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S 000	Initial Comments Annual Certification Complaint Investigations: 22910083/IL154486 2299331/IL153599 2390437/IL155418 2390503/IL155534 2390599/ IL155628 Facility Reported Incident Investigation: Investigation of Facility Reported Incident of December 16, 2022/IL154843 Investigation of Facility Reported Incident of December 5, 2022/IL154827 Investigation of Facility Reported Incident of November 3, 2022/IL153921 Investigation of Facility Reported Incident of October 2, 2022/IL152815 Investigation of Facility Reported Incident of December 19, 2022/IL154845 Investigation of Facility Reported Incident of December 12, 2022/IL154841 Investigation of Facility Reported Incident of October 13, 2022/IL153294 Investigation of Facility Reported Incident of November 28, 2022/IL154828	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a)	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 300.1210a) 300.1210b) 300.1210c) 300.1210d)2),3),6) 300.3210t) 300.3240a) 300.3240b) 300.3240e) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed, and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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.

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

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

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

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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.

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator.

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.

f) A facility that becomes aware of photographing or recording of a resident, without the resident's consent or knowledge, or any other abuse, shall comply with subsections (a) through (e) of this Section.

This REQUIREMENT is not met as evidenced by:

There are multiple deficient practice statements.

I. Based on observation, interview, and record review the facility failed to address and implement

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interventions to stop and/or prevent residents from sexually assaulting and exposing genitalia inappropriately to residents and visitors in the facility and failed to ensure female residents were protected from these behaviors. The facility failed to adequately supervise/monitor and implement effective interventions for R33.This failure resulted in R33 inappropriately touching female visitors (V43, V44 and V45) and exposing himself to other residents (R2, R113) in common areas with the potential to touch or harm other female residents within the facility. This affected 6 residents (R2, R113, R51, R98, R171 and R173).

Findings include:
A. R33's medical record notes R33 with diagnoses including paranoid schizophrenia, bipolar disorder, and major depressive disorder.

R33 progress notes dated 7/28/22 documents: Writer witnessed resident displaying inappropriate behaviors, including exposing himself while in the central area in front of peers. Staff immediately redirected his behavior.
R33 involuntary petition dated 8/23/22 documents: Resident is increasing agitated and socially inappropriate. He is slamming items in the facility to the floor, he is exposing himself to staff.
R33's aggressive behavior assessment dated 11/10/22 documents resident has history of abuse/neglect either as a recipient or perpetrator including abusive and/or inappropriate sexual behavior: moderate problem.
R33 progress notes dated 12/17/2022 at 13:02: Resident noted to be increasingly socially inappropriate. Res noted to be walking down the hall attempting to touch female staff and female residents on their breasts and behinds. Writer

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counseled resident on keeping hands to himself. Male MHT staff also redirecting resident. Staff will continue to monitor and redirect to ensure staff and resident safety.

R33's MDS (minimum data set), dated 12/14/22, notes section E for behavior shows R33 has hallucinations, delusions, verbal symptoms directed towards others (threating others, screaming at others) that occurred 1 to 3 days, other behavior symptoms not directed towards others (physical symptoms such as hitting or scratches self, pacing rummaging, public sexual act, disrobing in public, throwing or smearing food or bodily waste or verbal/ vocal symptoms like screaming, disruptive sounds) behavior of this occurred 1 to 3 days. R33 has behaviors of wandering, behavior of this occurred 1 to 3 days. Section E1100 shows R33 current behavior status in comparison to prior assessment is the same.

Review of R33's behaviors care plan, initiated 2/7/22, notes R33 exhibits sexually inappropriate behavior towards staff and co-peers. This care plan was last updated on 5/20/22. It has a target date 3/20/2023 denotes I (R33) exhibit sexually inappropriate behavior toward staff & co-peers. These behavioral symptoms are manifested by making crude, sexually orientated, profane, or suggestive remarks, and co-peers displaying sexually inappropriate behaviors. On 6/26/19- I was verbally displaying sexually inappropriate behavior towards female peer. On 8/13/19- I was displaying sexually inappropriate toward staff (nurse practitioner). On 2/6/2020: I allegedly displayed sexually inappropriate behavior toward female co-peer. On 9/30/21: I touched a female staff on the behind. On 10/30/21: I touched two female staff inappropriately on the behind and

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breast. On 12/1/21 and 2/16/22: I touched a female staff on the behind. On 12/7/2021: I attempted to grab a female staff's chest inappropriately. On 5/20/22: I touched a female staff on her behind. I will accept redirection, behave in a safe and respectful manner, and refrain from displaying sexually inappropriate behave. I will refrain from making sexually inappropriate remarks and displaying sexually inappropriate behavior through next review. Administer PRN medication as ordered. Implement limit setting with me. Specify appropriate versus inappropriate behavior. If I attempt to touch inappropriately place your hand over mine and gently (but firmly) push it down and away, clarifying it is not appropriate. R33 redirected to maintain appropriate boundaries w/ staff and peers - 5/13/22. R33 will be placed on 1:1 monitoring. Staff will intervene and redirect me when sexually inappropriate behavior is observed - 2/16/22. I (R33) have a behavior problem touching others inappropriately, as evidenced by it has been reported by staff that resident has tried and/or touched their butt or chest area. 8/17/2021: I inappropriately grabbed activity staff on her buttocks. I will display minimal episodes of touching others inappropriate behaviors related to grabbing at staff's chest or behind through next review date. Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet the resident's needs. Assist the resident to develop more appropriate methods of coping and interacting with others. Encourage the resident to express feelings appropriately. Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. If reasonable, discuss R33's behavior. Explain/reinforce why behavior is inappropriate

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S9999	Continued From page 7 and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Maintain an appropriate distance from resident when interacting. Per PAS/MH Level II Notice of Determination, I (R33) may be able to benefit from: medication monitoring/ management; - ADL (activities of daily living) training/reinforcement; - mental health rehabilitation; illness self-management; - incentive program to improve participation in treatment and community re-integration activities. I will meet with my PRSC as needed to address symptom management issues as well as negative behaviors through next review date. Encourage group attendance, encourage resident to participate in mental health treatment. PRN one on one sessions with PRSC to address behaviors and symptom management. On 1/8/23 around 9:45am, R33 was observed in the common hallway near the central nursing office approach V43 (surveyor) from behind and touch her breast. V7 MHT (Mental Health Tech/MHT) and other residents were present. V7 re-directed R33 away and into an area between the dining room and hallway. On 1/8/23 around 10:00 am, V44 (surveyor) was walking through the central station area after leaving the dining room. R33 was observed approaching V44 from the opposite direction and touch her right breast. Staff's back was turned while this happened. About 15 minutes later, V44 was speaking with R2 and R113 in the hall when R33 came up and pulled his penis out. V44 attempted to redirect R33 back to his room but	S9999		

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was unsuccessful. R33 then began making inappropriate comments and abruptly walked away. No staff witnessed these incidents.
On 1/8/23 10:30 am, V45(surveyor) said R169 stopped V45 in the hallway. V45 her back against wall. R33 approached V45, leaned forward, and touched V45's left breast and then walked away. R33 returned a few minutes later and attempted to touch V45 again. On 1/8/23 at lunchtime, R33 pulled penis out at the central monitoring station area, in front of mental health techs, residents, and V43.

On 1/8/23 at 2:58pm, R113 was interviewed about the incident with R33 that occurred on 01/08/23. R113 stated. "He took out his private parts while we were standing here talking. He will show it to people for no reason. When I see him in the halls, he is always bothering people. I would say he pulls out his penis about once or twice a week that I see. He shows it to all different people. Sometimes staff is there and see him do it. They will just tell him to put it away. Sometimes he listens and other times they have to give him a shot because he won't calm down. They don't do much more than that. I do see him touching people. I don't really see how many times he does that, but he grabs at girls' breasts and their butts. He does it to staff and other residents."

On 1/8/23 at 10:20am, R33 was observed walking past V45 (surveyor) and touch her right buttocks. At 10:30am, V45 was speaking with R169 in the hallway. R33 was observed approaching V45, leaning forward, and touching her left breast. R33 then abruptly walked away. A few minutes later, R33 approached V45 and attempted to touch her lower abdomen. There were no staff present during these incidents.

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On 1/9/23 around 10:15am, V44 was observed in the dining room speaking with a resident. R33 was observed approaching female visitor touching her buttocks and making inappropriate comments. V44 re-directed R33 not to touch her. R33 quickly walked away.

On 1/9/23 12:34pm, V7 (MHT) stated V7 heard the residents say R33 just touched a female visitor. R33 walked and sat down. V7 asked R33 if he touched the visitor, R33 just said "Hee, Hee". V7 told R33 about personal space and he sat in central area for about 5 minutes and then left. According to V7 there were only two mental health techs working day shift for 174 residents. V7 texted V13 (mental health supervisor) at 12:13pm about the incident with R33 and the visitor. V7 stated that V13 telephoned V7 and acknowledged that he received her text message.

Additional interviews were conducted regarding R33's behavior and planned intervention for recognized behaviors as follows: On 1/9/23 at 2:00pm, V9 (Psychiatric Rehabilitation Services Coordinator/PRSC) stated that at this time, there is no facilitator for group therapy programs. V9 reported, the PRSC staff are doing 1:1 session with each resident. V9 stated, social services discuss with the resident the behaviors identified in group therapy. V9 stated, there is no PRSD (psychiatric rehabilitation services director).

On 1/10/23 at 9:00am, V1 (Administrator) stated that the group facilitator and PRSCs should be doing 1:1 session with every resident. V1 stated that the group facilitator resigned in early December. V1 stated that the last day for group programs was on 12/9/22. V1 stated 1:1 session

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with residents should be weekly same as the frequency group meetings were held. V1 stated that V1 can't recollect if he told staff right away to start doing 1:1 session with residents after the group facilitator resigned. V1 stated 1:1 session is documented in the resident's progress notes.

On 1/10/23 at 9:55am, V9 (PRSC/psychiatric rehabilitation services coordinator) stated that R33 exhibits sexually inappropriate behaviors, R33 touches the buttocks and breasts of female staff. V9 stated that R33 was on V28's (former PRSD) caseload until she resigned in early December 2022. At 3:00pm, V9's documentation on 12/17/2022 of R33's behavior was reviewed with V9. V9 stated that V9 does not recall which staff or residents R33 touched. V9 stated that if she documented it, then it happened. V9 stated that V9 does not recall reporting this incident to any staff other than the MHT staff. V9 stated that R33 does not exhibit sexually inappropriate behaviors daily, possibly weekly. V9 stated that right before V9 came to speak with this surveyor, R33 attempted to touch her inappropriately. V9 stated that staff are expected to report all behaviors to the PRSCs.

On 1/10/23 at 10:30am, V15 (PRSC) stated that V15 has been covering R33 since PRSD left in December, about 2-3 weeks. V15 stated that R33 is receiving 1:1 session. V15 stated that R33 is not receiving any group therapy programs. V15 stated that she is not aware of R33 exhibiting any behaviors since R33 was re-admitted to facility in December 2022 when R33 was hospitalized for aggressive behaviors.

On 1/10/23 at 2:40pm, V13 (Mental Health Supervisor) stated that V7 (MHT) notified V13 of

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an incident of inappropriate behaviors with a female, possibly CNA (Certified Nurse Assistant). When questioned if V13 reported this incident to V1 (Administrator), V13 responded "No". V13 stated "I guess I should have reported it to V1". When questioned if V13 reported it to V1 on 1/9/23, V13 responded 'V13 did not work yesterday. When questioned if he notified V1 today, V13 stated that he thought it resolved on own.

On 1/10/23 at 2:58pm R113 was interviewed about the incident with R33 that occurred on 01/08/23. R113 stated. "He took out his private parts while we were standing here talking. He will show it to people for no reason. When I see him in the halls, he is always bothering people. I would say he pulls out his penis about once or twice a week that I see. He shows it to all different people. Sometimes staff is there and see him do it. They will just tell him to put it away. Sometimes he listens and other times they must give him a shot because he won't calm down. They don't do much more than that. I do see him touching people. I don't really see how many times he does that, but he grabs at girls' breasts and their butts. He does it to staff and other residents." On 1/13/23 at 11:14AM, R113 who was alert and oriented at time of interview said it made her feel bad and not safe at that time because she knew it was wrong.

On 1/12/23 at 3:19PM, V28 (former PRSD) said R33 has history of sexual inappropriate actions towards staff. V28 said she never received report about inappropriate behaviors towards resident. We educated staff on what to do if R33 became inappropriate with them. Interdisciplinary team was aware of his behaviors. Unable to recall any further staff names that were affected.

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On 1/13/23 at 10:15am, V7 (MHT) stated that R33 exhibits sexually inappropriate behaviors daily. V7 stated that all staff are aware of R33's inappropriate behaviors. V7 stated that R33 frequently pulls his pants down in front of staff/residents or pulls penis out. V7 stated on 1/8/23, R33 was calm and walking at a normal pace. V7 stated that the behaviors R33 was exhibiting were level one behaviors. V7 stated that R33 does not get sent out to the psychiatric hospital until he is exhibiting behaviors at a level 5, such as running through hallway, cursing staff and other residents, and destroying property.

On 1/13/23 at 11:25am, V9 stated that the PRSCs talk to residents 1:1 as needed, not once a week. V9 stated that the expectation is for the PRSC to document in the resident's care plan and progress notes. V9 stated that the PRSCs should be documenting every 1:1 session with a resident in his/her progress notes. V9 acknowledged that these 1:1 session should be occurring routinely, not after the resident exhibits inappropriate behaviors. V9 acknowledged that if it isn't charted, it didn't happen.

On 1/17/23 at 10:20am, V46 (Psychiatric Doctor) stated that R33 should have been placed on 1:1 supervision after the first incident on 1/8/23, to prevent the second and the third incidents of inappropriate touching. A behavior contract should have been created. V46 stated that V46 was not informed about R33 touching the staff the first time. V46 stated that V46 would have sent R33 to the nearest hospital at that time.

R33's medical record documented the following regarding R33's negative behaviors R33's Social Service Progress Review dated 7/28/22 by V28

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(former PRSD /psychiatric rehabilitation services director) noted: V28 witnessed R33 displaying inappropriate behaviors, including exposing himself while in the central area in front of peers. Staff immediately re-directed R33's behavior.
Progress note dated 8/23/22 by V2 (DON /director of nursing) noted: R33 is increasingly agitated and socially inappropriate. R33 is slamming items in the facility to the floor, R33 is exposing himself to staff, and threw water pitcher at floor nurse, and is not receptive to re-direction, an as needed medication administered and ineffective.
R33's petition for involuntary admission, dated 8/23/2022, notes R33 increasingly agitated and socially inappropriate. R33 was slamming items on the floor and exposing self to staff. R33 is not receptive to re-direction. These behaviors were witnessed by V2 DON and V13 (mental health supervisor).
R33's hospital admission record, dated 8/23/22-8/30/2022, notes R33 to continue the following therapies: assertive community treatment, cognitive behavior therapy (therapy to help change certain behaviors), illness-management skills, and social skills training.
R33's medical record, dated 7/28/22 - 1/10/2023, does not note R33 was receiving group therapy or 1:1 session with PRSCs. R33's medical record, dated 11/14/22 and 11/30/22, R33 was sent to the hospital each time for exhibiting verbal and physical aggression.

R33's medical record, dated 12/17/22, notes V9 noted: R33 noted to be increasingly socially inappropriate. R33 noted to be walking down the hall attempting to touch female staff and female residents on their breasts and behinds. V9 counseled R33 on keeping hands to himself.

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Male MHT (mental health tech) staff also redirecting R33. Staff will continue to monitor and redirect to ensure staff and resident safety.

Facility census dated 1/12/23 documents: 59 female residents. Facility census dated 1/8/23 documents 171 residents.
Facility abuse prevention and reporting policy revised 4/2022 documents: The resident has the right to be free form abuse, neglect, misappropriation of resident property and exploitation. Sexual abuse is nonconsensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to unwanted intimate touching of any kind especially breast and perineal area: all types of sexual assault battery such as rape, sodomy, and coerced nudity; forced observation of masturbation and/or pornography.

B. R51 was admitted to the facility on 3/18/21 with a diagnosis of major depressive disorder, schizoaffective disorder, panic disorder and borderline personality disorder. R51's minimum data set dated 12/14/22 documents a brief interview for mental status score 15/15 which indicates cognately intact.
On 1/13/23 at 1205PM, R51 who was alert and oriented at time of said she does not feel safe in the facility due to R25 behaviors. R51 said about 3 weeks ago R25 licked her chest and she hit him. R51 said she told an activity aide.
On 1/13/23 1:31pm, V1 (Administrator) denied any knowledge of incidents for R51.
On 1/13/23 at 4:12PM, V24 (Mental Health Tech/MHT) said he saw R51 and R25 in the hallway. R51 reported that R25 licked her chest. V24 said he told V19(MHT Supervisor).
Facility abuse reportable dated 1/13/23 documents under staff interviews: V24 (Mental

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S9999	Continued From page 15 health tech, MHT) "I saw it happened. R51 was fully clothed during the incident. I corrected R25 action and redirected him." C. R128 was admitted to the facility on 3/21/22 with a diagnosis major depressive disorder and psychotic disorder. R128's minimum data set dated 11/21/22 documents a brief interview for mental status score 15/15 which indicates cognately intact. On 1/13/23 at 12:05 pm, R128 who was alert and oriented at time of interview said one month ago, R25 grabbed her butt, and it happened 3 months prior as well while waiting in line for smoking. R128 said she was unclear if she reported second inappropriate touch but the first time, she thinks she reported the incident to V1 (Administrator). R128 said she does not feel safe in the facility due to R25 behaviors. On 1/13/23 1:31pm, V1 (Administrator) denied any knowledge of incidents for R128. D. R98 was admitted to the facility on 5/2/22 with a diagnosis of schizoaffective disorder, alcohol abuse, major depressive disorder, homicidal ideations, and psychosis. R98's Minimum Data Set dated 10/18/22 documents a brief interview for mental status score 15/15 which indicates cognately intact. On 1/19/23 at 1:50 pm, R98 who was alert and oriented at time of interview said R25 grabbed her butt 2 times while waiting in line for smoking. R98 said she threatened R25 and was sent to the hospital. R98's hospital record dated 1/11/23 documents under chief complaint: Patient stated, " I threatened to cut a man's d*** off because he smacked me on my a**." E. R171 admitted to the facility on 12/16/22 with	S9999		

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S9999	Continued From page 16 a diagnosis of schizoaffective disorder and conduct disorders. R171's Minimum Data Set dated 12/23/22 documents a brief interview for mental status score 14/15 which indicates cognitively intact. On 1/18/2023 at 2:57 pm, R171 who was alert and oriented at time of interview stated that 3 days ago, R74 entered R171's room without permission. R171 stated that R171 was lying in bed after breakfast. R171 stated that R74 approached R171 and started pulling down R171's pants to perform oral sex. R171 stated that R171 grabbed R171's pants to prevent R74 from R74 removing pants any further and yelled. R171 stated that R171 informed R74 to stop and pushed R74's head away. R171 stated that R74 then pulled R74's pants down and attempted to get in bed with R171. R171 stated that again R171 pushed R74 away. R74 pulled pants up and exited R171's room. R171 stated that R171 felt like he was being molested. R171 stated that during smoke break in the evening, R171 reported incident to V59 (activity aide). On 1/18/23 at 3:40pm, R171 identified R74 at smoke break as the resident who pulled R171's pants down. On 1/19/23 at 2:16pm, R171 reported the same story. On 1/18/2023 at 3:19pm, R173 who was alert and oriented at time of interview, stated that 3 days ago R173 was talking with R171 in their room when R74 came into R173's room without permission and asked R173 if R173 wanted to have sex. R173 stated that R173 declined and told R74 to leave. R173 stated that R173 witnessed R74 go to R171 and began pulling R171's pants down to try to have sex with R171. R173 said he heard R171 say no and then R74 left the room. R173 stated that R173 did not report the incident.	S9999		

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On 1/18/23 at 3:54 pm, V59 (Activity aide) said R171 reported to her during smoke break that R74 was going into R171's room and trying to pull his pants down. V59 does not recall which Mental Health Tech she spoke with.
On 1/19/23 at 11:25 am V29 (PRSC/Psychiatric Rehabilitation Services Coordinator) said that R74 said R74 had sex with R171 but could not provide date of incident. V29 stated that a capacity for sexual consent was completed yesterday. V29 stated that it has not been determined if R74 understands no means no because of R74's intellectual disability. V29 stated that R171 informed V29 that this incident was not consensual and R171 would not like this behavior to happen again to him. V29 stated that R74 went into R171's room and pulled R171's pants down and then pulled his own pants down.

II. Based on interview and record review, the facility failed to implement appropriate crisis prevention intervention techniques during a behavioral episode for one resident (R57). This failure resulted in R57 sustaining a left wrist fracture.

Findings include:

R57 was admitted to the facility on 9/21/22 with a diagnosis of paranoid schizophrenia, anxiety, and major depressive disorder.
R57's progress notes dated 11/11/22 at 6:31 pm documents: Writer notified by Mental Health Tech that resident was responding to internal stimuli and not able to be redirected. Resident unable to give description. Resident given prescribed medication. After medication was administered, resident charged at Mental Health Tech and staff-initiated Crisis prevention intervention (CPI).

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R57's progress notes dated 11/11/22 at 8:55 pm documents: Mental Health Tech informed writer resident left lower arm wrist area was swollen. Writer assessed area noted left lower arm /wrist area swollen, displaced, and discolored.
R57's hospital record dated 11/12/22 documents: left wrist distal radius fracture. severely displaced, comminuted distal radial fracture wit radial and palmar displacement.
On 1/10/23 at 10:30 am, V1 (Administrator) said V48(Mental Health Tech) was terminated due to improper Crisis Prevention intervention by placing his hands on the resident which resulted in a fall and fracture.
V48's employee file notice of corrective action dated 11/14/22 documents: Violation of company policy. After extensive investigation, it has been determined that associate used improper CPI on a resident. Associate was seen via camera footage lunging at resident and grabbing the resident's wrist, pushing her backwards, causing resident to fall. Residents left wrist was broken.

Facility abuse prevention and reporting policy revised 12/17/21 documents: Abuse means any physical assault inflicted upon another resident other than by accidental means.

III. Based on interview and record review the facility failed to prevent incidents of resident-to-resident physical assault. These failures affected 6 (R119, R29, R56, R60, R96, and R167) residents reviewed for physical abuse in the sample of 35. This failure resulted int R56 being assaulted and sustaining an abrasion to the chin area and a laceration to the left side of her head requiring 21 staples to the occipital area and treated for occipital condyle fracture.

Findings include:

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A. R56's diagnosis including, but not limited to Parkinson's Disease, Bipolar Disorder, Anxiety, Alzheimer's Disease, Dementia, Schizoaffective Disorder, and Dementia.
R56's Abuse/Neglect Screening dated 9/6/22 notes a score of 4= Moderate. Presents with a moderate level for abuse and neglect.
Progress Notes dated 1/6/23 notes R56 verbalized to writer that she was hit in the head from the back by peer, noted with slight blood at the side of her head. Noted with laceration in the scalp. First aid rendered and 911 called.
Progress Notes dated 1/8/23 notes R56 back from hospital with 21 staples in the head and neck brace because of fracture of the neck.

R119's diagnosis including, but not limited to Psychotic Disorder and Schizophrenia.
R119's Aggressive Behavior Assessment dated 6/20/22 documents she was involved in a physical altercation with a male peer and admitted to being the initial aggressor.

R119's care plan initiated on 11/14/18 documents she has the potential to be physically aggressive related to a diagnosis of psychosis. Documented behaviors directed towards other residents include scratching, pushing, physical altercations and aggression.
Progress Notes for R119 dated 12/28/22 documents R119 is reported to be aggressively throwing punches when no one is there and talking to self.

On 1/8/23 the surveyor observed R56 during initial observation made between 10:30-11:00 am. R56 was lying in bed, flat on her back, and wearing a neck brace. R56 was in an isolation

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S9999	Continued From page 20 room. Staff sitting, V23 (Certified Nurse Assistant/CNA) outside her room said she has COVID. The surveyor asked V23 what happened to R56. V23 replied I don't know what happened to her, it was last night. Surveyor did not enter the room to finish screening all other residents and then returned to kitchen for observations. Upon return to the unit 2:00 pm R56 was no longer in the facility. On 1/9/23 at 12:00 V6 (Registered Nurse) said she was on break in the Central Nurses' stations and R56 walked in and said R119 hit me from the back and she mad, she hit me. V6 said R56 said I don't know with what. V6 said R56 was alert. V6 said R119 won't speak to say why she hit R56. V6 said R119 was hallucinating, and I sent her out immediately. V6 said I saw the laceration on R56, and I called 911. V6 said I saw the laceration on the top of R56's head. V6 said R119 and R56 was walking in the hallway. V6 said R119 is no one's friend. V6 said this happened in the evening. V6 said I asked the CNAs about the incident, and they said they didn't see anything. V6 said R56's behavior does not include fighting; she has occasional anxiety. V6 said R119 always talks to herself, hallucinates, and when the psych doctor comes in, I tell them to evaluate R119. She talks like she is in conversations with 10 people. She was compliant with her medication. V6 said whatever they have done, "it was not effective." V6 said R119 had been yelling and hollering all the time andverbally aggressive. V6 said when she spoke to Psych doctors about the behavior, they said that was her baseline. V6 said "I told them she was not a baseline." V6 said I don't know what R119 used to hit R56 with. V6 said the incident happened in the back hallway.	S9999		

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On 1/9/23 at 12:24 pm V20 (Licensed Practical Nurse) said R119 and R56 are not physically aggressive, I never seen her hit anyone.

On 1/9/23 at 2:01 pm V9 (Social Services) said I am not aware of the situation with R56 and R119. V9 said she was not notified to perform an assessment or implement new intervention for R56 or R119.

On 1/10/23 at 9:57 pm V22 (CNA), said R119 is pleasant, calm, does not cause any problems, quiet, and she does not bother anyone.

On 1/10/23 at 2:06 pm V23 (CNA) said on 1/8/23 she sat outside of R56's room to monitor her. V23 said before the incident R56 used to walk around.

On 1/11/23 V35 (Doctor) was asked by the surveyor if he expects his patients to be safe in the facility? V35 responded "Yeah, absolutely." V35 said I would want my residents to be safe in the facility.

B. R60's diagnosis including, but not limited to Paranoid Schizophrenia, Unspecified Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety.
Abuse investigation form documents on 10/13/22 R60 has history of poor boundaries and impaired thought process. R29 has history of poor boundaries and physical aggression. It is documented that R60 and R29 were served at lunch and sat at the same table. R60 attempted to grab food off R29's tray. [This is different than V22's interview with surveyor.] R29 displayed poor boundaries and impulse control by striking R60. Nursing staff attempted to apply first aid to R60's superficial cut on lip, but R60 refused

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treatment.

R60's care plan initiated on 4/21/20 documents R60 displays poor boundaries. Care plan initiated on 9/20/16 notes R60 has a behavior problem, poor insight regarding mental illness, noncompliance with medications related to diagnosis of Schizophrenia. Care plan initiated on 11/10/16 documents R60 has impaired cognitive function/dementia or impaired thought process as evidenced by disorientation, recall deficit, disorganized thoughts.

R29's diagnosis including, but not limited to unspecified Psychosis, Schizoaffective Disorder, Bipolar Type, and Restlessness and Agitation. R29's PAS/MH Level II Notice of Determination dated 10/5/18 identified R29's findings to benefit from aggression/anger management

R29's care plan dated 10/13/22 documents I have the potential to be physically aggressive towards others related to Anger and poor impulse control.

R29's Aggressive Behavior Assessment dated 10/13/22 notes R29 was involved in a physical altercation with a female peer and admitted to being the aggressor after she snatched food items off his breakfast tray.

On 1/9/23 at 12:00 pm V6 (Registered Nurse) said I didn't see the incident with R29 and R60. V6 said R29 does not get along with others. He does not have friends. He just talks to himself. V6 said R29 still eats in the dining room.

On 1/10/23 at 9:57 am V22 (Certified Nursing Assistant) said on 10/13/22 R60 grabbed R29's food tray. V22 said R60 and R29 were sitting at separate tables. V22 said R60 grabbed R29's

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food in front of him. V22 said R60 took the food off the tray, R29 got up and hit R60 and then R60 sat back down. V22 said R29 quickly fisted R60 and made direct contact with her lip. V22 said I was sitting at back table in the dining room. V22 said I saw R60 grab the food. V22 said I did not get up the Mental Health Tech was walking towards R29 and R60.

On 1/11/23 at 10:31AM V2 (Director of Nursing) said residents should not be hitting other residents. V2 said that is considered abuse. V2 said the residents should absolutely be safe in the facility.

C. R96's diagnosis including, but not limited to Epilepsy, Schizophrenia, Depressive Disorder, Anxiety Disorder, Insomnia, and Tremor.

R167's diagnosis including, but not limited to Schizoaffective Disorder, Bipolar Type, Vitamin D Deficiency, Cannabis Dependence, Nicotine Dependence, Delusional Disorder.
R167's care plan initiated on 9/20/22 notes he has the potential to be aggressive. On 11/8/22 R167 was in a physical altercation with a peer due to hallucinations.

R167's Aggressive Behavior Assessment dated 11/8/22 notes R167 has a history of aggressive/agitated behavior or noncompliance with medications, treatment, regimen, or resisting care. R167 was involved in a physical altercation with a peer as he admitted to being the aggressor. Due to his hallucinations, he mistakes peer saying something disrespectful to him, resulting in physical aggression.
Progress note dated 12/12/22 notes a peer(R167) entered R96's room and became physically

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aggressive towards R96.

Incident report dated 12/12/22 documents physical abuse allegation. Summary of interview witness documents V19 said he observed R167 becoming physically aggressive towards R96. R167's statement was R96 was peeing on my bed. R96's statement was I didn't do anything. Investigation Findings states R167 has a history of physical Aggression, hallucinations, and confabulations. R167 was having hallucinations at the time of the incident believing R96 had urinated in R167's room. R167 approached R96 and struck him.

On 1/9/23 at 1:17 pm V15 (PRSC) said she followed up with R167 following the incident with R96. V15 said I was not in the facility the day of the incident. V15 said when she spoke with R167 he would not give me more information. V15 said I spoke with R167 about better ways to cope with his anger. V15 said I think R167 has a history of behaviors, he has shown aggression in the past. V15 said R167 can be aggressive with staff and residents, he was yelling at me the other day.

On 1/9/23 at 2:01 pm V9 (Social Services) said R167 was hallucinating and thought that R96 had gone into his room and peed on the towels. V9 said R167 is known to be delusional. V9 said R167 was the on schedule for anger management group. V9 said the goal of programs is to maintain safety.

On 1/10/23 at 1:22 V19, (Mental Health Tech Supervisor/MHT) said on 12/12/22 R167 struck R96. V19 said I did not see R167 hit R96. V19 said I went into the resident room to break it up. V19 said R167 said it was because R96 peed on his stuff. V19 said R96 had not been up that

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night shift, he was in his room, in his bed. V19 said "I believe he (R167) just wanted to get him (R96)." V19 said he checked both resident's rooms and didn't see anything wet with urine.

On 1/11/23 at 10:31 am V2 (Director of Nursing) said resident should not be hitting other residents. V2 said that is considered abuse. V2 said the residents should absolutely be safe in the facility.

The facility policy titled Abuse Prevention and Reporting revised 4/29/22 states as follows: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

IV. Based on interview and record review the facility failed to prevent a resident-to-resident sexual assault. This failure affected 4 (R39, R74, R171, and R427) residents reviewed for sexual assault. This failure resulted in R39 being sexually attacked by R427 and R74 to pull R171's pants down and attempt to provide R74 with oral sex.

Findings Include:

A. Police report dated 11/3/22 documents: while in R39's room, R427 used forced to push R39 backwards onto her bed. While lying on her back R427 laid his body on top of R39. R427 place his hand on R39's mouth, place his other hand inside the front of R39's pants and touched R39's vagina, after R427 removed his hand from R39's pants, he sniffed his hand.

Progress noted dated 11/3/22 documents: At around 1:30am a call was received from the police department stating that R39 called them

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and alleged that a male client (R427) attempted to sexually assault her. R39 stated that (R427) attempted to fondle her and hold her down against her will. R39 was noted with a small superficial scratch under the right nostril. Resident (R427) was being sexually inappropriate with female peer.
R427's hospital paperwork dated 11/4/22 documents: R427stated, "I am just compelled to touch women." Diagnosis: sexually aggression and physical aggression.
R39's brief interview for mental status dated 12/8/22 with a score of 14 which indicated cognitively intact. Care plan 4/15/22 documents: I (R39) am at potential risk for abuse/neglect. Abuse and neglect screening dated 10/5/22 documents: Resident (R39) triggers as potential high risk for abuse related to mental illness and history of poor and dysfunctional behaviors.

On 1/11/23 at 10:59am, V29 (PRSC) said, R427 pushed R39 down on the bed and reached under R39's skirt to touch R39's vaginal area/perineal area. R427 tried to sexually assault R39.

On 1/11/23 at 11:07am, V9 (PRSC) said, R39 reported R427 entered her room and was sexually inappropriate. R427 pushed R39 down on the bed and tried to penetrate R39.

On 1/12/23 at 1:36pm, V37 (Nurse) said R427 helped R39 into her room. Both residents were sitting on R39's bed. R427 attempted to pin R39 down by the shoulders. R427 touched R39's breast and vaginal area through R39's clothes.

On 1/12/23 at 3:29pm, V28 (former PRSD) said R427 attempted to sexually assault R39.

On 1/20/23 at 2:24pm, R39 who was assessed to

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be alert to person, place and time said, R427 pushed me on my bed by my shoulders, covered my mouth, I couldn't scream out. R427 held me down with his chest. R427 pulled his pants down, I saw his penis. R427 squeezed my breast and my nipples hard. R427 put his hand down to reach my vaginal area but my stomach was in the way. I felt violated.

Abuse Policy revised 4/29/22 documents: The resident has the right to be free abuse. Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to unwanted intimated touching of any kind especially of breasts or perineal area. Generally, sexual contact is non-consensual if the resident does not want the contact to occur.

B. On 1/18/2023 at 2:57 pm, R171 who was alert and oriented at time of interview stated that 3 days ago, R74 entered R171's room without permission. R171 stated that R171 was lying in bed after breakfast. R171 stated that R74 approached R171 and started pulling down R171's pants to perform oral sex. R171 stated that R171 grabbed R171's pants to prevent R74 from R74 removing pants any further and yelled. R171 stated that R171 informed R74 to stop and pushed R74's head away. R171 stated that R74 then pulled R74's pants down and attempted to get in bed with R171. R171 stated that again R171 pushed R74 away. R74 pulled pants up and exited R171's room. R171 stated that R171 felt like he was being molested. R171 stated that during smoke break in the evening, R171 reported incident to V59 (Activity Aide).

On 1/18/2023 at 3:19 pm, R173 who was alert and oriented at time of interview, stated that 3 days ago R173 was talking with R171 in their

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room when R74 came into R173's room without permission and asked R173 if R173 wanted to have sex. R173 stated that R173 declined and told R74 to leave. R173 stated that R173 witnessed R74 go to R171 and began pulling R171's pants down to try to have sex with R171. R173 said he heard R171 say no and then R74 left the room. R173 stated that R173 did not report the incident.

On 1/18/23 at 3:40 pm, R171 identified R74 at smoke break as the resident who pulled R171's pants down.

On 1/18/23 at 3:54 pm, V59 (Activity Aide) stated that during smoke break on Sunday, R171 informed V59 of incident involving R74. V59 stated that she reported this incident to MHT staff member. V59 does not recall which Mental Health Tech she spoke with.

On 1/19/2023 at 11:25 am, V29 (PRSC/Psychiatric Rehabilitation Services Coordinator) stated that R74 was assigned to V29's caseload upon his admission. V29 stated that R74 was admitted to this facility because of his mental illness, R74's family was unable to provide care for R74, and R74 is delusional. When questioned if V29 reviewed R74's pre-admission hospital record, V29 responded "I reviewed everything I needed to review". V29 stated that R74's hospital record notes R74 has an abusive history in which R74 is the abuser. V29 stated that there are no group therapy programs offered. V29 stated that V29 meets with R74 for 1:1 session to discuss ADLs (activities of daily living), dressing appropriately for the weather, getting help with what R74 wants to do with his life, and aggression issues. V29 stated that V29 documents these sessions in

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R74's progress notes. V29 stated that V29 tries to have 1:1 session with R74 once a week or once every two weeks. V29 stated that V29 has 39 residents on his caseload. When questioned if V29 feels he is meeting the needs of R74, V29 responded absolutely. V29 was unable to provide specific dates, times, details of these 1:1 session, or documentation to support V29 has provided any mental health services/support to meet the needs of R74.

Review of R74's pre-admission hospital record, dated 7/21/22-11/10/22, notes R74 is dually diagnosed, but has not received services that take into account R74's intellectual disability for most of R74's adult life. R74's trauma history notes R74 was the victim of sexual abuse as a child. R74 has poor to no insight, impulsive, intellectually disabled and has limited social skills and coping skills.
There is no documentation found in R74's hospital record noting R74 has a history of being abusive to others.

Review of R74's medical record notes R74 was admitted to this facility on 11/10/2022 with diagnoses including schizoaffective disorder, bipolar type, insomnia, mild intellectual disabilities, intermittent explosive disorder, and auditory hallucinations.

There is no documentation found in R74's medical record noting R74 was receiving group therapy or 1:1 session with any PRSC from 11/10/22 through 1/18/23 when R74 was transported to the hospital for aggressive and socially inappropriate behaviors.

Review of V29's documentation in R74's medical record notes on 11/11/22, V29 completed an

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to the age of 18. IQ testing was administered on 10/4/22 with results 52.

V. Based on observation, interview and record review, the facility staff failed to follow their abuse policy and protect a resident from being recorded by staff posted the resident on social media. This failure affected 1 resident (R136) reviewed for abuse involving social media.

Findings include:

On 1/19/23 at 10:33am, R136 was observed on two different (social media) videos with V56 (Activity Aide). One video was of R136 and V56 dancing and turning around. The second video was of V56 looking up at R136 then looking back at the phone screen smiling with the caption, "when my resident say the wrong (ninja emoji) name on ft (facetime). Both videos had V56's (social media) name and the (social media) symbols and wording.

On 1 /20/23 at 2:24pm, V40 (Activity Director) said, my employees are not supposed to be making/recording (social media) of residents on their personal social media accounts. Our audio, video and photographic release form is for facility activities or facility related things only.

On 1/20/23 at 2:46pm, R136 who was assessed to be alert and orient to person, place and time said, I have never given anyone permission to post any videos of me on social media. I don't know what (social media) is. V56 (Activity Aide) took videos of me on her phone moving around and dancing. R136 identified V56 via photo. I don't want everyone to see me dancing because I wasn't dressed up in pretty clothing.

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Acknowledgment of Receipt of employee handbook dated 11/1/22 documents: V56's electronical signature.

Termination papers dated 1/19/23 documents: V56 failed to comply with social media section per employee handbook page 22 by posting a (social media) of a resident. On 1/19/23, V1 (administrator) was provide video evidence that employee (V56) posted (social media) with resident (R136) of facility.

Abuse policy dated 4/29/22 documents: Photographing and recording resident/social media. Staff photographing or recording resident or their private space (even if the resident is not present) for other than medical or facility purpose as described in a signed "audio, video and photographic release form is strictly prohibited. Staff posting or sending a photo recording on social media or otherwise keeping or sending a photo or record thorough multimedia messaging other than for facility purpose as described in a signed audio, video and photographic release form is strictly prohibited.

VI. Based on interview and record review, the facility failed follow the physician order to monitor and conduct neuro checks after a head injury. This failure affected 1 resident R43 reviewed for post injury monitoring.

Findings include:

R43 was admitted to the facility on 12/22/2020 with a diagnosis of schizophrenia and hypertension.
Progress note dated 1/8/23 at 3:08 pm: Resident walked out of his room and was sleeping walking towards the exit door. He was bumping his

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forehead into walls and doors. Laceration with dried blood noted to his forehead with minimal swollen.

On 1/8/23 at 4:20 pm, R43 was observed with dried blood on his forehead and swelling noted to the bridge of nose and forehead. R43 was unable to say what happened.

On 1/8/23 at 4:22 pm, V4 (Nurse) said she observed R43 wandering, and staff reported that he bumped his head into something. V4 said R43 had dried blood on his head. V4 said she did not notify the doctor or conduct neuro checks on the residents. V4 said R43 was placed on one-to-one monitoring with staff.

On 1/8/23 5:30 pm, V34(Nurse) said R43 head was swollen. V34 said she did not call the doctor or the family about change in condition and the nurse who was assigned prior should have completed notification. V34 said they were not conducting any neuro checks at this time.

On 1/11/23 at 10:30AM, V2(Director of Nurse) said any resident that experiences a head injury the doctor should be notified, and neuro checks should be initiated, documented in the resident chart. V2 unable to provide any further monitoring for R34.

R43's progress note dated 1/11/23 11:51 am documents: R43 was sent to local hospital. On 1/11/23 at 6:00 pm documents resident returned with a diagnosis of head trauma and abrasion.

On 1/12/23 at1 12:35 pm, V36(MD) said he was notified of incident with R43 but unable to recall who contacted him and instructed staff to conduct neuro checks. V36 said he would expect staff to

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follow orders.

VII. Based on observation, interview, and record review, the facility failed to monitor residents during smoking breaks to prevent resident from bringing in smoking materials and smoking in an undesignated area. This affected 1 resident R98 reviewed for inappropriate smoking in the sample of 35.

Findings include:

R98 was admitted to facility on 5/2/22 with a diagnosis of schizoaffective disorder, alcohol abuse, major depressive disorder, nicotine dependence.

R98 smoking risk assessment dated 1/5/2023 documents: minimal problem for potential risk recommended require supervision only not able to store smoking materials.

On 1/8/23 at 10:04 am, R98 was observed smoking in her room. R98 said she took cigarettes in from smoke break this morning. R98 had a pop bottle on nightstand with 5 cigarette buds in it and verified with V7 (Mental Health Tech). R98 denied having a lighter.

On 1/8/23 at 10:40 am, the East smoking area was observed with multiple cigarette buds scattered on the ground.

R98's care plan revised on 7/11/22 documents: I am an inappropriate smoker with following interventions dated 5/2/22: Resident will keep smoking materials in a secured location. Resident requires supervision while smoking; intervention dated 7/11/22. Resident will watch a smoking cessation video.

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R98's care plan and progress notes did not document any smoking violations on 1/8/23.

Smoking Policy documents: Staff responsibilities: staff will monitor residents removing cigarette buds from ashtrays or form the ground. Staff will empty and sweep before leaving the smoking areas as needed. All reports of residents who have smoking violations must be reported, documented, and followed up.

VIII. Based on observation, interview and record review, the facility failed to develop and implement effective fall prevention interventions for 2 residents (R68, R327) with a history of falls. This affected 2 residents (R68, R327) reviewed for fall prevention in the sample of 35. This failure results in R327 sustaining a fall requiring 6 sutures to her lower lip and R68 falling and sustaining bruising to his left eye.

Findings include:

1. R327 was admitted to the facility on 9/20/22 with a diagnosis of epilepsy, unsteadiness on feet and schizophrenia.

R327's minimum data set dated 9/27/22 documents under balance during transitions a score of one which indicates not steady but able to stabilize without staff assistance for moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfer. Under mobility device it indicates a walker.

R327's therapy notes 9/24/22 under fall assessment documents: does patient feel

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unsteady when standing-Yes; Does patient feel unsteady when walking- Yes; Does patient worry about falling- Yes. Under ambulation documents walk 10 -50 feet requires partial to moderate assistance.

R327's progress note dated 9/26/22 at 5:30 pm, Narrative: Writer notified by Mental Health Tech resident had fallen as she was coming out her room. Resident assisted to her bed.

R327's Progress note 10/2/22 at 9:07 am documents: Nurse was informed by residents' roommate that she found her on the floor after coming in from breakfast. Full body assessment was preformed, vitals were checked and were within normal limits. Resident states that she hit her head and busted her lip on the nightstand.

R327's hospital record dated 10/2/22 documents: R327 states she tripped on something and fell on her face. 6centimeter laceration to lower lip down to subcutaneous tissue. Six sutures placed to lower lip.
R327's fall care plan dated 1/9/23 documents: 9/26/22 Physical therapy consult for strength and mobility; assessed for injury. 10/2/22 documents: continue with physical therapy for strengthening and mobility; neuro checks for 72 hours; refer to pharmacy for medication review.

On 1/10/23 at 12:30 pm, V17(Restorative Nurse) said she was unsure if R327 was on therapy prior to first fall. V17 said the interventions were to continue therapy for strength and mobility. V17 said they offered R327 a walker after the second fall, but she refused. V17 said she was unable to provide any documentation related to medication review or neuro checks performed. V17 was unable to provide another care plan with initiated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 37 dates for care plan interventions. On 1/13/23 at 3:56PM, V21 (Mental Health Tech) said he recalls R327 falling a couple of times but unable to recall exact dates. V21 said R327 could not stand by herself, and he would sit outside her room to assist with getting things for her. R327 needed to hold on your arm or side rail to keep herself up when walking. R327's fall risk assessment dated 9/26/22 documents not at risk for falls. Under gait/balance documents: balance problem when walking. Facility fall prevention program reviewed 1/22 documents: care plan incorporates identification of all risk/issue, addresses each fall; interventions are changed with each fall; preventative measure. Resident environment will be kept clear of clutter which would affect ambulation and remove hazards. 2. R68's diagnosis includes but not limited to Epilepsy, Schizoaffective Disorder, Dementia, Psychotic Disturbances, Mood Disturbances, and Anxiety, and Severe Intellectual Disability. Incident report dated 11/26/21 notes R68 noted running in the hallway when he slipped and fell. Progress Notes dated 10/22/22 documents maintain fall/safety precautions. Incident report dated 1/2/23 notes R68 was running in the hallway and fell. Report noted R68 was unable to provide description. Nothing was cited on precipitating and contributing factors. Report notes R68 sustained a swollen eye.	S9999		

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Fall Initial Occurrence for R68 dated 1/2/23 documents a fall occurred in the hallway. Description notes R68 was running in the hallway and fell. It is documented R68 was "unable to provide a description." Precipitating and Contributing Factor has nothing selected. Nero-checks notes the this was witnessed and R68 struck his head. Orientation of R68 notes e is alert and oriented to time, person, place, and situation. New injury observed "swollen eye." Report completed by V20 (Licensed Practical Nurse/LPN).

On 1/8/23 at 9:58 am, the surveyor observed R68 walking in the hallway without socks or shoes.

On 1/8/23 during initial round approximately 10:00 am R68 was observed ambulating without shoes or socks on in the hallway.

On 1/8/23 between 10:30 am-11:00 am R68 was walking barefoot, no shoes or socks on in the hallway. R68 was observed with dark bruised, black eye, to left eye.

On 1/9/23 between 10:30 am-11:00 am R68 was observed by the surveyor walking from the west unit to the central unit with no socks or shoes on. The surveyor did not observe any staff offering him socks, grip socks, shoes, approach, or redirect R68 for footwear.

On 1/9/23 at 12:00 pm V6 (Registered Nurse) said they told me R68 fell. V6 said she was told R68 fell face down and got a black eye. V6 said R68 goes running in the halls. V6 said she saw R68 running in the hall on 1/2/23 and I told his nurse to do something.

On 1/9/23 at 12:24 pm V20 (Licensed Practical

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Nurse/LPN), said I was told earlier that R68 was running up and down the hall (V20 unable to say who told her or when). V20 said V21 (Mental Health Tech/MHT), called me and said R68 fell in the hallway. V20 said I didn't see him on the floor. V20 said R68 had been at baseline before he fell. V20 said after the fall I assessed R68. V20 said R68 is not verbal, he just made his noises, his vitals were normal, and the bruising and swelling started later that day. V20 said the bruising and swelling progressed overnight. The surveyor asked V20 if R68 was at risk for falls and V20 said R68 doesn't have falls. V20 said I think R68 was running, and he fell.

On 1/9/23 at 12:36 pm V21 (MHT), said he saw R68 was running in the halls on 1/2/23. V21 said when R68 is running we usually redirect him. V21 said he told R68 to stop running and then R68 fell. V21 said he saw R68 tripped and hit the wall or the floor, and then bounced up like nothing happened. V21 said it was loud when he fell, you heard it. The surveyor asked what footwear R68 was wearing when he fell, V21 responded he is "almost positive barefoot."

On 1/9/23 at 12:46 pm V7 (MHT), said I have seen R68 running in the halls.

On 1/10/23 at 9:57 am V22 (Certified Nurse Assistant/CNA) said R68 is compliant. V22 said R68 "gets the zoomies, fast running like he is doing the track".

On 1/10/23 at 10:20 am the surveyor observed R68 sitting in his bed with regular socks on. The surveyor asked V32 (CNA) to show the surveyor R68's shoes. V32 said R68 doesn't have any shoes.

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1/10/23 at 12:52 pm V17 (Restorative Nurse) said when a fall occurs, we do team root cause analysis. V17 said I will enter the intervention in the care plan once determined. V17 said I would expect staff to carry out the interventions listed on the care plan. V17 said R68 is complaint with care.

On 1/11/23 at 10:31 am V2 (Director of Nursing) said on 1/2/23 R68 was observed by staff running in the hall and fell and hit his face on the floor. V2 said running is not a new behavior for R68. V2 said when R68 is observed running staff can redirect him. V2 said most of the time R68 responds to redirection, is cooperative, and I don't think he has fallen before. V2 said I do not think he was wearing footwear when he fell on 1/2/23. V2 said R68 is notorious for walking barefoot. V2 said staff should be offering to apply footwear if R68 has no shoes on. V2 said if R68 refuses then the staff should let the nurse know that they offered footwear and R68 said no. V2 said interventions for R68 can be trying to walk with him, offer a snack, and offer nonpharmacological interventions. V2 said R68 responds "fairly well" to nonpharmacological interventions. V2 said when R68 is running back and forth, it is not every day, and I would have someone with him to monitor him.

Care plan initiated on 4/5/17 notes R68 has impaired cognitive function and impaired thought process related to impaired decision making related to Dementia. On 11/16/21 a care plan was initiated for potential for falls related to use of psychotropic medication and seizure disorder intervention dated 11/16/21 noted appropriate footwear. No intervention is documented on the care plan following R68's fall on 1/2/23. No behavior of R68 running while inside the facility is

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documented. Additional, care plan initiated on 11/30/21 notes I am at risk for fall/injury related to wandering/poor safety awareness.

The facility Fall Prevention Program revised on 11/21/17 states the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized, as necessary. Care plan incorporates identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, preventative measures. Footwear will be monitored to ensure the resident had proper fitting shoes and/or footwear is non-skid.

"A"