure in preventing and protecting residents from verbal and physical abuse. This failure affected seven (R5, R6, R9, R10, R12, R18, and R20) of eleven residents reviewed for abuse. This failure resulted in R5 being hit with a cane by R6 and sustaining a laceration on the left side of head and closed fracture of the distal left ulnar shaft requiring surgical repair; R9 was hit by a staff member and sustained a hematoma to the forehead and was sent to the hospital for further evaluation; R10 was struck by another resident with a motorized wheelchair and sustained a scratch and swelling to his right foot; R12 was cursed out, accused of stealing personal

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belongings, and was struck on the hand and foot causing an abrasion; and R18 experienced abuse by a staff member who poured hot and cold water on R18, while pushing him around while in his shower chair.

Findings include:

R5 is a 62 year old, male, admitted in the facility on 07/11/2022 with diagnoses of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; Schizoaffective Disorder, Bipolar type; Major Depressive Disorder, Recurrent, Unspecified and Anxiety Disorder, Unspecified. According to MDS (Minimum Data Set) dated 01/01/2023, R5 has BIMS (brief interview for mental status) of 13, which means little to no impairment in cognition.

Incident report dated 01/12/23 documented that R6 struck R5 with his cane on his left arm and left side of his head. R5 stated his roommate hit him with his cane on his head and arm. R5 stated his roommate's (R6) table was in his way and when he moved it that R6 got up and hit him with his cane.

On 01/30/2023 at 1:54 PM, R5 was in his room, lying in bed, with soft cast on left hand covered with a bandage. R5 is alert and oriented, was asked on what happened to his hand. R5 stated he does not remember what happened. R5 was also asked if he had any incident with another resident that he was hit with a cane. R5 stated that there was none.

Per R5's progress notes dated 01/12/23, time stamped 8:36 PM, documented: R5 touches roommate's (R6) table ending up things on the

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floor. Roommate (R6) got upset and had exchange words and roommate (R6) hit him with a cane on the left side of his head and left arm.

On 01/31/23 at 3:47 PM, V30 (Licensed Practical Nurse, LPN/Supervisor) was interviewed regarding R5 and incident on 01/12/23. V30 stated, "A couple of weeks ago, I was called to the floor, went to their (R5 and R6) room. They were roommates. It was reported that they had a physical altercation. R5 was in the washroom washing his hands and was asked on what happened. He (R5) showed me a cut on the forehead and bruise on his left arm. He said R6 hit him with a cane. I asked why, he said that he tried to get the remote control on the table to turn down the TV. I cleaned his forehead because of the cut and asked if he has any pain. He denied any pain, dried the cut and applied antibiotic. I moved him to another room. I went to R6, asked what happened. He (R6) admitted that he hit R5 with his cane because he (R5) moved his table and everything went to the floor. Then I told him (R6) that if he had issues with another resident to call nurse or call for help. For R6, it was the first time. For R5, he always complained about his roommate's television volume.

Progress notes dated 01/14/23 recorded that R5 was experiencing left lower arm pain, X-ray to left arm was taken. X-ray result dated 01/15/23 documented:
X ray left radius/ulna, AP (anterior posterior) and lateral
Impression: Minimally comminuted acute fracture of the distal left ulnar shaft.

Progress notes dated 01/16/23 documented that R5 was sent to the hospital and was admitted with diagnosis of fracture.

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Hospital records dated 01/15/23 recorded:
Diagnoses: Assault, Closed fracture of upper end of left arm. Admission History and Physical also recorded:
Chief Complaint: Left elbow pain
HPI (History of Present illness) - 60 years old, male (R5) with Stage 4 lung cancer with metastasis to cervical spine s/p (status post) chemo (in remission), and epilepsy who presented to the ED (emergency department) after injury sustained at NH (nursing home). Patient (R5) was hit with a cane by co-resident at NH, resulting in head and ulnar injury. He presented to the ED two days later. In ED, hemodynamically stable, breathing well on room air, afebrile, CT (computed tomography) head with no acute intracranial abnormality. Imaging notable for left distal ulnar diaphyseal fracture, ortho team was consulted and requested preop clearance prior to surgical intervention.
Orthopedic Surgery Date of Service: 01/16/23 - Procedure Performed: Open reduction internal fixation of the left distal ulnar shaft fracture

On 01/31/23 at 12:01 PM, V10 (Social Services Director) was asked regarding R5 and R6 incident on 01/12/23. V10 replied, "I learned about the incident the night after it happened. That he (R5) was touching his (R6) personal belongings, and he (R6) just hit him (R5) with his (R6) cane. They were separated. They are both alert and oriented. R5 has a behavior of touching peer's belongings. It was addressed prior to the incident, it was care planned. We just need to encourage him (R5) to engage in activities and encourage him (R5) not touch peer's belongings."

R5's care plan on Behavior problem with touching my peer's belongings was only initiated on

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01/13/23. There was no other care plan created prior to 01/12/23 related to any of R5's behavior.

V6 (Patient Relations) was interviewed on 01/31/23 at 9:02 AM regarding R5 and R6. V6 verbalized, "They were roommates before. They shared the same model of television (TV). They both have the same remote. R5 grabbed R6's remote by mistake. I don't remember, maybe two weeks ago, they paged me. I went to the room. R6 said his TV remote was not working thinking R5 had his remote. I went to R5 and asked if he had his (R6) remote and was told he (R5) does not watch TV. I told him that there used to be two remotes and now there was one but not working. R5 said he had put it in his bag, his remote and R6's remote. So he (R5) gave me the little duffel bag, I found both remotes. So I told him (R5) if he could give back his (R6) remote and he said yes, that was it. I left the room. Throughout the whole thing, he (R6) stayed on his side and so was R5). It was morning shift when this happened. R5 actually was not on good terms with his former roommates because he (R5) said that TV was loud, so we gave him a room change. Again, he (R5) had an issue with TV being loud, so he (R5) was moved again, with R6. Next day, they had the remote issues. I resolved the remote issue and there was no problem afterwards. I don't have any documentation for this remote issue."

Per census report, R5 was moved to R6's room on 01/10/23. Therefore, the incident with R6 related to TV remote happened on 01/11/23.

On 01/30/23 at 1:42 PM, R6 was asked regarding incident with R5. R6 stated, "I did hit him, I don't know his name. One day, he took my TV remote and put it in his drawer. V6 knew, he helped me get back my remote. Then, all of a sudden, he

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knocked my table and we argued. He was trying to reach something from his bag, thought he is going to get something, so I took my cane and hit his left arm and hand."

According to progress notes dated 01/12/23 at 12:02 PM, R6 notified V17 (LPN) of concerns with roommate (R5) touching his belongings when he steps out of the room. V17 mentioned during interview on 01/31/23 at 2:20 PM, "On 01/12/23, R6 notified me that when he steps out of his room, R5 touched his belongings. I mentioned it to V1 (Administrator), V3 (Director of Nursing) and Social Services. I talked to R5 and R6 and notify management. It was during morning shift that he (R6) told me about him (R5) touching his belongings."

On 02/01/23 at 9:22 AM, V2 (Assistant Administrator) was interviewed regarding abuse investigation and incident between R5 and R6. V2 replied, "I am not the Abuse Coordinator, V1 (Administrator) is. I do the majority of the investigation together with team V1, V3 (Director Of Nursing) and V4 (Assistant Director Of Nursing) to get statements. Regarding R5 and R6 incident, it occurred on 01/12/23. It was reported that R6 hit R5 with his cane on his left arm and left side of his head. They were separated immediately. R6 was moved to another room. they were both assessed for injuries. He (R6) does not have any injuries. R5 had a cut on the left side of his head and fracture on the left ulnar. He (R5) was sent out to the hospital. Xray was taken due to him (R5) complaining of pain on the left hand. R6 was sent out to the hospital for psychiatric evaluation. Not to my knowledge that there were prior incidents that happened between the two. R6 was triggered by R5 because he (R5) reached for his (R6) cane that is why he (R6)

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struck him (R5) with his cane. He (R6) was sitting in his chair when R5 moved his (R6) side table, verbal altercation occurred and R5 attempted to grab his (R6) cane but he (R6) struck him with the cane. The verbal altercation issue was he (R5) wanted to turn down the volume of his (R6) TV. To my knowledge, that was the first time it happened to both of them. Not to my knowledge that there were prior reports or issues regarding TV remote on both residents."

On 02/01/23 at 11:58 AM, V3 was asked if regarding R5 and R6. V3 verbalized, "Prior to 01/12/23 incident, I was not aware of any issues going on between them. I am not aware of any behavior issues on R5 and R6.".

On 02/01/23 at 2:40 PM, V4 was also interviewed regarding R5 and R6, stated, "I was not aware of any issues going on between them or any behavior concerns for the two residents.'

V1 was interviewed on 02/01/23 at 12:21 PM regarding abuse and incident between R5 and R6. V1 verbalized, "I am the Abuse Coordinator, I investigate allegations on abuse and follow our policy and procedures regarding abuse prevention. All staff, including all CNAs (Certified Nurse Assistants), nurses, patient relations, management, dietary, everyone is trained throughout the year on abuse. Regarding R5 and R6, the incident happened on 01/12/23. V2 and myself did the investigation. It was reported that R6 struck R5 with his cane. R5 had mild pain on the left hand, fracture to his left ulnar and cut to his left side of head. We believed it was caused by being struck by R6's cane. I talked to him (R6), said he was sitting in his wheelchair and he (R5) pushed over the end table. He (R6) asked him (R5) why he did that. R5 said it was on his (R5)

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side. He (R5) also said what R6 is going to do with his (R6) cane. R5 attempted to grab the cane and that is when he (R6) struck him with the cane. I am not aware of any incidents or any issue going on between these two residents prior to the 01/12/23 incident. With what happened to these residents is considered physical abuse."

There was no documentation regarding incidents on 01/11/23 regarding TV remote. There was a documentation on 01/12/23 during morning shift when R6 reported his concern on R5 touching his belongings, but it was not addressed.

On 02/01/23 at 1:10 PM, V31 (Nurse Practitioner) was asked regarding R5 and R6. V31 stated, "I was informed about their physical altercation, don't remember when. That R6 got mad at R5 for invading his space, he (R6) hit him (R5) with his (R6) cane, on R5's left side of head, left arm, left thigh, left side. I don't think R6 got hurt but R5 had a cut on his head, and fracture of the left arm. The cause of the fracture was the cane because he (R6) hit him (R5). R5 said he was moving his (R6) table and thought he (R5) was in his (R6) space. R5 does not have any behaviors, never heard anything like that. He is awake and alert majority of the time and has some forgetfulness, occasional confusion and he has seizure disorder and cancer. No behavior. No problems whatsoever. R6 is a long-term patient, known to be aggressive. He had a roommate prior to R5. The roommate was R10. He (R6) got mad because I was told that he (R10) was touching his stuff and got angry and pushed him, shoved him with his motorized wheelchair. R10 is very, very confused but never been in any physical altercation. As far as I knew, it was addressed. There are a lot of things going on in the floor that staff are not telling me about. I

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would assume staff on the floor knew their behaviors.

R6's Physician Progress note dated 12/08/2022 recorded: Discussed with patient (R6) argument patient had with roommate (R10). R6 states he just made him get away from his belongings. That the other patient kept trying to take his things. He is not normally aggressive.

R6's Behavior/Mood Charting Assessment Dated 12/06/2022 documented he was verbally and physically aggressive, behavior triggers include others entering their personal space (getting too close) or their room; other resident yelling, cursing or verbal aggression directed at them. Mood exhibited included repeated verbalizations, displayed anger with self/others, agitated/easily upset.

There was no care plan initiated addressing R6's aggressive behavior upon further review of R6's medical records.

On 02/01/23 at 4:40 PM, V38 (Psychiatrist) was interviewed regarding R5. V38 stated, "I have been seeing R5 since July 2022. He came from the hospital, Psychiatric Unit. He has Schizophrenia, lung cancer. On 01/25/23, I saw him. He is alert, oriented to place, cognitively declined, unable to make decision, little bit withdrawn and has a flat affect. I don't think he has unusual behavior. I was informed that he was assaulted by another resident. I come to the facility every week. He is usually in his room, sits on his bed, try to sleep at night because he sleeps during the day. I don't think he (R5) would be aggressive, not likely. If another resident is verbally aggressive, I don't think he (R5) will react violently. Approaches or interventions that could

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help him (R5) be prevented from abuse are to reinforce him (R5) to come out and ask for help if having problems or issues with roommates since he has Dementia and might not remember what to do at times; if placing or moving him (R5) to another room, consider who the roommates would be. Whether his roommate has any unusual behavior towards other residents. His roommates should be assessed and observe for any aggressive behavior."

V1 also mentioned, "Any precipitating behaviors of resident in terms of acting out verbally, physically should be reported to Social Services and addressed it by notifying the doctor, initiating care plans and assess interventions for effectiveness."

2. R9 is a 72-year-old female who was admitted to the facility on 12/2/2022 with past medical history including, but not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified dementia, pneumonia due to coronavirus disease, unspecified lack of coordination, dysphagia oropharyngeal phase, hematuria, anxiety disorder, aphasia, etc.

1/29/2023 1:00PM, R9 was observed in her room in bed sleeping and unable to awaken to her name. Room was noted to be cluttered, bed not on low position, no floor mats noted on both sides of the bed, resident had half bed rails on both sides of the bed. No call light was noted by resident or within reach.

1/29/2022 at 2:35PM, R9 was observed in her room, awake, but unable to answer any questions. Resident's call light was still not within reach and still tied under the mattress. Observed

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a high back wheelchair at the bedside, with urinary catheter, noted in a privacy bag and half side rails were noted on both sides of the bed and lowered.

Facility abuse risk assessment dated 12/7/2022 coded resident with a score of 0, indicating low risk for abuse.

Facility reportable dated 12/12/2022 documented that R9 was allegedly abused by a staff member identified as V29 (C.N.A) investigation was initiated and will continue. The same reportable stated that resident was interviewed about the incident and she shook her head yes and gestured her hand to her forehead and whispered, the C.N.A, the one that changes me. The document states under actions for other residents who could be affected that staff member is suspended until investigation is completed. The investigation was signed as completed on 12/16/2022.

1/31/2023 at 1:49PM V1 (Administrator) said that the allegation between R9 and V29 (C.N.A) was unfounded, R9 had a bump on her head but the source is undetermined. V1 said he is not sure of resident's need, but she is probably dependent on staff, he is not sure if V29 has been named in another allegation, she was the assigned C.N.A for R9 on the day of the incident, she may have been called back to work before the other incident. Surveyor asked V1 if staff on suspension could be called back before the investigation is over and he said, "sometimes you can call them back, it is done on a case-by-case basis." V1 said that V29 no longer work at the facility, she was terminated for breaking rule #7 of the union code. Surveyor pointed out to V1 that the rule #7 was documented as abusing a

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S9999	Continued From page 14 resident or another staff, so was V29 terminated based on this, he said "Yes." V1 added that there is no proof that V29 abused resident, but she was terminated anyway. V1 was asked if it is the facility practice to terminate staff without proof and he said that it is determined on a case-by-case basis. 1/31/2023 at 2:54PM, V8 (Social Services) said that she is aware of the incident involving R9 and a staff, she was informed that the C.N.A supposedly hit the resident, she was shadowing her supervisor (Social Service Director) at that time and helped her with completing the incident report. V8 added that her supervisor spoke to the resident, she was not present and not sure what the resident said. 1/31/2023 at 3:07PM, V10 (Social Service Director) said that the C.N.A involved in the abuse allegation no longer works at the facility, the resident shook her head yes when she was asked about the incident, and she showed how the incident occurred by winging her hand to her head. V10 stated that herself, the nurse practitioner, and the administrator interviewed resident and she confirmed that the incident happened. V10 said that resident had a bruise to her forehead, she spoke to the daughter who was very upset, and said that she was filing a police report due to the incident. 2/2/2023 at 1:13PM, V41 (Wound Care Nurse), said that he went to do an admission assessment with R9's roommate when R9 motioned him to her bed, she was pointing to her head, she asked her if she have a headache and resident said no, he asked her if she was hit she nodded yes, V41 asked R9 by your nurse and she nodded her head no, he then asked by your C.N.A and she	S9999		

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nodded yes. V41 said he then reported to the nurse supervisor who told him to report to the administrator (V1).

2/2/2023 at 2:45PM, V42 (Nurse Practitioner) said that she is familiar with R9, her daughter showed V42 a video of what happened that she recorded in the emergency room, the resident nodded yes when she was asked if she was hit by staff. V42 stated that she saw the resident, did not notice any physical evidence, resident is aphasic and does not have a clear speech, she can only nod yes or no. V42 said that yes when herself, the administrator and another staff went to see her, the abuse was founded, the staff no longer work at the facility because that is unacceptable.

3. R18 is a 65-year-old male who has resided at the facility since 9/30/2022 with medical history including, but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, major depressive disorder, lack of coordination, essential primary hypertension, muscle weakness, etc.

On 1/30/2023 at 12:45PM, R18 was observed in his room in his motorized wheelchair, awake, alert and oriented and stated that he is doing okay. R18 stated that he recalls having an issue with a staff member, she was angry with him because he had a bowel movement. The staff kept on pouring hot water and cold water on him and pushing him around while in his shower chair. R18 said that he reported the issue to staff and called the police, a police report was done.

Facility reportable dated 12/14/2022 documented that the same staff member V29 (C.N.A) was

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involved in another abuse investigation with R18. R18 alleged that V29 was being rough with him while assisting him with ADL care. Police report (#) documented on the reportable. Further review of the reportable indicated that the C.N.A (V29) was interviewed on 12/14/22 during the investigation. This investigation was concluded on 12/19/2022.

4. R10 is an 87-year-old male with a diagnoses history of Dementia, Major Depressive Disorder, Hearing Loss, Epilepsy, History of Falling, and Spinal Stenosis who was originally admitted to the facility on 8/1/2022.

R10's progress note dated 12/6/2022 documents: Around 9PM while V7 (Licensed Practical Nurse) was walking along the hallway, he witnessed two residents up against each other's wheelchair in their room. V7 called the floor staff to separate the two. Assessed both residents for injuries. R6 denies any pain, however when the writer assessed R10, he observed that his right foot has a minor scratch on the dorsal section. Resident was moved temporarily to another room. The family member was notified and explained the situation.

R10's Physician progress note dated 12/07/2022 documents: he was seen for right foot pain; Patient was recently struck by another patient in his motorized wheelchair. Patients right foot mildly swollen but no bruising or malformation seen. Will obtain X-rays to verify no fracture or dislocation. Encouraged patient to use analgesic if he feels he needs it; assessment and plan for x-rays of right foot 3 views.

R10's Current Care plan initiated 08/26/22 documents he is at risk for abuse/neglect related

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to Dementia, history of physical abuse with interventions initiated 08/26/22 including observe resident in care situations; Observe resident when in company of peers. R10's care plan initiated 08/17/2022 documents he has cognitive impairment and experiences disorientation to time and has problems with recall/periods of confusion, which is related to a diagnosis of dementia with interventions including: provide me with orientation/grounding information (verbal, description) information throughout the day to help me increase my comfort level and awareness of my environment.

On 02/01/2023 from 9:41 AM - 09:43 AM R6 stated in December while he and R10 were both ambulating in their wheelchairs in opposite directions, R10 observed R6 reach for hismcane and stated "what are you about to do with that stick?" R6 stated R10 then grabbed R6's wheelchair remote control and pulled it. R6 stated he then began pushing R10 out of the room so he can get staff to come and remove R10. R6 stated V7 (Licensed Practical Nurse) had observed him and R10 during this time when their wheelchairs were in contact with each other and had another staff remove R10.

R6's Physician Progress note dated 12/08/2022 documents Discussed with patient argument patient had with roommate. R6 states he just made him get away from his belongings. That the other patient kept trying to take his things. He is not normally aggressive.

R6's Behavior/Mood Charting Assessment Dated 12/06/2022 documents he was verbally and physically aggressive, behavior triggers include others entering their personal space (getting too close) or their room; other resident yelling,

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cursing or verbal aggression directed at them. Mood exhibited included repeated verbalizations, displayed anger with self/others, agitated/easily upset. Location of occurrence was resident's room. Physician and family notified.

On 01/31/2023 from 09:19 AM - 09:25 AM V6 (Patient Relations) stated R10 and R6 shared a room and R10 was in bed one. V6 stated R6 was irritated with R10 constantly calling out for the nurse so R10 was moved out of the room. V6 stated R6 has been in the facility for 13 years and has been in his current room the entire time so he feels he has seniority. V6 stated R6 was moved from his room January 12 due to an altercation with another resident.

On 01/31/2023 from 10:23 AM - 10:35 AM V7 (Licensed Practical Nurse) stated he found R6 and R10's wheelchair were in contact while facing each other and overheard R10 saying back off, back off. V7 stated he immediately informed V32 (Charge Nurse/Registered Nurse). V7 stated he stayed with R6 and R10 and continued to observe them then V32 came immediately to separate them. V7 stated he advised V32 to immediately remove R10 because he has some confusion and will move around and try to go in the bathroom on his own, so he was moved two doors down to another room. V7 stated R10 doesn't use the call light and will have bowel incontinence and spread feces on floor and walls. V7 stated R10 does go in other residents rooms and bathrooms. V7 stated if he was in charge of making room changes, he would not put someone who is confused or could go in other people's belongings or touching other people's items with a resident who is alert and oriented and independent. V7 stated R6 is very neat and independent. V7 stated R10 does not generally get agitated.

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S9999	Continued From page 19 On 01/31/2023 from 2:01 PM - 2:17 PM V1 (Administrator) stated it was documented in the medical records that there was an incident with R6 and R10 where one rolled over the other one's foot. V1 stated it was reported that V7 (Licensed Practical Nurse) passed by the room observed R6 and R10's wheelchairs together and one of the resident's foot was rolled over and that resident was sent to the hospital. V1 stated he was not given any additional details about the incident and that's all that he was told. V1 stated if more information was provided, he may possibly have looked further into it. V1 stated if something indicated that an allegation of abuse occurred then an abuse investigation would have been initiated. V1 stated indicators of abuse would include someone reporting a deliberate hit or comment. V1 stated based on the information reported by V7 to the surveyor about this incident there could possibly be a need to determine if R10's foot was ran over intentionally or unintentionally however there were no details to indicate to investigate further at the time. V1 stated once an investigation is initiated it would then be reported to the state. V1 stated if willful intent occurs care plans would be updated, room changes may occur, a resident may be sent out for evaluation, a psychosocial/emotional well-being report and an abuse assessment would be completed, and 72 charting for nursing and social services regarding the incident would be conducted. V1 stated staff need to report an allegation immediately once they feel an allegation is made. On 02/01/2023 at 09:52 AM V39 (Certified Nurse's Assistant) stated she has worked at the facility for seven months. V39 stated R10 becomes confused when leaving the dining area	S9999		

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S9999	Continued From page 20 while looking for his room. V39 stated R10 does attempt to use the bathroom by himself and cannot use the bathroom by himself. V39 stated when R10 attempts to use the bathroom by himself he may make a mess and spread his excrements around the bathroom. V39 stated at times, typically in the morning R10 will be extra alert or excited and will attempt to go to the bathroom by himself. V39 stated if she observed R10 in this state she will take him out of his room or have him near her.. On 02/01/2023 from 12:33 PM - 12:51 PM V1 (Administrator) stated if R6 pushed R10 out of the room during their incident on 12/06/2022 it was willful and if R6's foot was hurt in the process that would be willful. 5. R12 is a 75-year-old female with a diagnoses history of Morbid Obesity due to Excess Calories, Type 2 Diabetes Mellitus, and Recurrent Major Depressive Disorder who was originally admitted to the facility 7/8/2015. R20 is a 67-year-old female with a diagnoses history of Schizoaffective Disorder Depressive Type, Vascular Dementia, and Human Immune Deficiency Virus who was admitted to the facility 06/13/2022. On 01/30/2023 from 11:38 AM - 11:46 AM R12 stated in the last room she was in her roommate scratched her and the social worker was informed. R12 stated her roommate was prone to that type of behavior and she asked the facility why they didn't just place her roommate in a room by herself. R12 stated she had two scratches on her hand as a result of the incident. R12 stated her roommate was aiming to scratch her legs and when the nurse saw this she instructed her	S9999		

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S9999	Continued From page 21 roommate to leave her alone. R12 stated her roommate called her a profane name, told her to shut up, and told her she wished she was dead. On 02/01/2023 from 10:53 AM - 10:56 AM R12 stated when she shared a room with R20, R20 was always cursing at her and calling her names. R12 stated this did upset her and hurt her feelings. R12 stated she was scared R20 might "do something to her" in her sleep. R12 stated she expressed these concerns to the Certified Nursing Assistant's but they would always say that R20 won't do anything to her. Abuse Investigation Report dated 01/12/2023 documents: on 01/10/2023 after a comment was made by R12 about R20 being loud, R20 began using profanity at R12 and reached for R12; V21 (Licensed Practical Nurse) was present during the incident and grabbed R20's wheelchair to pull her away from R12. V21 observed redness on R12's foot; R12 reported that when R20 was escorted into the room by V21 she made a statement about R20 being loud leading to a verbal disagreement and during this incident R20 reached over and grazed R12's foot; R17 was present during the incident reported that she heard R20 cursing and going back and forth verbally and R20 has these outburst often; Care plans were updated, and residents 72 hour checks were initiated. Statements attached to abuse investigation report dated 01/12/2023 documents: V21 (Licensed Practical Nurse) reported on 01/10/2023 R20 became upset about a statement that R12 made that "Here comes R20 she's so loud," and yelled to R12 "shut up (profane word)!"; R12 told R20 "you need to stop cursing at me."; R20 continued to curse at R12 calling her a profane word and stating to R12 "you need to stop stealing my stuff you ugly (profane	S9999		

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S9999	Continued From page 22 word)."; R20 then turned around from her wheelchair and attempted to reach R12's foot and was pulled away and removed from the room; when R12 was assessed there was redness noted on her right foot but no scratch was seen." R12 reported that when R20 was in her wheelchair she turned around and attempted to grab her foot and when she pulled her foot away R20 told her to get the (profane word) out of her room; when R20 reached and scratched her foot/hand that's when the nurse pulled her away R20 "never liked me." R17 Reported she heard R20 cursing and cursed R12 out real bad and told her to stay out of it before she puts me out, R20 also used profanity at R17, R20 curses at everyone." R12's Progress note dated 1/10/2023 documents: Resident was seen having a verbal disagreement with her roommate concerning the inappropriate behavior she expresses such as cursing out loud and accusing her of stealing her personal belongings. Roommate was up in her room in her wheelchair receiving her medication via feeding tube when roommate reached out to resident's foot and scratched her. Roommate was then removed and re-educated. Resident requested a room change. Social Services made aware. Resident was transferred from to another room oriented to new room belongings in place and medication in cart. R12's Physician Progress note dated 1/11/2023 documents: Patient also upset because she had an altercation with one of her room mates. They ended up moving her to a different room and not all of her possessions are with her yet. R12's progress note dated 1/12/2023 created by V21 (Licensed Practical Nurse) documents:	S9999		

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S9999	Continued From page 23 This writer followed up with resident regarding behavior on 1/10 no injury noted only redness on resident's foot at the time. R20's progress note dated 11/28/2022 documents: Resident attempting to get on the elevator alone, when writer tried to detain her, she hit writer & continued to swing at her. Resident calling writer out her name & using profanity, writer attempted to re-direct without success. R20's progress note dated 1/3/2023 documents: Behavior, resident screaming and shouting from the bed, using curse words at roommate, resident stated she is getting out of the (curse word) bed, staff made several attempts to redirect resident, she tried to get out of bed and rolled herself to the floor, writer and certified nursing assistant helped resident back to the bed, when staff departed the room resident rolled herself on the floor a second time, writer and certified assisted resident back to bed for a second time, writer administered psychotropic medication, resident was able to calm herself and fell asleep. R20's progress note dated 1/10/2023 documents: Behavior Note, Resident was seen having a verbal disagreement with her roommate concerning the inappropriate behavior she expresses such as cursing out loud and accusing her roommate of stealing her personal belongings. Resident was receiving her medication via feeding tube when she reached out to roommate's foot and scratched her. Resident was removed and re-educated regarding her continuous behavior towards her peers. Resident stated, "I am sorry." Social Services made aware.	S9999		

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S9999	Continued From page 24 R20's progress note dated 1/12/2023 documents: Behavior Note Text, This writer spoke to resident regarding her behavior she did not intend to scratch her roommate. Resident is oriented times two with a Vascular dementia without behavioral disturbances staff will continue to monitor; at 2:10 PM Behavior Note Text: After this writer spoke to resident who had no intentional or act upon intended. No injury noted only redness on roommate's foot staff will continue to monitor as needed. R20's current care plan initiated 07/01/2022 documents she has a mood problem related to Admission with interventions including administer medications as ordered; Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these; Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.); Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. R20's care plan initiated 01/12/2023 documents she has the potential to be verbally aggressive related to poor impulse control with interventions including: Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document; monitor behaviors (Specify Frequency) Document observed behavior and attempted interventions. R20's medical records do not document that she had a behavior consult, was seen by the psych doctor regarding a pattern of abusive behavior, that a root cause analysis was conducted regarding her behavior, hospitalization for behavior, placed on a 1:1, or an attempt to place her in a private room.	S9999		

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S9999	Continued From page 25 On 02/01/2023 from 10:43 AM - 10:51 AM V21 (Licensed Practical Nurse) stated on 01/10/2023 she had brought R20 back to the room she shared with R12 and was preparing to administer medication to her via a tube feeding. V21 stated R20 was impatient and was complaining that she wanted go smoke a cigarette. V21 stated she explained to R20 that she really needed to administer the medication and that as soon as she was done she could continue with her day. V21 stated during this exchange R12 made a comment such as oh boy here comes the loud one which triggered R20 to become verbally aggressive with R12. V21 stated R20 began swearing at R12 and called her profane name. V21 stated R12 responded to R20 that she didn't like being called that term. V21 stated the arguing continued while she was administering medication to R10. V21 stated when she had finished administering medication to R20 she ambulated in her wheelchair towards R12 and reached for R12's foot. V21 stated she pulled R20 back before she could attack R12 however, R20 was able to grip R12's foot briefly causing her foot to turn red. V21 stated she redirected R10 and attempted to deescalate the situation. V21 stated R12 then stated she didn't want to be in a room with R10 anymore because she is consistently cursing at her. V21 stated R20's behavior is considered verbal abuse and it was reported to V2 (Assistant Administrator) and V1 (Administrator). V21 stated R12 did not go out to the hospital and did not report any pain. On 02/01/2023 from 12:33 PM - 12:51 PM V1 (Administrator) stated he believes the incident that occurred between R12 and R20 didn't meet the qualifications for an abuse incident to that needed to be reported to the state agency such as a willful infliction of injury or verbal abuse	S9999		

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S9999	Continued From page 26 depending upon the words used. V1 stated the social services staff would be responsible for handling behaviors or incidents between the residents and would report any allegations of abuse to the administrator. V1 stated being called a profane name, being told to shut up using profane words, or being told I wish you were dead would potentially constitute abuse and this would have been investigated if reported. V1 stated if R12 expressed to the certified nursing assistants that she was fearful that R20 may harm her they should have reported it and it may be a sign of some type of potential abuse. V1 stated that R20 scratching R12 while grabbing her was not willful. V1 stated R20 was being verbally aggressive towards her R12 during the incident. V1 If he grabs someone during a disagreement and they pull back they may be scratched in the process, but he didn't intend to scratch them. V1 stated if R6 pushed R10 out of the room that is willful and if R6's foot was hurt in the process that would be willful. 02/02/2023 2:19 PM V1 stated if a resident is exhibiting a pattern of abusive behavior the facility should investigate and find out the root cause, there may be a room change, hospitalization, separating residents, or possibly putting them on a 1:1. V2 (Assistant Administrator) stated this might also include having the psychiatric doctor come in and see the resident. V2 stated a resident may need to be placed in a private room if necessary. V40 (VP Clinical Operations) stated the resident may need to be sent out for a psych evaluation. V40 stated all residents should be assessed to identify who's at risk for being abused, and the facility should ensure dementia residents are not with aggressors. V2 stated that the facility would ensure that residents are appropriately matched with residents to ensure	S9999		

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S9999	Continued From page 27 their safety. V40 stated he is not sure that he can say that a minor abrasion from physical contact made between two people can be considered a willful attack because the aggressor in the incident with R12 has dementia. V1 stated that none of the interventions mentioned for a resident exhibiting a pattern of abusive behavior including the investigating the root cause, room changes, hospitalization, separating residents, placing on a 1:1, having the psychiatric doctor come in and see the resident, or placing the resident in a private room was implemented for R20. V1 stated placing R5 in the room with R6 turned out not to be a good match. V40 stated there could have been a better match made in that situation. V2 stated a behavior consult would be initiated when a resident is exhibiting behaviors. The facility's Abuse Prevention and Reporting Policy reviewed 01/31/2023 states: Guidelines: "The resident has the right to be free from abuse." "Abuse is the willful infliction of injury with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse and physical abuse." "During orientation of new employees, the facility will cover at least the following topics: What constitutes abuse or mistreatment of resident. Staff obligations to prevent and report abuse and mistreatment. Dementia management and resident abuse prevention.	S9999		

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On an annual basis, staff will receive a review of the above topics."

"As part of the resident social history evaluation and Minimum Data Set assessments, staff will identify residents with increased vulnerability for abuse and mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse or mistreatment. Staff will continue to monitor the goals and approaches on a regular basis."

"Employees are required to report any incident, allegation or suspicion of potential abuse or mistreatment to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. Employees, without fear of retaliation, may also indpendently report to the state survey agency any allegation of abuse or mistreatment."

"Reports should be documented and a record kept of the documentation."

"Employees of this facility who have been accused of abuse, mistreatment, will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator."

"All incidents will be documented, whether or not abuse or mistreatment occurred, was alleged or suspected."
"Any incident or allegation involving abuse or mistreatment will result in an investigation."
"The appointed investigator will. at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge

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of the incident and the resident, if interviewable."

"The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident."
"The administrator or person designated to act as administrator in the administrator's absence will review the report. The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the Department of Public Health within five working days of the reported incident. The administrator or designee is also responsible for informing the resident or their representative of the results of the investigation and of any corrective action taken."

(A)

Two of five findings

300.610a)
300.2210b)2)3)

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

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by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.2210 Maintenance

b) Each facility shall:

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

3) Maintain all electrical cords and appliances in a safe and functioning condition.

These regulations were not met as evidence by:

Based on observation, interview, and record review, the facility failed to follow facility policy and failed to identify that an air mattress power cord was damaged while in use (the cord was frayed with exposed wires). After a loss of power in resident room, facility staff proceeded to plug in the damaged cord into another outlet across the room, where the power proceeded to go out a second time after a visitor stepped on the cord that was going across the room floor and experienced electrical shock. The facility failure to identify that the damaged cord was continuing to be used had the immediate potential to affect two (R25 and R26) residents residing in the room, putting them at risk of fire hazard/injury. (R26) is ambulatory and at risk for injury.

Findings include:

R25 is a 58 year old female admitted to the facility on 1/20/23 with diagnoses that included Morbid

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obesity, Pressure Ulcer of left heel Stage 3, Major Depressive Disorder, Hypertension and Anxiety Disorder. According to MDS (Minimum Data Set) assessment dated 1/25/23, R25 requires Extensive physical assistance for bed mobility and transfers.

R26 is a 56 year old woman admitted to the facility 1/20/23 with diagnoses that include, Immune Thrombocytopenic Purpura, Unsteadiness on Feet and Hypokalemia. R26's medical records were reviewed. MDS dated 1/31/23 notes that R26 ambulates with supervision without the use of ambulatory devices. According to progress notes dated 2/7/23, R26 was out at appointment during the day shift.

R25 and R26 share a room.

On 2/7/23 at 11:43AM Surveyor entered R25 and 26's shared room and observed an electrical cord extending from R25's bed to an outlet across the room. R25 was lying in bed on an air mattress and was wearing a nasal cannula via an oxygen concentrator. Once surveyor identified self as an IDPH worker, R25 frantically began speaking about events that occurred just prior to the surveyor entering the room. R25 said, "I am very upset! The power went out in my room and was out for an hour, until finally the wound care nurse came in. He had to call maintenance and tell them that I was on an air mattress for my wounds and that it was a medical emergency. While the CNA (Certified Nursing Assistant) was giving me a bed bath, the power went out suddenly. The TV's shut off, the concentrator went out, and the mattress went out. It happened between 10am to 11am. The CNA told the nurse who came in and gave me some medicine. Later, the wound care

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S9999	Continued From page 32 nurse came in and told maintenance. The power was re-set, and everything came back on. They never moved me off of the bed at all. The mattress is hurting me because it isn't inflated all of the way and it is hurting my back. I wear the oxygen as needed. While still in R25's room at approximately 12:00PM, surveyor was completing interview with R25 and accidentally stepped back on an electrical cord powering R25's air mattress. Immediately, there was a flash of light, small puff of smoke, and surveyor received an electric shock to the body. R25 was lying in bed and power loss was observed to the oxygen concentrator, the television, and the air mattress, which began to deflate. After R25 verbalized she was unharmed, surveyor noted that the electrical cord on the floor had wires that were exposed. Shortly after, V15 CNA entered the room, saying it was because the call light activated outside the room. V15 went to deactivate the call light on the wall in between the beds and said that the light wasn't on in the room but was on outside the room. R25 notified V15 that the power went out again and V15 went to get the nurse. Surveyor went to R26's bed, pressed the remote buttons to move the bed and assessed that there was no power. R26's cords were plugged up behind the bed. At 12:04PM, V49 RN came into the room with V15 saying that V15 CNA notified her of the power outage. R25 informed V49 that the power went out again and mentioned the electrical cord. V49 picked up the cord close to the bed and surveyor informed V49 to be careful and that it had caused a shock. V49 viewed the cord and verbally identified wires were exposed, and hesitantly unplugged from the wall outlet.	S9999		

Illinois Department of Public Health

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At 12:05PM V15 CNA said, I was here when the power went out earlier. I told the receptionist and a nurse about it and I didn't follow up to know what happened because I was in another resident's room. V49 RN said, another nurse on the floor let me know about the power outage because I was caring for another resident. By the time I came in to give R25's medication, the power was not out. I saw that the air mattress was back on and I didn't bother with it. We are going to get her up now, so that we can change the mattress and the pump. R25 and V15 prepared to get R25 up, and R25 attempted to sit on the side of the bed to get in the wheelchair but requested to V15 that they get the mechanical lift.

At 12:12PM V49 RN said, I am the assigned nurse for R25 today. I knew the power was back on in the room because maintenance came to tell me that it was.

At 12:30PM V23 Maintenance Director was asked how often he made rounds to resident rooms and he said, I walk through the units every day and I fix things if a request is made. I get stopped in the hall and am notified verbally, by text message, or by the maintenance request logs. I have one other person working as my assistant. I review the logs daily. V23 was asked about the power outage in R25 and R26's room and V23 said, somehow the power tripped in the room and the breaker went off. I flipped the breaker, and I went into the room and checked for frayed cords. I checked the blow up mattress and TV cords and they were okay. I don't know what caused the issue because I'm not an electrician. The pump was plugged into the outlet by the foot (across the room); No, it was not plugged into the outlets by the headboard behind the bed. The issue has

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since been resolved because the power came back on. I wouldn't expect for the power to go out twice, if it continued, I would call the electrician. We have already switched the mattress pump out for R25. We do check cords to see if they are damaged and it would be my responsibility to make sure of that.

At 2:45PM R25 was observed in room, on a different bed and mattress.

At 2:51PM V48 RN was asked about their knowledge of the power outage in R25's room and said, the wound care nurse told me there was no electricity on R25's side. When I went in, I unplugged the cord from the outlet behind the bed, thinking that the outlet was not working and plugged it in across the room. The power was back on, and I called maintenance right away, who told me that it was a short circuit and he had to go to the fuse box to get it working. I didn't notice anything wrong with the electrical cord.

At 2:56PM V49 RN was interviewed again and said, after the second power outage, maintenance came to remove the pump and the air mattress. When I was in the room at that time, I saw there were naked wires on the electrical cord and the mattress was deflated so the CNA and I put R25 to the chair, they came and replaced it and we waited for it to inflate.

On 2/15/23 at 2:14PM V2 Assistant Administrator said, we don't have any monthly resident room inspection results or inspection schedules available to be reviewed.

The facility provided a policy titled "Preventive Maintenance and Inspections" undated, which stated in part; Preventative maintenance is the

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care and servicing by personnel for the purpose of maintaining fixture, equipment and facilities in a satisfactory operating condition by providing for systematic inspection, detection, and correction of incipient failures either before they occur or before they develop into major defects. Maintenance includes tests, measurements, adjustment, and part replacements that are performed specifically to prevent faults from occurring; Each resident room will be inspected and documented monthly.

Facility provided user manual for air mattress and pump (undated) which states in part; Warning- to reduce the risk of burns, electrocution, fire or injury to persons: 5. Never operate this product if it has a damaged cord or plug, If it is not working properly, if it has been dropped or damaged, or dropped into water. Return the product to a service center for examination and repair. 12. Connect this product to a properly grounded outlet only.
Grounding Instructions:
Danger- Improper use of the grounding plug can result in a risk of electric shock. If repair or replacement of the cord or plug is necessary, do not connect the grounding wire to either flat blade terminal. The wire with insulation having an outer surface that is green with or without yellow stripes is the grounding wire. Note- If the repair or replacement of the cord is necessary, please contact a qualified electrician or serviceman. To reduce the risk of electric shock, do not modify the cord or plug in any way. Check with a qualified electrician or serviceman if the grounding instructions are not completely understood, or if in doubt as to whether the product is properly grounded.

United States Department of Labor - (OSHA)

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Occupational Safety and Health Administration webpage discussing Electrical - Hazards / Flexible Cords, reads: "A flexible cord may be damaged by door or window edges, by staples and fastenings, by abrasion from adjacent materials, or simply by aging. If the electrical conductors become exposed, there is a danger of shocks, burns, or fire."

(B)

Three of five findings

300.610a)
300.1210a)
300.1210b)
300.1210d)6)

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.

300.1210 Section General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility,

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S9999	Continued From page 37 with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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-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.	S9999		

Illinois Department of Public Health

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These regulations were not met as evidence by:

Based on interview and record review, the facility failed to follow facility policies and failed to have fall interventions in place per the resident's plan of care by not ensuring that bed rails were in place for resident use to aid in repositioning and they failed to ensure that bed and side table were locked to prevent them from sliding. This failure applied to one (R15) of one resident reviewed for bed rails and resulted in R15 falling out of bed and sustaining a laceration to the right eyebrow and continuing to experience pain related to the injury of the left shoulder since the fall.

Findings include:

R15 is an 85 year old male who was originally admitted to the facility on 10/24/2022 and still resides in the facility.

R15 has multiple diagnoses including but not limited to the following: hemiplegia, CHF, type II DM, prostate cancer, AFib, HTN, depression, abnormalities of gait and mobility, unsteadiness on feet, intestinal obstruction, hyperlipidemia, anxiety, anemia, and GERD.

On 1/30/23 at 12:40 PM, R15 was interviewed regarding the falls he had in the facility. At this time it was observed that two quarter side rails were in place on R15's bed. R15 said he has had two falls while at the facility. R15 said his most recent fall was on 12/28/22, he was reaching for something on his bed side table on the left side of his bed. The bed side table rolled away and he fell off the bed. R15 said, the bed side drawer was open and I hit my head on the side table drawer. I attempted to grab on to something but there was nothing there to grab hold of. R15

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demonstrated how he uses the side rails for bed mobility and to assist with transferring. R15 says since this fall he has had pain in his left shoulder and at this time rates his pain 8/10. At night time, his pain will get as bad as a 9-10 and it prevents him from sleeping. R15 said that on 12/16/22 he had another fall where he slid out of the bed. R15 said he was attempting to reposition himself in bed when the bed slid out from underneath him due to the bed not being locked.

Review of R15's medical record includes Emergency Department Provider Note, which states in part but not limited to the following: Patient endorses head and neck pain following fall. Patient reports headache and lower back pain. Patient states when he hit the floor he had right-sided head bleeding. Review of systems: Skin: abrasion right side of head.

On 2/1/23 at 11:00 AM, V17 (Licensed Practical Nurse) was interviewed regarding R15's fall on 12/28/22. V17 said I was the nurse on duty during R15's fall on 12/28/22. V17 said, I was notified by a staff member that R15 was on the floor. When I went in R15's room he said that he was sitting on the side of his bed, he reached for an item on his bedside table, and the bedside table rolled away. He slid down the bed and hit his head. There was no side rail on the left side of his bed because he had stated that he attempted to grab onto something to stop his fall and there was nothing there.

Side Rail Assessment dated 10/24/2022 states in part but not limited to the following: Benefits of bed rail use: increased bed mobility, increased transfer ability, increased independence for self-care during rehabilitation; Least restrictive rail device that is appropriate for this resident: quarter

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S9999	Continued From page 40 rail; right, quarter rail: left R15's care plan with initiation date of 10/25/2022 states in part but not limited to the following: Focus: I have been assessed to need bedrails: quarter rail-right, quarter rail-left. Goal: I will benefit from side rails and have increased bed mobility, no adverse outcomes, safe transfers, independent turn and reposition. Focus: I am at risk for falls and injury related to falls. Goal: I will have interventions in place and reviewed as needed to address risk for falls and injury related to falls through next review. Interventions: Assist with ADLs as needed. Anticipate and meet the resident's needs. Ensure a safe environment with personal items within reach. Ensure the bed is in lowest position with wheels locked. 2/1/23 at 2:26 PM, V37 (Restorative Nurse) was interviewed regarding R15's fall on 12/28/22. V37 said, I am responsible for completing the side rail assessments. From there, if a resident is appropriate for side rails, I let maintenance know and they install them. Side rails are used to help with positioning, transfers, and to provide stability. At 3:00 PM, V23 (Maintenance Director) was interviewed regarding side rails. V23 said when a side rail needs to be installed on a resident's bed, restorative will notify me. This is typically done by word of mouth. We do not keep any logs or records when a side rail needs to be installed. At 3:10 PM, V34 (Certified Nursing Assistant) said side rails are used to help prevent the residents from falling. Side Rails/Bed Rails policy with revision date of 10/24/2022 states in part but not limited to the	S9999		

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following: Purpose: To ensure the appropriate, safe and correct installation, use, and maintenance of bed rails.

Fall Prevention Program policy with revision date of 11/21/27 states in part but not limited to the following: Purpose: To assure the safety of all residents in the facility, when possible. Fall/safety interventions may include but are not limited to: The bed locks will be checked to assure they are in the locked position at all times. The resident's personal possessions will be maintained within reach when possible. These items include tissues, water, drinking glass, and phone.

(B)

Four of five findings

300.610a)
300.1210a)
300.1210b)3)
300.3240a)

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

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the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

300.1210 Section General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much

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normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations were not met as evidence by:

Based on observation, interview, and record review, the facility failed to follow facility policy and failed to provide timely incontinence care for residents known to require staff assistance with toileting. This failure affected six of six residents (R11, R12, R14, R22, R24, R25) reviewed for incontinence care and resulted in three residents (R12, R14 and R24) developing multiple urinary tract infections while in the facility. The facility also failed to follow professional standards of catheter care by not emptying the bedside urinary catheter bag for a resident, putting them at risk of urine backing up into the bladder. This failure applied to one (R23) of one resident reviewed for catheter care.

Findings include:

1. R11 is a 63 year old male admitted to the facility 12/27/2019 with diagnoses that include Paraplegia, Morbid obesity and Pressure Ulcer Stage III. Review of R11's medical record MDS (Minimum Data Set) dated 2/3/23 indicates that he is cognitively intact and requires extensive two person physical assistance with toileting as he is

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always incontinent of bowel and has an indwelling urinary catheter.

On 01/30/2023 from 11:59 AM - 12:10 PM R11 stated he has to call down to the nurse's station to get staff to respond to the call light. R11 stated he begs the staff to change him.

2. R12 is a 75 year old female admitted to the facility 11/5/2015 with diagnoses that include Arthritis, Morbid obesity, and Urinary Tract Infections. MDS dated 1/16/23 indicates that R11 is cognitively intact and requires one person physical staff assistance with toileting due to urinary and bowel incontinence.

On 01/30/2023 from 11:38 AM - 11:46 AM R12 stated it takes staff hours to answer her call light and there was a couple of times that she wasn't provided with incontinence care timely. R12 stated the excuse staff gives is that they are short of staff.

On 01/30/2023 from 11:34 AM - 11:48 AM R12 stated she rang the call light at 8:15 AM because she had urinated and needed to be changed and urinated again at 10 AM. R12 stated at 11:15 AM she notified V6 (Patient Relations) she needed to be changed because no one had responded to her call light and her bed and adult brief were soaked with urine. R12 stated V6 then sent a CNA (Certified Nursing Assistant) to assist her and the CNA told her she wasn't assigned to her but did provide her with incontinence care.

Medical Record reviewed for R12. Urinalysis collected 12/1/22, resulted with positive culture results on 12/6/22 and indicated Escherichia coli and Proteus mirabilis bacteria present.

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S9999	Continued From page 45 Progress notes dated 12/7/22 written by V31 Nurse Practitioner stated that R12 was diagnosed with a UTI (urinary tract infection) and placed orders for antibiotic Ciprofloxacin 250mg every 12 hours for 3 days. Medication Administration Record dated 12/7/22 indicated that R12 received antibiotic Ciprofloxacin 250mg every 12 hours for 3 days for infection. 3. R14 is a 73 year old woman admitted to the facility with diagnoses which included Chron's Disease, Heart failure, Polyneuropathy and Anxiety Disorder. According to MDS (Minimum Data Set Assessment) dated 1/5/23 indicates that R14 is incontinent of bowel and bladder functioning and requires extensive two person staff assistance with toileting. On 1/30/23 at 1:00PM, R14 was observed in bed, alert and oriented. R14 said, I usually have to wait a long time to be changed. I have Chron's Disease and have diarrhea frequently sometimes and since I can't get up to the toilet I go in my brief. Sometimes the staff gets mad at me because I have diarrhea but I can't help my body. I haven't been changed since this morning and need to be changed now. I keep getting Urinary Tract Infections because I'm sitting in my stool. At 1:20PM V27 CNA came into the room and removed R14's lunch tray. V27 did not provide incontinence care for R14. During observations on the unit, it was noted that R14 had not received any incontinence care between 1:00PM and 2:45PM. At 2:00PM V21 LPN Unit Manager was seen collecting R14's belongings. V21 said, R14 has a urinary tract infection that requires isolation because it is highly transmissible and may be resistant to some antibiotics. We are moving her	S9999		

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S9999	Continued From page 46 room temporarily. She was complaining of symptoms over the weekend and the final results for the culture came back today, positive for E. Coli bacteria with ESBL (extended spectrum of beta lactamase). Urine culture collected 12/6/22 resulted on 12/9/22 and was positive for E. Coli bacteria. Physician orders dated were placed for treatment. On 12/29/22, a follow up culture was obtained via urinary catheter and was negative for bacteria. Urine culture reported 1/28/23 noted that sample was collected on 1/26/23 and was positive for Escherichia coli (E. Coli) bacteria of greater than 100,000 colonies. 4. R22 is an 82 year old female admitted to the facility 10/6/22 with diagnoses that included Dementia, Osteoporosis, and Major Depressive Disorder. According to MDS (Minimum Data Set Assessment) dated 12/19/22 R22 is incontinent of bowel and bladder function and requires extensive staff assistance with toileting and hygiene. On 1/30/23 at 2:33PM, R22 was observed lying in bed, on a low air loss mattress with a strong smell of urine. At 2:43PM, V27 CNA (Certified Nursing Assistant) was observed sitting at the nurse's station on the phone. Surveyor asked to check R22 for incontinence care and at 2:45PM V27 and surveyor went to R22's room. When V27 removed the top covers, R22 was observed in a heavily saturated brief. V27 was observed wiping the front genital area and buttocks and placed a new brief. Surveyor asked V27 the proper way of cleaning female genitals while providing incontinence care and V27 cleaned between the legs and labia, after prompted by surveyor. V27 finished providing care and placed a new brief without changing gloves or performing hand	S9999		

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S9999	Continued From page 47 hygiene. Surveyor noticed large dark yellow rings on the bed pad. V27 said it could be urine but it's not wet. I haven't changed the bed pad today; it was put there by the night shift. I last checked her this morning. Care plan dated 10/7/22, revised 1/8/23 states that R22 has the potential for complications related to incontinence, with a past medical history of UTI (urinary tract infection). Interventions include that the CNA should wash, rinse and dry perineum; change clothing as needed after incontinence episodes. Assist with toileting before and after meals, upon rising in the AM and before bed at night and as needed. On 2/1/23 at 11:10AM V3 DON (Director of Nursing) said, CNA's should document that they provided incontinence care for every occurrence in the Point of Care section of the chart. Delays in receiving incontinence care may lead to poor results in customer service, skin breakdown and poor hygiene. I can tell if an incontinent resident has not been changed for an extended period of time based on a heavily soiled brief or if they told me. R14 has Chron's Disease and should be changed more frequently because she has frequent stools. I would not expect her to have to wait in a soiled brief for over an hour because a delay in changing could contribute to developing UTIs (urinary tract infection). At 12:59PM V31 NP (Nurse Practitioner) said R14 has been treated for several UTIs while in the facility. Poor incontinence care could be the cause of frequent UTIs. I ordered a urinalysis because she complained to me of painful urination. UTIs can occur with residents who are incontinent because stool has E. Coli and can get in to the urinary hole if the resident is sitting for	S9999		

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S9999	Continued From page 48 any time. 5. R24 is a 73 year old woman admitted to the facility 12/30/22 with diagnoses that include, Spinal Stenosis, Morbid obesity, Abnormalities of gait and mobility and Urinary Tract Infection. MDS dated 1/2/23 indicates that R24 has full cognition and requires extensive one person staff assistance with toileting as she is frequently incontinent of bowel and bladder functions. R24's medical record was reviewed. On 1/30/2023, Physicians Order Sheet included an order for urinalysis with a reflex culture. The specimen was collected 1/31/23 and resulted 2/3/2023 and contained E. Coli bacteria. On 2/1/23, an order was placed for antibiotic Ciprofloxacin 250mg by mouth every 12 hours for UTI for 7 days. Care Plan for incontinence initiated 1/2/23 stated R24 had a past medical history of UTI. UTI care plan initiated 2/1/23 included interventions that state "Check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas." 6. R25 is a 58 year old female admitted to the facility 1/20/23 with diagnoses that included Morbid obesity, Pressure Ulcer of left heel Stage 3, Major Depressive Disorder, Hypertension and Anxiety Disorder. According to MDS (Minimum Data Set) dated 1/25/23, R25 requires Extensive physical assistance for toileting and hygiene and is incontinent of bowel and bladder function. On 2/7/23 at 11:45AM R25 said, On Saturday 2/4/23, it was about 1:15PM when I had a bowel movement and called for help. I was waiting for about 30 minutes or so, and then I called down to the front desk using my cell phone to get some assistance. At about 2pm someone came in but	S9999		

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brought the wrong size brief. Shift change is at 3pm. They never came back. Someone on the second shift changed me at 3:50PM.

Facility Policy titled Incontinence Care revised 4/20/21 states in part;
Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity.
Guidelines: Incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. 4. Wash the labia first then groin areas; In the female, separate labia wash with strokes from top downward each side separately with a clean cloth or clean area of the cloth. Keep labia separated with one hand. 9. Change gloves and perform hand hygiene; 10. Apply clean incontinence brief or incontinence pad.

7. R23 is a 70 year old male who was admitted to the facility 9/3/21 with diagnoses that include Spinal Stenosis, Vascular Dementia, and urine retention.

On 1/30/23 at 2:08PM, V25 RN (Registered Nurse) was observed in the hallway outside the room of one resident, R23, with a new urinal in hand and preparing medications. At 2:10PM V25 said, I asked the CNA to empty R23's urinary drainage bag hours ago when I saw it was pretty full. She still hasn't done it and now it is about to burst open. When going into the room with V25, Surveyor noted that the urinary bag was so full that it was tightly expanded, and urine was backed up into the tubing. R23 said, I can feel when the bag is full because it starts pulling and it is uncomfortable. I asked the CNA to empty it earlier because it hasn't been emptied since last shift- about 6AM. I put on my call light, and they

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came in to turn it off and told me they would be back. They came to give me lunch and removed my tray but didn't empty the bag. Surveyor observed urinary bag to have approximately 2500ml of urine. V25 RN was seen filling up the urinal fully, twice, and then a third time. V25 said, I wasn't really paying attention to the amount because I had to empty it three times, as you saw, but I think it was about 2300ml.

At 2:20PM V26 CNA (Certified Nursing Assistant) was observed at the nursing station with a personal bag of food, using a personal cell phone and speaking with coworkers. V26 said I haven't changed R23's urinary bag this shift. I have been in the room several times today. The nurse asked me to empty it earlier but I got busy. I haven't washed him up or cleaned his bed today. I'm about to help with a transfer and then I leave at 3PM.

(B)

Five of five findings:

300.610a)
300.1210b)4)
300.1210d)3)
300.3240a)

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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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.

300.1210 Section 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.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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-week basis:

3) Objective observations of changes in a resident's condition, including

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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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to provide an individualized, resident-centered, plan of care and interventions to address significant weight loss for a resident with a history of weight loss and failure to thrive. This failure affected one (R13) of three residents reviewed for nutrition services and resulted in R13 having an unintended weight loss of over 40 pounds in a period of approximately two months.

Findings include:

R13 is a 53 year old woman who was admitted to the facility on 10/21/22 with diagnoses that include hemiplegia and hemiparesis following cerebral infarction, Adult Failure to Thrive and Vascular Dementia. MDS (Minimum Data Set Assessment) dated 10/26/22 indicated that R13 was cognitively intact and required one person staff supervision with eating.

During her stay, R13 lost a total of 43.4 lbs from the date of admission to discharge which calculates to 26.67% percent weight loss. R12 was transferred to the hospital 12/19/22 for evaluation of failure to thrive.

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On 1/31/23 V51 (Family Member) said, the facility called to inform me that R13 was losing weight, and there was a point where I asked for gastric tube consult because she had one in the past that was effective. Two weeks went by, and she was still losing weight. The next thing they are telling me, is they ordered a palliative care consult that we never discussed. They finally told me they would do the consult and sent her out.

On 2/1/23 at 11:10AM, V3 DON (Director of Nursing) said, I believe R13 was determined to have a diagnosis of failure to thrive due to weight loss and poor eating habits. Nursing staff should have been documenting the amount of food that was eaten with each meal. We followed dietary recommendations and reached out to the family. Unfortunately, since the recommendations were not successful, the team sought hospice or palliative care. The Nurse Practitioner would have made the decision to place a consult for hospice or palliative care. I don't recall if there was ever a GI consultation to place a gastric tube.

On 2/7/23 at 11:40AM V31 Nurse Practitioner said, I was aware of R13's weight loss and was often refusing the foods and shakes (house supplements) due to psych issues. I remember talking to R13 and the family about increasing portions to double during mealtimes. R13 needed encouragement during meals, but the facility doesn't have enough staff to sit there for a 1:1 feed and watch her eat. I think I asked R13 about a gastric tube but I don't know if it is documented. I usually would document that sort of consult. Later R13's daughter asked about a g-tube consult and I placed the order.

On 2/7/23 at 2:24PM V44 Physician said, I was

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S9999	Continued From page 54 aware of R13's significant weight loss and the interventions we placed were not effective. I tried to speak with her, and she was very depressed. Surveyor asked V44 about the rationale for increasing portions and frequency of house supplements when the medical team was aware that R13 was already not accepting prior orders and V44 said that they weren't sure. V44 was asked if a gastric tube consult would have been appropriate after it was determined that R13 lost 20.8 lbs over 28 days (from 10/22/22-11/19/22) and at what point would it have been appropriate to seek higher level of care for R13 when it was documented that the interventions in place for nutrition status were not effective? In response, V44 abruptly ended the interview without answering the last questions asked. R13's medical record was reviewed from 10/21/22 to 12/19/22. Admission progress note 10/21/22 said R13's admitting diagnosis included failure to thrive. Physician Order Sheet dated 10/30/22 included order to give house supplement 3 times daily. October Documentation Survey Report indicates meal intake was not reported 7 times, and R13 ate 17 out of 24 meals reported. Physician Order Sheet dated 11/21/22 added additional nutrition supplements. In November 2022, Documentation Survey Report indicated that meal intake was not reported 26 times and R13 ate 50% or less of 46 out of 73 meals reported. December Medication administration Record indicated that R13 regularly refused all nutritional supplements including house shakes and on 12/12/22, nutritional shakes were increased in frequency from 3 times to 4 times daily. On December 2022 Documentation Survey Report indicated meal intake was not reported for	S9999		

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21 of 54 meals, 19 meals were refused and only 5 meals were reported to have been eaten over 50%.

Weight results from admission to discharge were recorded as follows (in lbs):
10/22/2022 162.8
11/6/2022 162.5
11/17/2022 144.5
11/19/2022 142.0
11/25/2022 137.5
12/8/2022 127.0
12/19/2022 119.4

Facility Policy titled Physician-Family Notification-Change in Condition revised 11/13/18 states in part; The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is: (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment; A need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on the at resident before). (D) A decision to transfer or discharge the resident from the facility.

(B)